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(Im)possible Patients?

Negotiating discourses of trans health in the UK

by

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Table of Contents

Acknowledgements	vi
Declaration	vii
Abstract	viii
List of Abbreviations	ix
Dedication	x
1. Introduction: Coming to terms with trans health	
Trans health...who cares?	1
Framing the project	4
<i>Terms of analysis</i>	7
A transgender tipping point?	11
2. Condition or Movement? A genealogy of trans discourse	
Discursive repertoires: unpacking trans possibility	13
<i>Repertoires of possibility</i>	15
Condition and cure: fixing trans	16
<i>Sexual inversion</i>	16
<i>Transvestism and transsexualism: grounds for transition?</i>	18
<i>The power of a diagnosis</i>	21
<i>An 'intermediate type': the transgenderists</i>	25
<i>Shadows of the Empire: radical feminist critiques</i>	26
'A Movement Whose Time Has Come': the emergence of 'trans'	28
<i>Individual movement: the gender outlaws</i>	29
<i>Social movement: collective transgender solidarity</i>	32
<i>The transsexual condition: rejecting movement?</i>	33
<i>Trans movement language and activism</i>	34
<i>Naming oppression: transphobia and cisgenderism</i>	37
Movement as condition: towards a more inclusive model of trans health?	40
Condition as movement: towards gender pluralism	41
<i>Sociological understandings of trans possibility</i>	41
<i>Qualitative accounts of trans health</i>	44
<i>Quantitative and mixed-methods accounts of trans health</i>	47
Conclusion: negotiating medical discourse	48

3. Trans Health in Practice: Conditions of care, 2010-2016

Not worth the trouble?	51
The wider context of trans health	53
<i>A right to good care?</i>	56
Gender identity services: the patient journey	57
<i>Diagnostic criteria</i>	57
<i>NHS gender identity services: a linear pathway?</i>	59
<i>Referral and waiting</i>	60
<i>Waits within the system: assessment, diagnosis and Real Life Experience</i>	62
<i>Hormones and surgery</i>	65
<i>Private pathways and the politics of provision</i>	67
<i>Self-medication</i>	69
<i>Gaming the system?</i>	70
Reform and austerity: 2012-2016	71
<i>Changes in Scotland</i>	71
<i>Abolition of PCTs</i>	71
<i>NHS England: national funding and a new protocol for England and Wales</i>	72
<i>Waiting times</i>	73
Conclusion: characterising care	74

4. Evoking the Field: Methodological and ethical considerations

At the heart of the matter	76
Epistemological considerations	77
Locating discourse online	79
<i>The Internet as a repository of trans stories</i>	79
<i>The Internet as social reality</i>	81
<i>The Internet as 'space': three spheres</i>	82
<i>The Internet as material encounter</i>	84
Exploring the field	84
<i>Defining the scope of the field</i>	85
<i>Digital notetaking</i>	87
<i>Temporal features of the field</i>	87
<i>'When' did the fieldwork take place?</i>	89
<i>Engaging in analysis</i>	89
Positionality: my relation to the field	91
<i>Centring trans voices</i>	91

<i>'Insider' research? Turning a critical lens on myself</i>	92
Ethical considerations	95
<i>Responsibility to participants</i>	95
<i>Responsibility to self</i>	99
Conclusion: state of the heart	103
5. (Re)defining Trans: Intersecting possibilities of being	
Cisgenderism and the bounds of possibility	104
Transsexual histories and posttranssexual possibilities	107
Conditional possibilities	110
<i>Trans as transition</i>	111
<i>Gatekeeping: the gender experts</i>	113
<i>Reifying identity through medical discourse</i>	117
The possibility of movement	123
<i>Alternatives to the transsexual narrative</i>	123
<i>Embracing diversity? Building trans communities</i>	124
<i>'Be yourself': validation through individual belonging</i>	127
When discourses clash: unpacking differing understandings of trans health	129
<i>'Misgendered three times': essentialising gender, erasing trans realities</i>	129
<i>'Trans Broken Arm Syndrome': transition as definition</i>	131
<i>'My name change was too ambiguous': authoritative expertise vs personal identity</i>	133
Conclusion: the (im)possibilities of trans patienthood	136
6. Trans Temporalities: Imagining a future in a time of anticipation	
Living in the time of anticipation	138
Interrogating trans temporalities	141
<i>Telling anticipatory stories</i>	145
The long wait	147
Mistrust	150
<i>Background: narratives of cisgenderism and transphobia</i>	150
<i>Fearing mistreatment</i>	153
<i>Strategic futurities</i>	154
<i>Myths of malpractice?</i>	156
'Trans enough' to pass the test: anticipating difficulty in assessments	158
<i>Anticipated difficulty</i>	158

<i>Preparing for the test</i>	159
<i>Failing the test?</i>	161
The possibility of joy: a discourse of hope	164
Circumventing the time of anticipation: private treatment and self-medication	167
Suicide, and the collapse of possible futures	171
In which I continue to wait (a contingent conclusion)	174
7. Changing Trans Health: Negotiating credible knowledge	
A Trip To The Clinic	176
Establishing credibility: the epistemic politics of trans health	180
Recognition and repetition: promoting patient knowledges	183
<i>Personal or individual interventions</i>	185
<i>Interventions from journalists</i>	188
<i>Interventions from health-oriented professionals</i>	190
<i>Collective activist interventions</i>	192
<i>Expertise through authority; authority through expertise</i>	196
Negotiating change: the depathologisation and non-binary movements	198
<i>Discursive shifts: embracing movement?</i>	198
<i>The depathologisation movement</i>	201
<i>The non-binary movement</i>	207
Conclusion: the epistemic politics of epistemic analysis	211
8. Conclusion: Towards affirmative care?	
'Living like a woman': gatekeeping, power, and models of care	214
Producing, reifying and legitimating trans possibilities	217
<i>Contribution to knowledge</i>	219
Negotiating discourses of trans health	220
<i>Individual negotiations</i>	220
<i>Collective negotiations</i>	221
<i>Negotiating the field of trans health as a social researcher</i>	222
<i>Contribution to knowledge</i>	223
Beyond assessment	224
<i>Looking to the future</i>	225

postscript: mists and landscapes	227
Appendix: A sketch of the field	228
Activist sphere	228
<i>Blogs and activist websites</i>	229
<i>Facebook</i>	230
<i>News media</i>	231
<i>Twitter</i>	231
<i>Miscellaneous</i>	232
Community sphere	232
<i>Forum 1</i>	233
<i>Forum 2</i>	233
Practitioner sphere	233
Bibliography	237
<i>Acts of Parliament</i>	262

List of Images and Tables

Figure 1: A Trip To The Clinic (a)	176
Figure 2: A Trip To The Clinic (b)	176
Figure 3: A Trip To The Clinic (c)	177
Figure 4: A Trip To The Clinic (d)	177
Figure 5: A Trip To The Clinic (e)	178
Figure 6: Five models of care	215

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Declaration

I declare that the contents of this thesis are my own work, and that no material within has been submitted for a degree at any other university.

I have drawn upon reflections and findings from this project for the following conference presentations:

Pearce, R. (2011) *Transgender: Time to Recognise Change?* Presented at: 'Trans* Education and Determination', King's College London.

Carrigan, M., Moon, L. & Pearce, R. (2012) *Mind the [Gap]: Emotionality, Social Change and Research Cultures Within Sexuality Studies*. Presented at: 'Sexual Cultures Conference: Theory, Practice and Research', Brunel University.

Pearce, R. (2014) *#transdocfail: What makes a Twitterstorm important?* Presented at: 'British Sociological Association Annual Conference', University of Leeds.

Pearce, R. (2014) *To those who would exclude me from feminism*. Presented at 'Daring to be Bad? An interdisciplinary workshop', University of Warwick.

Pearce, R. (2015) *Trans temporality: Anticipation and fear in accessing healthcare*. Presented at 'Trans* Health Workshop', King's College London.

Fernandez, J., Gupta, K., Pearce, R., Stewart, J. (2015) *Trans* and non-binary activism*. Keynote panel at 'Sexual Cultures 2: Academia meets Activism', University of Sunderland.

Pearce, R. (2015) *Living in Trans Time*. Presented at 'The Subjectivity of the Body in Mental Health', University College London.

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Pearce, R. (2016) *Reconceptualising Trans Health*. Presented at: 'LGBT Workshop: "Inclusion"', University of Warwick.

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Abstract

Trans people are increasingly visible in society, yet remain highly vulnerable to ignorance and discrimination. This can be particularly damaging in the context of healthcare, where trans people often find it difficult to access both general and specialist services. However, trans people are not powerless; they frequently exercise agency in navigating and addressing challenges in healthcare settings.

This thesis provides an ethnographic account of how *discourses* of trans health are negotiated in the UK within and between trans community spaces, activist groups and the professional sphere of medical practice. A descriptive and interrogative account of healthcare services and health literatures is provided; this is interwoven with an analysis of emotional and temporal narratives of patient experience, as constructed collectively on the Internet. Drawing upon conversations, articles and documents produced and/or published online, the thesis explores how competing and intersecting understandings shape not only the material conditions of healthcare, but also the means by which trans identities and experiences are defined and made possible.

Trans possibility is conceptualised in terms of two overarching discursive repertoires: 'trans as condition' and 'trans as movement'. The former emerges largely from medical accounts, and broadly positions 'trans' as clearly definable and delineated. The latter emerges largely from the ideas of the emergent trans social movement and broadly positions 'trans' as queer, fluid and flexible. Health professionals, trans patients and activists draw differently upon discourses of condition and/or movement within a range of contexts in order to justify, reify, survive or question modes of healthcare provision and understandings of trans possibility.

This thesis concludes that interactions between trans patients and the practices of specialist 'gender identity' services play a particularly key role in mediating discourses of trans health. Through understanding this process, we might better understand and address the wider challenges that trans people face.

List of Abbreviations

The following abbreviations are used in this thesis.

CCG:	Clinical Commissioning Group
CRG:	Clinical Reference Group
DSM:	Diagnostic and Statistical Manual of Mental Disorders
FTM:	Female-to-Male
GIC:	Gender Identity Clinic
GIRES:	Gender Identity Research and Education Society
GMC:	General Medical Council
GP:	General Practitioner
GRA:	Gender Recognition Act 2004
GRC:	Gender Recognition Certificate
HBS:	Harry Benjamin Syndrome
HRT:	Hormone Replacement Therapy
ICD:	International Classification of Diseases
MTF:	Male-to-Female
NHS:	National Health Service
PCT:	Primary Care Trust
RLE:	Real Life Experience
WPATH:	World Professional Association for Transgender Health

This work is dedicated to the memory of:

Helen Thomas

1989 - 2013

Sophia Butler

1994 - 2015

1

Introduction

Coming to terms with trans health

It can be seen from the search strategy and inclusion criteria that trans health research was originally going to be included in this systematic review. Unfortunately, having trawled through all of the literature, no peer-reviewed and published UK- specific information was found on the general health of trans people.

- Catherine Meads and colleagues (2009)

No social study that does not come back to the problems of biography, of history and of their intersections within a society has completed its intellectual journey.

- C. Wright Mills (1959)

Trans health...who cares?

The origin of this project lies in the emergence of sexology in the late 19th Century, as learned doctors sought to describe and categorise the deviant behaviour of those who failed to conform to norms of sex and gender.

The origin of this project lies in the emergence of 'transsexualism' in the mid-20th Century, as a means by which individuals desiring social and physical transitions from one gender to 'the other' could be identified and managed.

The origin of this project lies in the emergence of the 'trans' movement in the 1990s, which sought to redefine and recognise a great range of gender variant identities and experiences as an aspect of human diversity, rather than as conditions requiring treatment.

The origin of this project lies in the emergence of my own trans identity in the early years of the 21st Century, as a lonely teenager reaching out for solace, support, understanding and community on the Internet.

The origin of this project lies... in a warm Birmingham meeting room gently devoid of character, in which I sat listening to presentations in March 2009. Spring was (in theory) just around the corner, but that wasn't apparent on this overcast day, with its blustery wind and occasional showers of rain. I was attending a seminar entitled *LGBT Health...Who Cares?* as a representative of the loosely-organised, broadly Internet-based national advocacy and support group Trans Youth Network. The short walk to the venue from the train station had been somewhat challenging; I was in the latter months of a gruelling recovery from the surgery I had undergone the previous summer, in what I imagined at the time to be the final stage of my long social and physical transition from 'male' to 'female'.

I listened to a number of fascinating presentations on LGBT health that day, delivered variously by practitioners, social researchers and community advocates. What played on my mind after the event, however, was not any particular item of information I had picked up. Rather, it was the expressed *lack* of information on *trans* health in the UK, as exemplified in the quote from Meads et al. (2009) that opens this thesis. I felt that this gap in knowledge was particularly concerning given the exceptionally high rates of discrimination, harassment and violence faced by trans people in all areas of public life (Whittle et al., 2007).

Catherine Meads and colleagues – who launched their research review at *LGBT Health...Who Cares?* – understood 'trans' as an umbrella term, incorporating a range of identities and experiences that might be variously described as 'transsexual', 'transgender', 'transvestite', or 'crossgender' (Meads et al., 2009: 95-100). This understanding recognises 'trans' as emergent from both medical accounts and collective social movement, with links forged between each constituent social category on the grounds of shared marginalisation. The flexible Trans Youth Network definition of 'trans' was wider still, reflecting a move towards open-ended accounts of trans possibility within the connected worlds of trans activism and academia. For instance, Stephen Whittle describes how:

A trans identity is now accessible [...] to anyone who does not feel comfortable in the gender role they were attributed with at birth, or has a gender identity at odds with the labels 'man' or 'woman' credited to them by formal authorities. (Whittle, 2006: xi)

It is this 'open' definition of trans possibility that informs my own use of the term 'trans' throughout this thesis. I use it to refer to a wide repertoire of identities,

experiences and modes of gender presentation. The trans possibilities found within this repertoire are frequently – but *not always* – linked to a notion of social and/or physical ‘transition’, from an attributed or assigned gender to an alternative preferred, desired or felt state of gendered (or non-gendered) subjectivity.

As Meads et al. (2009) note, research on *trans health* typically focuses only on the transition process; indeed, the authors’ extensive review failed to uncover a single peer-reviewed article looking at trans health more widely. Moreover, I would soon discover that critical, UK-based academic accounts of the *trans-specific* ‘gender identity’ services created to facilitate physical transition – through the provision of hormones, surgeries, hair removal and/or voice therapies – were also rare outside of the medical literatures. This is because the intellectual field of trans health has historically been shaped by the health professionals who oversee gender identity services. However, since the 1990s in particular, a range of alternative approaches to categorisation, diagnosis and treatment have begun to emerge from the trans movement, reflecting (and drawing upon) similar contestations in the realms of feminist and queer health (Hanssmann, 2016). It is within this tradition that my project is located.

I left *LGBT Health...Who Cares?* feeling inspired and motivated to address the ‘gaps’ in the literature. As both a trans patient and an active member of trans community groups, I felt intimately connected to the challenges faced by trans people in accessing healthcare services. My transition had been a lengthy process, mediated by multiple appointments, assessments and waits. Having first approached my GP for help at the age of 16, I eventually found myself attending the ‘Charing Cross’ gender identity clinic in London almost four years later. I received approval for hormone therapy around the time of my 20th birthday, and eventually acquired my first hormone prescription after a wait of around four months. I was nearly 22 by the time I underwent an operation to surgically reconfigure my genitals. In the meantime, I had found my GP to be indifferent at best and obstructive at worst; he was dismissive in appointments, denied me access to the regular blood tests required by the gender clinic, and misgendered me in my medical records.

In conducting a sociological investigation into trans health, I have sought to connect these ‘personal troubles’ to wider ‘public issues’ (Mills, 1959: 8). I was aware even back in 2009 that my own frustrating experience of long waits and extensive assessment procedures for physical transition, coupled with the definite ignorance and suspected bigotry of my GP, paled in comparison to the challenges faced by many of my peers. I felt that my progress through the transition period had, in relative terms, been quick

and easy. This was facilitated by the support of local health commissioning bodies, and the manner in which my relatively straightforward (white, middle-class, abled, English) female gender identity happened to 'fit' the existing diagnostic models and modes of assessment. By contrast, I had met trans people who spent years fighting for funding from their local commissioning bodies, whilst others – particularly those whose gender identities could not be categorised straightforwardly into the normative male/female binary – had trouble meeting the clinical criteria for treatment even as they experienced severe dysphoria. Within the wider realm of healthcare provision beyond the trans-specific gender identity services, trans people I knew were insulted and harassed (sometimes sexually) by health professionals, and denied treatment even for conditions to which their being trans was entirely irrelevant.

As the literature that has emerged since 2009 shows, the experiences of my trans friends and acquaintances are part of a wider picture in which trans people continue to be marginalised for our non-normative relation to sex¹ and gender (McNeil et al., 2012; Stryker & Aizura, 2013; Reisner et al., 2016). This informs acts of ignorance and prejudice that remain widely unaddressed within contexts such as the UK's National Health Service (NHS) (Bailey & McNeil, 2013; Ellis et al., 2015; Barrett, 2016; European Union Agency for Fundamental Rights, 2016; Women and Equalities Committee, 2016). Problems such as these within healthcare settings and beyond can be linked to a high prevalence of mental health problems amongst the trans population, with approximately a third of trans people attempting suicide (Whittle et al., 2007; McNeil et al., 2012). There is therefore a vital need to better understand trans health and address the issues reported by trans patients.

Framing the project

In seeking to address the issues outlined above within the context of a social research project, I came to realise that simply addressing a perceived 'gap' in academic discourse and understandings would be insufficient. If it was enough to note that trans people face discrimination and ignorance in public life, then these issues might have been tackled decisively at least two decades ago. However, it is apparent that both discrimination and ignorance are rooted in *different* understandings of what it *means*

¹ This thesis primarily addresses the *social* process of 'doing' gender (West & Zimmerman, 1987). On occasion, this social process is relevant to conversations around 'sexual' features of the *physical* body. However, my analysis with regards to embodiment focuses primarily on how the 'sexed' body is 'gendered'. As such, I occasionally refer to the use of language around 'sex' (e.g. 'opposite sex') in terms of 'gendering' processes.

to be trans and/or gendered. For instance, the broad scope of trans possibility as understood by writers such as Whittle and grassroots organisations such as Trans Youth Network contrasts with the more rigid categorisation employed by the health professionals who assessed me at the gender clinic. Similarly, my understanding of myself as a *woman* contrasts with my former GP's view that I was 'really' a man, as evidenced by his use of male pronouns in reference to me in my medical notes. This thesis therefore goes beyond simply chronicling the challenges faced by trans patients, to ask *why* these differences of perspective occur, *how* they might be characterised, and in *what ways* they might be linked to the complex interaction of 'medical' and 'trans' ideas both historic and present. I frame these queries in the context of two key research questions:

- 1) How are the meanings and possibilities of 'trans' produced, reified and legitimated through health discourses and practices?
- 2) How are discourses of trans health *negotiated* within and between trans community groups, trans activists and health professionals? How are they disseminated, and how are they contested?

Through asking these questions, I aim to uncover how both 'trans' and 'trans health' are *understood* in multiple contexts, in order to grasp the social processes at play in encounters where trans patients feel marginalised, misunderstood and/or discriminated against. In these questions I also recognise that – like this project – both 'trans' and 'trans health' have multiple points of origin and definition. In discussing 'health' within this thesis, I focus primarily on *healthcare provision*, looking at trans patients' discursive interactions with the organisations and individuals that offer these services. In analysing *discourse* I seek to centre the importance of narrative in generating understanding and mediating relations of power, thereby asking '[w]ho is telling the story [of trans] for whom?' (Stone, 1991: 228) in the context of healthcare provision.

With this approach, I position my project within a wider poststructuralist framework. Poststructuralism 'asks us to consider the ways in which subjects are constituted in and through social institutions and the *language* employed by these [...] bodies', thereby enabling scholars to 'examine the *constitution* of subjectivity in social life' (Namaste, 2000: 16-17, emphasis mine). However, I also follow poststructuralist sociologists of transgender such as Surya Monro (2005), Sally Hines (2007) and Zowie

Davy (2011) in looking beyond language in and of itself, to link my discussion of discourse to an acknowledgement of the *material conditions* of trans health.

In responding to the research questions, this project primarily draws upon and contributes to the interdisciplinary field of transgender studies.² Transgender studies can be understood as ‘an effort to account for the profound shifts in culture, society, and political economy that are indexed by *transgender’s* dramatic emergence and rapid dissemination more than two decades ago’ (Stryker & Aizura, 2013: 3, emphasis in original). The field coalesced in response to the othering of trans people within the academy prior to the 1990s, with trans people presented as deviant bodies, medical curiosities and/or metaphorical figures stripped of agency within a range of disciplines (Stone, 1991; Stryker, 2006). Transgender studies therefore speaks to the discourses around trans possibility and the lived experiences of trans people in order to produce ‘desubjugated knowledges’ (Stryker, 2006), but also looks beyond these in demonstrating the relevance of ‘trans’ insights for wider understandings of social and political phenomena.

The first research question for this project was originally phrased in a manner that more closely reflected the *wider* concerns of transgender studies. I asked: ‘In what ways does “trans” reflect a point of convergence for multiple discourses of healthcare provision?’ In this way, I originally sought to position the project specifically within the sociology of health, by asking how ‘trans’ might help us better understand social and cultural determinants of health (White, 2002; Wilkinson & Marmot, 2003) and address contemporary phenomena such as privatisation, neoliberalisation and individualism within the UK’s healthcare system (Rose, 1996; Department of Health, 2010; Tallis, 2015). However, as the project progressed I began to realise that a story was emerging *about ‘trans’* in the context of healthcare provision, rather than the other way around. I had obtained a great wealth of data that enabled me to examine how trans subjectivities are produced and mediated through trans people’s interactions with healthcare systems, particularly gender identity services. This is important because it speaks to my initial concern to account for trans experience, and produce research that is relevant specifically to improving trans lives. It is for this reason that I effectively

² I largely use ‘transgender’ interchangeably with ‘trans’ in this thesis, as both are employed in a range of settings as umbrella terms and/or fluid categories in a manner similar to that described by Whittle (2006). Whilst my own preference is for ‘trans’, context occasionally dictates that ‘transgender’ is more appropriate. For instance, given the great range of words that include the prefix ‘trans-’, ‘transgender’ is useful for cataloguing academic work within contemporary online databases and search engines; hence, ‘transgender studies’. Similarly, as I discuss in Chapter 2, the ‘trans movement’ initially used ‘transgender’ instead to denote solidarity between gender variant peoples.

'reversed' the question, providing the basis for an analysis that centres the emergence and negotiation of trans discourse, and the *meaning* of this for trans patients in a range of settings. The sociology of health is therefore presented as one of a number of secondary literatures that this thesis draws upon and contributes to, in addition to literatures of feminist theory and Internet studies. Moreover, this thesis directly engages with and speaks to the literatures of trans health within the psychological, psychiatric and therapeutic fields.

Terms of analysis

This thesis provides an ethnographic examination of the production, dissemination and negotiation of discourse and practice pertaining to trans health in the UK between 2010 and 2016. The fieldwork for this project was undertaken on the Internet, in recognition of the great importance of online communities for bringing together the largely disparate and frequently invisible trans population (Whittle, 1998; Shapiro, 2004; Ekins & King, 2010). Internet research enabled me to observe conversations taking place within trans community spaces and activist groups over an extended period of time. It also gave me access to a wide range of blogs and media articles written by trans people, alongside websites and documents produced by and for health professionals and service providers. I frequently found myself present within this field as a blogger, social media user and as a trans patient myself; consequently the project also features autoethnographic elements as I seek to position and analyse my own presence within the field. This approach provides a qualitative empirical grounding for the claims that follow.

My first research question asks how the meanings and possibilities of 'trans' are produced, reified and legitimated through health discourses and practices. In responding to this question, I conceptualise trans *meanings* and *possibilities* in terms of two intersecting discursive repertoires that work to inform conceptualisations of trans health, as well as policy and practice: 'trans as condition', and 'trans as movement'.

Discourses of *trans as condition* frame 'trans' as fixed and *fixable*. 'Trans' in this sense is also *resolvable*: whether as medical condition or social condition, it can be clearly defined and delineated, whilst the problems it raises can be addressed and managed in a particular way. Fixing or resolving 'trans' typically entails a certain level of expertise: in this sense, 'trans' is also *conditional*, in that it requires identification

from a qualified expert such as a health professional with reference to a set of quite static criteria, usually rooted within binary conceptions of gender.

Discourses of *trans as movement* recognise the potentiality and actuality of changes to theory, subjectivity, embodiment, space and temporality, taking place through continual creation, fluidity and worldbuilding. Rather than being a categorical matter, 'trans' in this context describes an open-ended 'movement across a socially imposed boundary away from an unchosen starting place' (Stryker, 2008: 1). 'Trans as movement' can hence refer to collective 'social movements' – that is, 'politicised communities of identity' (Stryker, 2006: 5) – but I also use the phrase to describe queer discourses of individual identity and experience. Expertise on 'trans' possibility is in this context typically located in 'the movement', be that social movement or individual subjectivity.

Discourses of trans as movement – and, in particular, the notion of *trans* itself – emerged from critiques of trans as condition by writers such as Sandy Stone (1991) and Leslie Feinberg (1992). These interventions are often said to have heralded a change in paradigm (Nieder et al., 2016). For instance, Walter Bockting (2009a: 104) describes 'a shift from a disease-based model (something went wrong during the individual's development that needs to be corrected) toward an identity-based model of transgender health'. However, paradigmatic accounts such as this risk creating a simplistic binary between disease or pathology on one hand, and social or political identity on the other. While the empirical findings of this project *do* broadly support Bockting's account of a discursive shift, I also show how conditional notions of trans as pathology continue to powerfully frame both the provision of healthcare services and the construction of trans subjectivity. Moreover, through the wider concept of *condition*, I seek to explore the discursive links between medical accounts of disease and pathology, trans notions of fixed and definable identity, and, briefly, gender essentialist and radical feminist accounts of trans *impossibility*. In describing 'discursive repertoires', therefore, I intend to broadly categorise ideas on the basis of discursive similarity, while also creating space for difference and contestation *within* categories.

My second research question asks how discourses of trans healthcare provision are *negotiated* within and between trans community groups, trans activists and health professionals. Like Maria do Mar Pereira (forthcoming), I regard negotiation in this context as an ongoing social process 'without rest', in which change arises from *constant* interventions on the part of trans patients and activists as well as health

professionals. Trans health can be negotiated on a personal level, as patients and practitioners navigate practical, emotional and temporal challenges within healthcare systems; it can be negotiated on a collective level, as community members engage in identity work and/or practices of mutual support and care; and it can be negotiated on a political level, as various parties seek particular changes or continuities within the realm of service provision. In light of these complexities, I follow Kyra Landzelius (2006: 536) in understanding 'patienthood' not simply as a site of 'affliction, treatment and research', but as a 'field of contention' and the possible basis for 'experiment[s] in power-sharing'.

The next three chapters of this thesis provide some initial responses to these questions, as well as context for the research findings that follow. Chapter 2, *Movement or Condition?*, offers a genealogical account of the discursive repertoires of trans as condition and trans as movement. In it, I describe the negotiation of differing positions on trans condition and movement by health professionals and radical feminists as well as trans patients, activists and academics. In addition to providing a roughly chronological history of ideas, I structure the discussion around Emmi Vähäpassi's (2013: 32) call to focus on the 'urgent', grounded question of how trans lives become 'liveable'. The chapter thereby offers a review of literature – focusing particularly on historical clinical accounts, feminist interventions and transgender studies – in order to explore how contemporary 'trans' possibilities have emerged through categorisation and contestation, and to explain why medical discourse played a particularly important role in this process. I also provide a theoretical framework for the thesis, locating my work within a recent, 'gender pluralist' (Monro, 2005) turn within the sociology of transgender.

Having provided a broad account of trans discourse in the second chapter, Chapter 3, *Trans Health in Practice*, focuses on the very specific topic of healthcare provision in the UK during the 2010s. In this chapter, I describe the *material context* of this project in terms of both public and private healthcare provision, making visible the systems that trans patients must negotiate in order to access care. I outline the medical pathway and extensive assessment procedures for the trans 'condition' with reference to clinical guidance such as Barrett (2007) and public health documents such as the *Gender Reassignment Protocol* (NHS Scotland, 2012) and *Interim NHS England Gender Dysphoria Protocol* (NHS England, 2013), whilst also examining the challenges faced by patients outside of trans-specific services. I show how this context has been shaped by recent political events such as the passage of the Equality Act 2010 and the Health and

Social Care Act 2012, as well as by international guidance such as the World Professional Association of Transgender Health *Standards of Care* (Coleman et al., 2011). The discussion is framed by a description of the *power differentials* between practitioner and patient, as well as an account of *binary logic* in healthcare provision, as exemplified by the binaries of male/female and trans/not-trans. I further show how there has been a marginal shift away from this binary logic – and a slight relaxation of assessment procedures – due to ongoing reforms within the NHS.

In Chapter 4, *Evoking the Field*, I examine the challenges of researching trans health online. This chapter introduces the discursive context and electronic architecture of the online spaces in which I undertook ethnographic and autoethnographic fieldwork, drawing upon the literature of Internet studies (e.g. Kendall, 2002; Markham, 2008) to explore the complexities and benefits of empirical work in this area. Moreover, I provide a methodological account of decisions made for this project regarding data collection and analysis, thereby describing my own negotiation of the field as a researcher. With reference to reflexive methodological works such as Carolyn Ellis' (1999) *Heartful Autoethnography*, my narrative here focuses largely on the practical and ethical dilemmas and difficulties that arose during this project. I examine my own position in relation to the field as a trans scholar, with particular reference to my supposed 'insider' status, and to mental health problems that intersected with the immersive demands of my research methods.

Three chapters then focus on analysing the specific findings of this project. Chapter 5, *(Re)Defining Trans*, looks primarily at how a considerable number of the ideas and conflicts discussed within Chapter 2 remain relevant, as the discursive repertoires of trans as condition and trans as movement continue to operate within the contemporary settings of trans health in the UK. I examine how trans possibilities are both constructed and constrained within and between health services and trans community groups. In particular, I draw upon the concept of 'cisgenderism' (Ansara & Hegarty, 2012; Kennedy, 2013) to show how some trans narratives are rendered *impossible* within particular healthcare settings due to the power differential between practitioner and patient. I link this process to the challenges that many trans patients encounter in accessing treatment in a range of settings, with reference to the discursive clashes that can occur when health professionals and trans patients subscribe to different notions of trans possibility.

Chapter 6, *Trans Temporalities*, focuses on transitioning patients' collective temporal engagements with systems of healthcare provision that prioritise

understandings of trans as condition. This chapter unpacks the emotional experience of waiting, theorising this through a model of 'anticipation'. I examine how the temporality and emotional process of anticipation can shape patients' hopes, worries and despairs, as well as a common mistrust of health professionals. My analysis here draws particularly on theories of trans and queer temporalities (Halberstam, 2005; Muñoz, 2007; Carter, 2013; Horak, 2014) in order to describe the means by which transitioning patients draw upon community discourses in order to negotiate the typically stringent, binary-oriented requirements of assessment and diagnosis.

In Chapter 7, *Changing Trans Health*, I examine the negotiation of *change* within the realm of trans health through an analysis of epistemic politics (Epstein, 1996; Hess, 2004). I focus specifically on the process of trans patient advocacy, and the means by which individual interventions can collectively shape both discursive and material change. With reference to a number of case studies, including the depathologisation and non-binary movements (Nestle et al., 2002; Vähäpassi, 2013; Davy, 2015), I show how trans activists have sought to challenge the practitioner/patient power differential in both the micro-setting of the healthcare encounter and the macro-setting of medical discourse. I demonstrate that these challenges are most successful when trans knowledges are reproduced and established as credible through continual acts of mutual recognition and iterative citation in social media spaces, journalistic articles, guidance documents, academic papers and medical literatures.

Finally, in Chapter 8 I conclude the thesis with a summary of my arguments, relating these to the research questions raised in this chapter. I also take a further look at the discursive power wielded by gender identity specialists, and relate this to the manner in which 'trans health' might be constituted through the operation of this power.

A transgender tipping point?

The 2010s have been a time of both great change and considerable continuity for trans people. Even as I emerged from a seminar into the grey Birmingham streets with a sense of optimism back in 2009, I could not have anticipated the shifts in public, medical and trans discourse that were to take place over just a few years. The Equality Act 2010 enshrined in law protections from harassment and discrimination for a great many trans people in most areas of public life. The once quite private concerns of trans community and activist groups have become very public, buoyed by the opportunities

afforded to them by new platforms in the mainstream and social media. Terms such as 'trans' and 'genderqueer' have found their way into dictionaries and newspaper columns as trans people begin to appear more regularly on television and in film, in dramas, on reality television and in news programmes. In 2014 the influential American magazine *Time* featured out trans woman and *Orange Is The New Black* actress Laverne Cox on its front cover, and declared that 'the transgender tipping point' was at hand; a claim that has since been repeated or interrogated by numerous columnists within the UK media (Penny, 2014; Vaid-Menon, 2015; Loughrey, 2016). As I shall show, this very public emergence of 'trans' has also been accompanied by the growing presence and influence of trans people and trans ideas within the sphere of health.

However, as I cast my gaze back, the recent past is also disappointingly recognisable. Yes, the present 'tipping point' is perhaps unprecedented in offering some acknowledgement of contemporary *movement-oriented* 'trans' discourse (as opposed to the more *condition-oriented* discourses of 'transvestism' and 'transsexualism' that enjoyed more attention in the recent past). However, the emergence of high-profile American trans celebrities only echoes the media frenzy over 'GI turned blond bombshell' Christine Jorgensen in the 1950s, whose transition attracted more attention in the news than either the Korean War or the development of a polio vaccine (Stryker, 2008). Moreover, an increased public awareness of trans people and the establishment of new legal rights has not led to an immediate improvement in the lives of many trans people, particularly within the realm of health. Instead, the longitudinal findings of my project show a very gradual, complex process of change, mediated by the constant collective *work* of negotiation.

There is not one easy narrative to this tale of trans health, with a clear beginning and a neat set of findings and conclusions. However, I have sought to identify particular stories that can help us to understand the shape of the field, the origin and journey of ideas, the interplay of discourse and material experience. The 'tipping point' is perhaps too blunt a narrative for this task, denoting as it does a supposed point in time where one state simply gives way to another. By contrast, the threads of 'condition' and 'movement' – and *negotiation* between the two – enable a coherent and productive story to emerge, even as this thesis delves deep into the myriad investments and multiple complications of trans health.

2

Condition or Movement? A genealogy of trans discourse

Here on the gender borders at the close of the twentieth century, with the faltering of phallogentric hegemony and the bumptious appearance of heteroglossic origin accounts, we find the epistemologies of white male medical practice, the rage of radical feminist theories and the chaos of lived gendered experience meeting on the battlefield of the transsexual body: a hotly contested site of cultural inscription, a meaning machine for the production of ideal type.

- Sandy Stone (1991)

The epistemological habits of poststructuralist thought tend to be locked in the same questions; how have we come to understand transgender as we do, how is binary gender naturalized in the process, or how is it destabilized. While these questions are not wrong, they do not allow for other questions that might be more urgent, such as, how do lives become liveable, or how can more varied bodies and relationships between genders and bodies become liveable in today's world.

- Emmi Vähäpassi (2013)

Discursive repertoires: unpacking trans possibility

Two decades and a series of important discursive shifts lie between the quotes from Sandy Stone and Emmi Vähäpassi that open this chapter. During this time of ideas and change, the 'battlefield of the transsexual body' (Stone, 1991: 230) was seized upon by trans people themselves, who amidst 'the chaos of lived gendered experience' sought to inscribe new meanings and possibilities upon this contested cultural site, as well as upon wider social notions of trans and gender variant possibility.

This chapter describes the discursive negotiation of models of trans possibility that arise from medical literatures, radical feminist theories and an emergent trans movement. I show how contemporary understandings of trans identity and experience have their roots in the complex interplay of historical ideas, and how medical settings

in particular provide a means by which we can come to terms with the emergence and continual (re)definition of 'trans'. While the introduction to this thesis offered a definition of the term for the purpose of my own usage and claims, this chapter unpacks the multiple, competing and sometimes contradictory means by which trans might be understood.

Individual and collective bodies and histories, medical diagnoses and treatments, social and political phenomena, feelings and emotions may all be described in terms of trans language. 'Trans' is a historically and socially contingent term (Rubin, 2003; Stryker, 2006; Davy, 2010; Enke, 2012); it describes a contemporary, Western and (broadly) Anglophone collection of understandings related to a diverse range of gendered identities, practices and experiences.³ 'Trans' can be used as an adjective (describing an *aspect* of personhood: e.g. 'they are a trans person') or as a verb (describing what people *do*: e.g. 'to trans'); it is sometimes also employed as a noun. The wider *trans language* of gender variance, gender diversity and gender identity – as evidenced in related, quasi-subsumed concepts such as 'transsexualism', 'transvestite', 'transition' and 'genderqueer' – can also be understood as historically and socially contingent, giving rise to *and* emerging from 'trans'.

This chapter therefore traces the *genealogy* of trans language in the Western world in order to explore where contemporary UK understandings of trans 'came from', encompassing both the particularly dynamic two decades of change that passed between the accounts of Stone (1991) and Vähäpassi (2013), and the century of more gradual shifts that preceded them. A genealogical approach acknowledges and examines how subjectivities are *constructed* through social processes: '[w]here a positivist assumes that better science or a more nuanced history could accurately identify and distinguish between categories of sexuality or gender, a genealogist

³ While this thesis focuses largely on contemporary, Western approaches to gender diversity, it is important to note that alternatives to the binary norms of Western gender categories have been imagined and experienced across a range of times and places. Edward Carpenter (1914: 164) argues that, with regards to what we would now refer to as gendered behaviour and sexual orientation, 'the varieties of human type, intermediate [sic] and other, are very numerous, almost endless [...] and cannot be dispatched in sweeping generalisations'. Present-day majority world and/or indigenous gender identities that depart from strict male/female categories include Native American 'two-spirit' identifications (Jacobs et al., 1997; Wesley, 2014), 'fa'afafine' within Samoan society (Roen, 2001), 'tom' and 'khatoy' in Thailand (Jackson, 2004; Ravine, 2014), 'travesti' in Latin America (Vek, 2010), 'hijra' and 'kothi' in a number of South Asian countries (Monro, 2007; 2010; Dutta & Roy, 2014), and 'mak nyah' in Malaysia (Goh, 2012). Complex intersections and flows of discursive influence can be traced between these various subjectivities and the Western language of 'trans'; majority world and indigenous understandings of gender diversity have influenced white trans thinkers such as Feinberg (1992) and Bornstein (1994), but 'trans' language can also operate as a colonising vernacular (Roen, 2001; Vek, 2010; Dutta & Roy, 2014).

refuses the assumption that individuals exist apart from the historically changing categories that made them.’ (Rubin, 2003: 483). This can be seen, for example, in Michel Foucault’s (1978) account of the discursive construction of the gay male subject.

In taking a genealogical approach in this chapter, I do not seek to abstract trans identity through discussion of socio-historical context, nor do I engage extensively in debates around what trans ‘means’ for the naturalisation or destabilisation of binary gender. Instead, I follow the example of Vähäpassi (2013) in centring lived trans subjectivity. Drawing upon the work of Jay Prosser (1998) and Viviane Namaste (2000), Vähäpassi (2013: 32) urges an engagement with ‘more urgent’ questions around ‘how [...] lives become liveable’. My discussion here is therefore focused upon discourses that have made trans language (and, by extension, trans lives as variously understood today) *possible*. Moreover, I shall show how the genealogy of trans possibility is necessarily also a genealogy of trans health: both in terms of the medical discourse from which contemporary trans language has evolved, and in terms of the counter-discourses that have emerged from trans communities as well as from scholarly critique in the humanities and in social studies.

Repertoires of possibility

I identify two main discursive repertoires of trans possibility: trans as condition, and trans as movement. As outlined in the previous chapter, the repertoire of condition entails understandings of trans as fixed, fixable and/or conditional. Trans in this sense can be clearly defined and also *resolved*, often (but not necessarily) through some form of cure or treatment. I explore understandings of trans as condition in the context of evolving medical discourses, ‘transgenderist’ subjectivities, and radical feminist accounts. The repertoire of movement entails a continual potential for and actuality of change, being linked to queer notions of fluidity and the constant work of negotiation. This can entail individual movement – through identities that are not necessarily fixed or resolvable – as well as collective social movement; I explore the relationship between the two through a discussion of transgender studies and the notion of trans solidarity.

In addition to exploring difference and diversity *within* these broad categories, I also seek to examine how the two repertoires intersect and influence one another. The final two sections of this chapter work to avoid the limiting notion of a condition/movement binary by respectively exploring the place of ‘movement’ within

understandings of trans as condition, and of ‘condition’ within understandings of trans as movement. The former section will examine how recent interventions from health professionals have sought to acknowledge movement-oriented trans identities and experiences within a broadly pathological, condition-oriented approach to treatment. The latter will look at how recent sociological studies have sought to acknowledge condition-oriented identities within broadly movement-oriented accounts of trans community, focusing particularly on Surya Monro’s (2005) concept of ‘gender pluralism’.

Condition and cure: fixing trans

Sexual inversion

Early medical accounts of gender variance – by which I refer to variations from binary male/female norms – tended to conflate experiences that we might now describe as ‘trans’ with wider forms of gendered and sexual difference. These included intersex phenomena, gay, lesbian, bisexual and/or asexual preferences, and individual acts of gender nonconformity. Terms such as ‘invert’ – popularised by psychologist Havelock Ellis in the early 20th Century (Stryker, 2008: 38) – described individuals who deviated from sexual norms by behaving (or identifying their behaviour) in a manner associated with the ‘opposite’ sex. For example, a female invert – that is, a gender variant individual assigned a female gender at birth – might have a ‘male’ frame, dress and smoke like a man, be assertive, uninterested in needlework and sexually attracted to (or active with) women (Prosser, 1998; Rubin, 2003). Early sexological work from scholars such as psychiatrist Richard von Krafft-Ebing (1877 [2006]) provided detailed case studies of different forms of what would come to be known as sexual inversion. Krafft-Ebing sought to categorise inverts, identifying particular traits – such as ‘androgyny’, ‘gynandry’ and ‘defemination’ – for the purposes of classification.

While his views on the matter were to shift with time, Krafft-Ebing initially regarded individuals exhibiting gender variant behaviour as ‘profoundly disturbed’, and described any desire on their part for ‘self-affirming transformation’ as ‘psychotic’ (Stryker & Whittle, 2006: 21). His accounts laid the groundwork for similarly psychopathologising research, as well as treatments that aimed to ‘cure’ inverts of their condition. Henry Rubin’s (2003) account of the female-to-male ‘logic of treatment’ describes how attempted cures differed according to the medical field of the practitioner involved in administering treatment. From the 1930s through to the

1950s, endocrinologists drew upon the emerging science of hormones to administer hormone therapy to inverts. If the inversion was considered ‘acquired’ (through social factors such as nurture) then a ‘homo-sexual’ hormone regime – ‘oestrogens for [assigned] females and testosterone for [assigned] males’ – was seen as necessary to restore normal sexual behaviour (Rubin, 2003: 489). Conversely, if the inversion was considered ‘innate’, then ‘hetero-sexual’ hormones could be used to ‘hormonally castrate inverts and prevent them from acting out their pathological nature’ (498). ‘Hetero-sexual’ hormonal treatments were most often employed in the administration of oestrogen to assigned male patients.⁴ The provision of testosterone to ‘female’ inverts was seen as risky as it could increase their libido, thereby undermining the normative role of women as sexually passive.

The apparent failure of endocrinology to cure inversion informed a shift towards psychological and psychiatric treatments in the 1950s, including psychoanalysis and aversion therapy. With reference to a corpus of case notes from the 1950s and 1960s, Rubin (2003: 493-496) argues that ‘nascent FTM’⁵ accounts can be identified in these notes, with a number of patients requesting access to hormone therapies in order to facilitate a physical transition from female to male. However, as in the early work of Krafft-Ebing, the health professionals in these instances typically regarded their patients as deluded. Rubin (2003: 496) describes a range of practices that misgendered and psychopathologised patients; ‘[t]he use of the female pronoun throughout these cases, plus the ubiquitous comments on the normal physiological condition of these patients, indicates the psychologists’ beliefs that these patients are delusional’.

The logic of inversion could however also be used to *affirm* the gendered experiences of those who deviated from the norm. The most prominent example of this can be found in Radclyffe Hall’s (1928) novel *The Well of Loneliness*, which sees (assigned female) protagonist Stephen Gordon struggle at length with normative expectations of gender and sexuality. Upon reading Krafft-Ebing’s *Psychopathia Sexualis*, Stephen comes to regard her⁶ difference as pathological and herself as

⁴ This is mostly famously seen in the tragic case of computer scientist Alan Turing. Following a conviction of gross indecency for engaging in a sexual relationship with another man, Turing was required to take injections of a synthetic oestrogen as a condition of his probation. He committed suicide two years later.

⁵ FTM stands for ‘female-to-male’. The ‘FTM spectrum’ incorporates trans men, cross-dressing women, transmasculine non-binary and genderqueer individuals, and other movements towards ‘male’ and/or ‘masculine’ from individuals who have been assigned a female gender. MTF similarly stands for ‘male-to-female’.

⁶ My use of the female pronoun here reflects the author’s use of female pronouns in the text, along with the character’s identity as a ‘female invert’.

inherently damaged; however, she later comes across the more affirmative work of Havelock Ellis, who regarded inversion as a form of natural difference. While Stephen arguably never fully comes to terms with her sexual deviance, the book functions to both promote the category of inversion and reflect the sexual identity of its author (Prosser, 1998; Rubin, 2003). Inversion, of course, is as much a historically and socially contingent identity as trans, as can be seen in Prosser's (1998) reading of Stephen as a trans man. However, the important point here is that inversion could be embraced as a productive identity and account of selfhood in a similar manner to the 'trans' terminologies of transvestism, transsexualism and transgenderism that would follow; as a condition it provided a potential basis for self-understanding and stable non-normative subjectivity.

Transvestism and transsexualism: grounds for transition?

Sexologist Magnus Hirschfeld's book *The Transvestites* offered an alternative model to inversion. In a forerunner of feminist work on the sex/gender distinction, as well as trans and intersex accounts of sex/gender complexity, Hirschfeld's (1910 [1991]) theory of sexual intermediaries distinguishes four distinct aspects of sexual difference: 'sexual organs', 'other physical characteristics', 'sex drive', and 'other emotional characteristics'. This account contrasts with the conflation of these characteristics within discourses of inversion, and provided grounds for distinguishing between transvestites and homosexuals. Moreover, Hirschfeld seeks to highlight the social contingency of certain gendered norms: for instance, he provides a proverbial account of a small naked boy unable to recognise similarly naked girls *as* girls because they were undressed. This aspect of his work foreshadows later theoretical and empirical accounts of the role of gender presentation in shaping presumptions of genital status, as undertaken by feminist and/or trans researchers such as Suzanne Kessler and Wendy McKenna (1978) and Talia Mae Bettcher (2007). In contrast to later uses of the term 'transvestite', however, Hirschfeld's work does not simply refer to individuals who desired to engage in gender variant *behaviour* such as cross-dressing. Instead, for Hirschfeld 'transvestite' signals a range of subject conditions that might – according to patient need or desire – be affirmed and/or cured. In 1919 he founded the Institute for Sexual Science in Berlin, which both employed transvestites and – in collaboration with endocrinologists and surgeons – provided some of the first tailored medical procedures for patients seeking to transition from male to female or vice-versa (Stryker, 2008: 39).

Later writers sought to delineate different forms of gender variant condition. Where ‘transvestism’ came to refer specifically to the practice of (and/or an identity centred on) cross-dressing, *transsexualism* (or transsexuality) – popularised by Harry Benjamin (1966) in his work *The Transsexual Phenomenon* – specifically described individuals who sought to live permanently in the ‘opposite sex’. The figure of the transsexual emerged through extensive negotiation between practitioners and patients across a number of decades, as individuals actively sought treatment by approaching health professionals – including Hirschfeld and his one-time colleague Benjamin – to request medical interventions such as hormone therapy and genital or chest surgeries (Stone, 1991; Meyerowitz, 2002; Rubin, 2003). Benjamin’s work represented an attempt to take these patients seriously, and his 1966 book in particular provided a guide for both the diagnosis of transsexualism and the management of transition. Consequently, ‘transsexuals became recognizable and treatments were made available’ (Rubin, 2003: 489).

As with Radclyffe Hall’s experience of inversion, the transvestite and transsexual models have provided a liveable subjectivity for many (Prosser, 1998; Namaste, 2000; Ekins & King, 2006; Hines, 2007; Davy, 2011). This was particularly the case with transsexualism after the male-to-female transition story of Christine Jorgensen – a patient of Benjamin’s – received a great deal of media attention in 1952 (Stryker, 2008: 48-49). Jorgensen’s sudden fame served to popularise a terminology and language by which gender variant individuals might come to describe themselves and reify their experiences, particularly as Benjamin ultimately used the incident as an opportunity to begin promoting his model of a supposed transvestite/transsexual distinction. Both Jorgensen’s story and Benjamin’s work ultimately provided a language by which individuals wishing to transition could understand themselves as *transsexual* and seek treatment accordingly. I explore contemporary examples of the reification of trans identity and experience through professional medical discourse in Chapter 5, *(Re)defining Trans*.

However, many health professionals have echoed the early work of Krafft-Ebing as well as the psychologists and psychiatrists described by Rubin (2003) in regarding transsexualism as the product of a deficient mind and/or body. For example, David Cauldwell (1949: 274) describes the ‘psychopathic transsexual [sic]’ as ‘an individual who is unfavorably affected psychologically [and] determines to live and appear as a member of the sex to which he or she does not belong’. While Cauldwell – with reference to the work of Hirschfeld – acknowledges that transsexual individuals can

live productive and ‘useful’ lives, his own account (drawing upon a single female-to-male case study) portrays the transsexual as a figure prone to lies and deceit, misleading practitioners, his⁷ family, and – most of all – himself. The trope of the ‘deceptive transsexual’ would later come to define a large part of the medical literature (Stone, 1991) and has also become common within wider social and political discourses⁸ (Bettcher, 2007; Serano, 2007). In this way, transsexualism can be regarded as a condition associated with wider mental health issues, requiring psychological, psychiatric and/or psychotherapeutic management rather than medically-mediated physical interventions.

Benjamin, by contrast, acknowledged that many of his patients could benefit from physical transition. He regarded transvestism and transsexualism as complex phenomena, and sought to distinguish the different ways in which these conditions might manifest. He initially outlined three forms of male-to-female desire and behaviour. The ‘principally psychogenic transvestite’ does not ‘want to be changed, but wants society’s attitude towards him [sic] to change’, seeking typically to dress ‘in the clothes of a female’ and ‘lead a woman’s life’ (Benjamin, 1954: 48-49). The ‘somatopsychic transsexualist’ by contrast exhibits an ‘intense and often obsessive desire to change the entire sexual status including anatomical structure’ (46). Therefore, while the male-to-female transvestite ‘enacts the role of a woman, the transsexualist wants to *be* one and *function* as one’ (46, emphasis in original). Recognising that his patients didn’t always fit neatly into these two categories, Benjamin (1954: 49) also noted the existence of ‘the intermediate type’, who ‘inclines towards transsexualism, but is at other times content with merely dressing and acting as a woman’. While the transvestite and the intermediate type can generally be provided with psychotherapy to help them manage their condition, this is not the case with the transsexualist, for whom this is a ‘waste of time’ (51). Benjamin (1954; 1966) therefore advocates for the provision of ‘conversion surgery’ for such individuals, with hormone therapy to follow in order to mitigate the impact of physical castration.

⁷ I use male pronouns here to reflect the individual’s explicitly expressed gender identity in Cauldwell’s case notes. Cauldwell, however, refers to his patient as female.

⁸ The wider impact of the ‘deceptive transsexual’ trope is perhaps exemplified by fierce public debates over trans access to public toilets in the United States at the time of writing. Trans activists and their allies are advocating for access to public toilets in line with an individual’s gender identity, in order to affirm trans genders and somewhat alleviate the risk of gendered violence against trans women in particular. Opponents of this approach – including legislative bodies, conservative commentators and radical feminist activists – frequently argue (contrary to any evidence on the matter) that it will afford ‘men’ the opportunity to spy on and perhaps commit sexual violence against young girls. I read the depraved figure of the ‘man’ in this instance as clearly intended to signify the trans woman as well as the male-to-female cross-dresser.

However, he also argues that psychiatrists should play a role in assessing patients to ensure their psychological suitability for the procedure. This laid the groundwork for a mode of treatment that continues to this day.

By the 1980s, 'a routine set of procedures and protocols for medically managing transgender populations had fallen into place' (Stryker, 2008: 112). In 1979 the Harry Benjamin International Gender Dysphoria Association (later the World Professional Association for Transgender Health, or WPATH) was created by clinicians working within the paradigm Benjamin had established. They issued a document entitled *The Standards of Care*, which outlined the means by which transsexualism might be assessed and managed. A year later, in 1980, transsexualism was 'officially' recognised for the first time, through a series of formal differential diagnoses for *gender identity disorder* in the third edition of the American Psychiatric Association's internationally recognised *Diagnostic and Statistical Manual of Mental Disorders* (or DSM-III). An updated version of gender identity disorder - 'gender dysphoria' - can be found in the current edition of the manual, DSM-5 (American Psychiatric Association, 2013). Following the example of the DSM, a number of gender identity disorders (including 'transsexualism' and 'dual role transvestism', along with the 'disorder of sexual preference' known as 'fetishistic transvestism') were also included in the current edition of the World Health Organization's (1992) *International Statistical Classification of Diseases and Related Health Problems* (ICD-10).

The power of a diagnosis

The creation of gender identity disorder (and gender dysphoria) diagnoses has had four important consequences for trans people. Firstly, it placed a capstone on the process of *pathologisation* that had gradually unfolded for over a century. In seeking to categorise gender variant conditions, sexologists and mental health professionals succeeded in framing deviation from (binary) gender norms as pathological *even when the deviating individuals in question do not seek medically supervised transition*.

Secondly, gender identity disorders have created a *binary division* between transvestism and transsexualism that persists to this day, even as 'intermediate types' (Benjamin, 1954) proliferate within trans communities and medical accounts. While the actual term 'transvestite' is less popular as a contemporary form of identification, a line continues to be drawn between trans people who 'require' physical transition, and those who (supposedly) do not, within both medical and social contexts. This has

placed an onus upon trans people to prove themselves as ‘trans enough’ within both community and healthcare settings (Catalano, 2015; Nicolazzo, 2015), informing the emergence of hierarchies of trans identity that sometimes valorise medical interventions, and other times celebrate the ‘transgressive’ nature of those who do not desire physical transition (Bornstein, 1994; Serano, 2007; Stryker, 2008).

Thirdly, while many health professionals who are *not* gender identity specialists continue to echo Cauldwell (1949) in regarding transsexualism primarily as a mental health issue that cannot be treated through physical intervention (as discussed by Combs et al., 2008; Schonfield & Gardner, 2008; Bailey & McNeil, 2013), *formal diagnoses can ensure that treatment is available*.⁹ In the UK, access to gender identity services through the NHS is a legal right, following a number of important court victories for trans rights advocates in the 1990s and 2000s (Burns, 2013). However, a number of health professionals have argued that the existence of the diagnosis underpins this right, providing a basis for public funds to be allocated to gender identity services (Richards et al., 2015).

Fourthly – and finally – the creation of gender identity disorders has worked to construct a professional class of gender identity *experts*. These experts are variously responsible for assessing and managing patients seeking physical transition, for reflecting upon their experiences in the clinical literatures, for preparing protocols and care pathways for their patients, and for peer-reviewing these reflections, protocols and care pathways (Barrett, 2007; Lev, 2009; Ahmad et al., 2013; De Cuypere et al., 2013; Bouman et al., 2014; Richards et al., 2016). This process of epistemic production has granted health professionals power not simply over medical processes, but over the *trans identities that emerge from these processes* (Stone, 1991; Hines, 2007; Sanger, 2012; Davy, 2015). The location of expertise within the medical professions can simultaneously work to delegitimise accounts emerging *from trans people* working in the social sciences and humanities, reflecting wider epistemic hierarchies in which work on gender from marginalised peoples (e.g. feminist scholarship) is framed as ‘partly outside’ the realm of ‘proper knowledge’ (Pereira, 2012: 296). This can be observed in the imbalance of citation between the interdisciplinary field of transgender studies – in which the medical literatures are frequently referenced – and the medical

⁹ That is, for those who succeed in proving themselves ‘trans enough’. I touch upon this further in Chapter 3, and analyse the concept in detail in Chapters 5 and 6.

literatures of gender identity, in which authors usually only cite and speak to others in the field.¹⁰ For instance, Davy describes how the DSM-5 workgroup:

disregarded the plethora of work in feminist social science which criticizes the inherency of gender roles, gender identities, and sex differences, as well as research in transgender studies that depicts non-dysphoric transpeople, desires for different embodiments, non-conventional transitioning trajectories, and sexualities. (Davy, 2015: 1170)

There are, nevertheless, multiple discourses of trans possibility present within the medical literatures (Richards & Lenihan, 2012; Richards et al., 2014). For example, in recent years a significant number of specialists working with transitioning patients have begun to argue against the pathologisation of trans identities and experiences (Bockting, 2009a; 2009b; Bouman et al., 2010; Richards et al., 2015). An alternative medical model instead emphasises psychological *distress* for the purposes of diagnosis (Nieder et al., 2016). Some writers have focused upon the distress of gendered ‘incongruence’ (e.g. Neider & Strauss, 2015), while others have emphasised the distress of belonging to a marginalised social group: ‘it is the discrimination rather than the membership of this specific group which is psychopathogenic’ (Richards et al., 2016: 97). These positions are, however, complicated by the maintenance of assessment procedures that continue to centre diagnosis, with expert gender identity specialists overseeing these procedures (e.g. NHS Scotland, 2012; Ahmad et al., 2013; NHS England, 2013; Royal College of Psychiatrists, 2013). Endocrinologist Leighton Seal argues that psychiatric assessment and diagnosis of transitioning patients is necessary to ensure that:

other possible diagnoses are excluded where hormonal and surgical intervention is not of benefit, such as psychosis, bipolar depression, or dysmorphia. With a rise in queer culture and exploration of gender identity, medical treatment is not always in the patient’s best interest in people with gender non-conformity. (Seal, cited in Morgan, 2016: 207)

The resulting tension between depathologisation and the role of clinical expertise can be seen for instance within the latest edition (Version 7) of the WPATH *Standards of Care* (Coleman et al., 2011). Furthermore, misunderstandings continue to play out within clinical settings between gender identity specialists and patients who do not

¹⁰ I noted only a small number of exceptions to this, usually in cases where health professionals who are themselves trans are involved in co-writing the papers in question (e.g. Bockting, 2009b; Bouman et al., 2010; Richards & Lenihan, 2012; Richards et al., 2016).

easily 'fit' diagnostic categories as well as those who object to the strict criteria and extensive process of assessment associated with physical transition pathways (Hines, 2007; Bauer, 2009; Davy, 2011; Burke, 2011; Ellis et al., 2015).

In contrast to tentative moves towards depathologisation, misgendering practices (comparable to those described by Rubin, 2003) have persisted within the literatures of psychology and psychiatry (Ansara & Hegarty, 2012). As Charles Taylor (1994, cited in Davy, 2011: 129) argues, 'nonrecognition or misrecognition can be a form of oppression, imprisoning someone in a false, distorted, reduced mode of being'. Y. Gavriel Ansara and Peter Hegarty (2012) describe how the practice of casting trans patient experiences into doubt by disregarding their stated gender identities and/or preferred gendered pronouns has been maintained by an 'invisible college', centred around American-Canadian psychologist and prolific author Kenneth Zucker. The invisible college consists of a network of collaborating authors who work to maintain their collective academic profile through co-authorship, peer-reviewing one another's articles, and editing relevant journals. This has enabled authors such as Zucker to represent forms of cisgenderist, ethnocentric 'aversive conditioning' – such as 'restricting the gender expression' of children (Ansara & Hegarty, 2012: 139), or 'shaming' children and parents into pursuing conformity (Pyne, 2014) – as good practice. In this way, Zucker – a co-author of DSM-5 and the Version 7 WPATH *Standards of Care* – maintained both his academic position and his role as head of a Toronto gender clinic for many years,¹¹ in spite of numerous allegations of unethical or abusive behaviour being made by academics, activists and former patients (Tosh, 2011; Pyne, 2014; Zinck & Pignatiello, 2015).

In this way, the power of medical diagnosis can work to both make trans lives *possible*, and limit the liveable scope of these possibilities. The following chapters of this thesis demonstrate how the interaction of the outlined four consequences of diagnosis has complexly impacted the liveability of trans lives.

¹¹ In December 2015 Zucker's Gender Identity Service at Toronto's Centre for Addiction and Mental Health was closed, following an extensive review undertaken by the Centre. A report published as part of the review carefully indicated that Zucker may have been practising reparative or 'conversion' therapies on gender variant children: 'We cannot state that the clinic does not practice reparative approaches [...] with respect to influencing gender identity development' (Zinck & Pignatiello, 2015: 22).

An 'intermediate type': the transgenderists

I have previously noted that sexological categories of condition – including inversion, transvestism and transsexualism – provided the basis for personal identity claims through the reification of gender variant experience. I now turn to examine how *non-medical* condition-oriented trans identities can emerge, through an examination of American activist, academic and community organiser Virginia Prince's concept of the 'transgenderist'. This discussion accordingly draws upon the wider notion of 'condition' outlined in the introduction to this thesis; a fixed or resolvable, yet conditional mode of being.

Prince (1973 [2005]) draws upon the work of Hirschfeld (1910 [1991]) and the ideas of the fledgling Women's Liberation movement to argue for a distinction between 'sex' and 'gender' within accounts of male-to-female experience. Like Benjamin (1954; 1966), she seeks to distinguish between transsexuals and transvestites, arguing that while both groups 'do' the same thing – that is, wear the clothes of the 'opposite' gender – they do so for different reasons. She further distinguishes between transvestites who cross-dress for sexual reasons (a category inclusive of both gay men and the 'fetishistic transvestite' who was later to appear in the DSM and ICD) and 'femiphile' transvestites. While male-to-female transsexuals seek a sex *change* to live as women, femiphile transvestites seek *recognition* as women without having to physically transition: 'my gender, my self-identity is between my ears, not between my legs' (Prince, 1973 [2005]: 30).

As Prince's thinking developed, she came to regard some femiphilic transvestites – including herself – as *transgenderists*. She outlines her thinking in this regard in an article entitled *The "Transcendents" or "Trans" People* (Prince, 1978 [2005]); an early example of the standalone 'trans' being used as an umbrella term for a range of gender variant identities and experiences. In contrast to those femiphiles who shifted between 'female' and 'male' modes of living and gendered presentation (later to be termed 'dual role transvestites' in ICD-10), transgenderists 'are people who have adopted the exterior manifestations of the opposite sex on a full-time basis but without any surgical intervention' (Prince, 1978 [2005]: 43). In this sense, they are an alternative form of 'intermediate type' to that described by Benjamin (1954).

Prince's writings – distributed largely through her magazine *Transvestia* – are therefore important in offering an alternative form of *knowledge* to medical accounts of trans phenomena. However, her works also resemble these accounts in providing a

categorical, prescriptive sense of trans possibility. The bounds of femiphile and transgenderist possibility are quite clearly delineated: such people are assigned male at birth, necessarily sexually attracted to women, do not (in the long term) have a sexual motivation for cross-dressing, and do not wish to physically transition (Prince, 1973 [2005]; 1978 [2005]; Stryker, 2008). These are, therefore, accounts that ultimately rely upon the binary divisions of male/female and masculine/feminine while working to exclude female-to-male and non-binary expressions of gendered possibility, reflecting the strict rules by which Prince controlled membership of the social groups she oversaw (Stryker, 2008: 55; Hill, 2013). Moreover, the dissemination of Prince's writings within the professional realm was limited by the aforementioned positioning of medical practitioners as 'trans experts' who presided over both the transition process *and* wider expressions of trans identity. Susan Stryker (2005) notes that in a 'preamble' to Prince's first-known article in a formal academic journal, she is 'vouched for' by Harry Benjamin. This demonstrates the manner in which expertise was historically located not simply in the medical professions, but also within the detached perspective of *non-trans* writers:

[Prince] was a superbly well-educated person with medical credentials of her own. [...] And yet, because she was openly a transvestite, Prince could speak 'only' as a transvestite, and not as a medical expert whose professional knowledges and competencies were respected by her professional peers. (Stryker, 2005: xvi)

Shadows of the Empire: radical feminist critiques

An alternative non-medical model of trans as condition is articulated by a particular branch of radical feminist thinking. During the 1970s, a number of feminists began to critique what they saw as an unquestioning reification of sexist gender norms by trans people and health professionals alike. This is exemplified in Janice Raymond's (1979) *The Transsexual Empire*, a book that Sandy Stone (1991: 223) characterises as arguing that 'transsexuals are constructs of an evil phallogocentric empire and were designed to invade women's spaces and appropriate women's power'.

In a similar manner to the postmodern and poststructuralist trans theorists who would emerge following the publication of her work, Raymond (1979: xv) notes the historical contingency of the transsexual phenomenon, and the manner by which practitioners such as Benjamin 'make transsexualism a reality' by offering treatment.

She posits that transsexualism has been constructed as an ‘individual solution’ to the social problem of rigid sexual stereotyping within ‘a patriarchal society, which generates norms of masculinity and femininity’ (Raymond, 1979: 70). Instead of fighting these norms, surgeons and psychologists have reified them by creating a means by which ‘men’ can be ‘transsexually constructed’ into women.

Raymond (1979: 26-27) ultimately regards transsexualism as a *male* activity: ‘a creation of men, initially developed for men’, with the ‘female-to-constructed-male transsexual’ being ‘the *token* that saves face for the male “transsexual empire”’ (emphasis in original). She accurately notes that the vast majority of authors writing within the contemporaneous medical field of transsexualism were men,¹² even as psychiatric accounts of the transsexual condition frequently attributed its genesis to the role of unruly women, with (for example) overbearing mothers held responsible for feminising children assigned a male gender at birth. Moreover, she draws upon interview data to argue that trans women define themselves as female ‘in terms of the classic feminine stereotype’ (78). This entails passive, nurturing behaviour, an interest in feminine clothes and make-up, a belief in traditional heterosexual gender roles and a preference for occupations such as housework and secretarial employment. The exception to this can be found in the ‘transsexually constructed lesbian-feminist’, who brings ‘masculinity and masculinist behaviour’ into women-only feminist spaces (101). In this way, the activities of stereotypically heterosexual, feminine trans women *and* the behaviour of lesbian-feminist trans women represent different means by which ‘men’ might problematically occupy womanhood: ‘[a]ll transsexuals rape women’s bodies by reducing the real female form to an artefact, appropriating this body for themselves’ (104). Raymond therefore asserts that, ‘[t]ranssexuals are *not* women [...] they are *deviant males*’ (183, emphasis in original). With Raymond therefore taking the biologically determinist view that gender is determined in line with (binary) designations at birth, she recommends an alternative, *feminist* solution to this deviant condition: that of counselling and peer support through feminist consciousness-raising.

The Transsexual Empire provides an ideological and analytic basis for a strand of ‘trans-exclusive’ radical feminist thought that continues to be represented in both academic and popular media contexts to this day. Writers such as Bernice Hausman

¹² This imbalance has shifted significantly since the 1980s. while authors are still predominantly male, there is a growing body of articles in the medical literature of transsexualism in which women professionals are first authors. Moreover, I informally observed that approximately half of the attendees at WPATH’s 2016 Symposium were women (although this was not reflected in the choice of plenary speakers for the event, in which men were very much overrepresented).

(1995), Sheila Jeffreys (1997) and Germaine Greer (1999) have continued to argue that trans women embody and reify sexist stereotypes of womanhood; Jeffreys (2014) echoes Raymond in accusing transsexuals of ‘invading’ women’s spaces; Julie Bindel (2009) has called for hormone therapies and genital surgeries to be replaced with counselling and therapy. However, these accounts have done little to build upon Raymond’s (1979) theoretical and empirical work. Moreover, they have been largely superseded by trans-affirming and trans feminist accounts in terms of wider ideological resonance and praxis within contemporary feminist scholarship and activism (Bettcher, 2009; Elliot, 2009; Bunch, 2013).

Ironically, for all that Raymond and her followers criticise the medical establishment, their accounts also echo medical discourses of trans possibility. Even as they denounce transsexual people and health professionals for reinforcing sexist stereotypes, they subscribe to a binary notion of sex and gender rooted in biological determinism by asserting that trans women will always *really* be men, and that trans men will always *really* be women. This perspective goes beyond the binarist thinking of Benjamin (1966), who at least provides some narrative space and clinical provision for the possibility of movement through sex *change*. It ultimately echoes the view of the 1950s psychologists described by Rubin (2003), and informs a practice of misgendering and misrecognition similar to that described within contemporary psychological and psychiatric literatures by Ansara & Hegarty (2012). In taking this perspective – and in outlining a form of *treatment* for transsexual deviancy – Raymond and her followers thereby similarly regard trans as condition: definable, resolvable, fixable, curable. Furthermore, like Benjamin and his colleagues, they position *non-trans* expertise as the appropriate basis for knowledge about trans lives, thereby effectively objectifying and silencing trans voices (Namaste, 2000; Serano, 2007).

‘A Movement Whose Time Has Come’: the emergence of ‘trans’

Sandy Stone’s (1991) *The Empire Strikes Back: A Posttranssexual Manifesto* provides a nuanced engagement with Raymond (1979). Stone rejects a number of Raymond’s more outlandish claims, but also accepts and provides further analysis of some key elements of her arguments regarding sexism and the reification of traditional gender roles within medical systems. Together with works such as Leslie Feinberg’s (1992) influential pamphlet *Transgender Liberation: A Movement Whose Time Has Come*, this laid the groundwork for the emergence of the new interdisciplinary field of

transgender studies (Stryker, 2006). Drawing upon the insights of feminist and queer theories, the embodied realities of marginalised trans peoples and the extensive medical literature of transsexualism and transvestism, transgender studies enabled the 'establishment of subjects in new modes, regulated by different codes of intelligibility' (Stryker, 1994: 248). I characterise these as modes of *movement*, with new codes of 'cultural intelligibility' (Butler, 1993) grounded specifically in emergent *trans* knowledges.

Individual movement: the gender outlaws

Stone (1991) argues that Raymond's portrayal of transsexual women as intentionally complicit in reifying gender norms is both simplistic and misleading. She focuses her analysis particularly on the role that gender identity specialists play in socially constructing transsexualism. Raymond (1979: 135) states that gender identity specialists engage in 'behavioural modification' procedures, but she does not analyse these processes in any depth, nor does she link this discussion back to her earlier account of passive, stereotypically feminine heterosexual trans women. Stone therefore examines Raymond's claims with reference to a wider field of evidence. In particular, she focuses upon the gendered discourses present within transsexual women's autobiographies, noting that – at first sight – the concerns raised by Raymond and her followers seem quite legitimate:

All these [transsexual] authors replicate the stereotypical male account of the constitution of woman: dress, makeup, and delicate fainting at the sight of blood. Each of these adventurers passes directly from one pole of sexual experience [male, attracted to women] to the other [female, attracted to men]. If there is any intervening space in the continuum of sexuality, it is invisible. [...] No wonder feminist theorists have been suspicious. Hell, *I'm* suspicious. (Stone, 1991: 227, emphasis in original)

Later trans feminist theorists such as Julia Serano (2007) argue that Raymond's account holds trans women to a different standard than *non-trans* women, as plenty of women from all backgrounds adhere to gendered norms. Others have noted the restrictive cultural conditions under which these accounts were published: 'Up until the last few years, all we'd be able to write *and get published* were our autobiographies, tales of women trapped in the bodies of men or men pining away in the bodies of women [...] the romantic stuff which set our image as long-suffering, not the challenging stuff' (Bornstein, 1994: 12-13, emphasis in original). Stone's critique,

however, focuses on the role of medical literature and practice in the construction of the traditional transsexual narrative found in autobiographical accounts. Noting that the early gender clinics facilitating transition were ultimately 'in the business of helping people', Stone (1991: 227-228) explains how their treatment criteria favoured patients who seemed most likely to 'succeed' in navigating the world in their new gender role: 'In practice this meant that the candidates for surgery were evaluated on the basis of their *performance* in their gender of choice' (emphasis in original); a performance that extended to autobiographies. Stone further examines how the publication of Benjamin's (1966) *The Transsexual Phenomenon* effectively provided a manual for patients seeking to transition. This created a discursive feedback loop in which many patients met the expectations of health professionals (or pretended to so) in order to access treatment, thereby reinforcing the idea that 'true' transsexuals necessarily conform to such stereotypes. The resulting situation was clearly not conducive either to the advancement of medical knowledge or to the long-term possibility of gender nonconformity for those who transitioned.

Stone therefore concludes her article with a call for the creation of a 'posttranssexual' counterdiscourse. Where the traditional transsexual is 'totalized' by conditional discourses, Stone (1991: 232) represents posttranssexual identities and experiences as diverse, rich and complex. Where the traditional transsexual is 'programmed to disappear' by performing gender in a stereotypical manner, she calls upon the posttranssexual to 'forgo passing, to be consciously "read", to read oneself aloud – and by this troubling and productive reading, to write oneself into the discourses by which one has been written' (Stone, 1991: 232). In this way, Stone imagines a new mode of being: a form of living that acknowledges and embraces movement in terms of gendered discourse, identity, and embodiment. Further 'posttranssexual' accounts of gendered possibility would follow. Like Stone (1991), these works typically drew upon recent innovations in feminist and gender theory, including the 'cyborg' feminism of Donna Haraway (1991) and Judith Butler's (1988) account of gender as 'performative'.

In response to an invocation of Frankenstein (and his monster) by Raymond (1979) in her discussion of the medical construction of transsexual bodies, Stryker (1994) theorises transsexualism as 'monstrous' in her paper *My Words to Victor Frankenstein above the Village of Chamounix: Performing Transgender Rage*. While the paper does not explicitly reference her work, Stryker echoes Haraway's (1991) *Cyborg Manifesto* in celebrating the revolutionary feminist potential of transformative technologies of the

body: 'To encounter the transsexual body, to apprehend a transsexual consciousness articulating itself, is to risk a revelation of the constructedness of the natural order' (Stryker, 1994: 250). This process of articulation is grounded in 'transgender rage', a 'queer fury' that arises in response to the '*unliveability*' of normative gender for many (248, emphasis mine). Stryker illustrates the origins of transgender rage with a story about the birth of her lover's baby. As the baby is born, somebody declares, 'it's a girl' (245). In this utterance, Stryker locates an important moment of gendered violence: the *non-consensual* assignment of gender at birth. At this moment it is possible to locate the imposition of essentialist norms upon the gendered body; norms that form the basis of patriarchal power relations, norms that will eventually compel the trans subject to enter 'a domain of abjected bodies, a field of deformation' (Butler, 1993: 16). Transgender rage provides a means of revolt against this 'naturalized order': 'by mobilizing gendered identities and rendering them provisional, open to strategic development and occupation, this rage enables the establishment of subjects in new modes, regulated by different codes of intelligibility' (Stryker, 1994: 248). Transgender rage therefore responds to the fixity of binary gender norms – *and* to the seeming fixity of the transsexual condition – through re-imagining notions of gendered identity, imbuing them with a sense of fluidity and movement that reflects the constructedness of the transsexual body.

An altogether more playful account of identity as *movement* can be found in Kate Bornstein's (1994) book *Gender Outlaw*. Like Stryker (1994), Bornstein draws extensively upon her personal experiences of transition to illustrate an account of gendered possibility through revolt against the 'natural' order. 'Standing outside of a "natural" gender,' she explains, 'I thought I was some kind of monster, I thought it was my fault' (Bornstein, 1994: 12). Building upon Butler's (1990) description of gender as 'performative' – that is, constructed and reified through social (inter)action – Bornstein questions how she might render the artificial bounds of gender visible, and furthermore seek to live beyond these bounds as neither female *nor* male. Having transitioned from male to female in line with the traditional transsexual pathway, Bornstein finds herself feeling that her experience is neither that of a 'man' *or* of a 'woman'. Her account therefore paves the way for a multiplicity of gendered possibilities beyond the male/female binary: 'there are as many truthful experiences of gender as there are people who think they have a gender' (Bornstein, 1994: 8). While an acceptance of gendered multiplicity, complexity and fluidity is portrayed by Bornstein as a potentially liberating means to make 'gender outlaw' lives more liveable,

she does not have a clear account of how this might be achieved. 'I love the idea of being without an identity, it gives me a lot of room to play around', she states, 'but it makes me dizzy, having nowhere to hang my hat' (Bornstein, 1994: 39). I therefore move next to explore how Stone, Stryker and Bornstein's imagined 'different codes of intelligibility' (Stryker, 1994: 248) were *implemented* through the collective action of a new social movement.

Social movement: collective transgender solidarity

The term 'transgender' certainly existed prior to its use by Leslie Feinberg. However, it tended to refer to individual relationships with gender diversity, as in Prince's (1978 [2005]) 'transgenderist', which was used specifically to describe male-assigned individuals seeking to live permanently as women without medical intervention. In calling for *transgender solidarity*, Feinberg played an important role in popularising 'transgender' – and later, the stand-alone 'trans' – as the basis for a *social movement*, a politicised version of Prince's (1978 [2005]) largely overlooked use of the umbrella term 'trans people'.

Feinberg (1992, 1999) argues that a language is needed to bring together people with a shared experience of marginalisation on the grounds of gender variance, while also recognising differences between these people. This would be a language *by and for* trans people, as an alternative to externally imposed terminology.

When I first worked in the factories of Buffalo as a teenager, women like me were called 'he-shes.' [...] There are other words used to express the wide range of "gender outlaws": transvestites, transsexuals, drag queens and drag kings, cross-dressers, bull-daggers, stone butches, androgynes, diesel dykes [...] [w]e didn't choose these words. They don't fit all of us. It's hard to fight oppression without a name connoting pride, a language that honours us. (Feinberg, 1992: 206)

Notably, Feinberg lists the medical terms 'transvestite' and 'transsexual' alongside a range of other stigmatised identities. There is a racial and class dimension to this divide between medical and non-medical terminology, particularly within the US context in which Feinberg was writing. The cultural and financial capital required to access medical literature and/or a formal diagnosis was historically more likely to be held by white, middle- and upper-class trans people (Stryker, 2008; Koyama, 2004). Subcultures such as drag scenes and butch/femme scenes therefore offered a means by

which more marginalised individuals could build community around gender diversity (Munt, 1998; Nestle et al., 2002; Stryker, 2008). Feinberg's priority, however, is *unity* between transgender people regardless of their background. In stating that '[g]enuine bonds of solidarity can be forged between people who respect each other's differences,' she argues from a Marxist perspective for a single but diverse trans movement, united through shared oppression (Feinberg, 1992: 220). In this way, her work incorporated space for a movement away from strictly delineated identities and externally imposed gender identities in a similar manner to Stone (1991), Stryker (1994) and Bornstein (1994), while also seeking to incorporate these individual movements into a collective social movement. Moreover, while 'inversion' and many interpretations of Hirschfeld's (1910 [1991]) model of 'transvestism' presented a somewhat monolithic categorical account of gender variant possibility, 'trans' as imagined by Feinberg enables a myriad of identifications and experiences within its loose, unbound contingent category.

The transsexual condition: rejecting movement?

In explicitly including 'transsexuals', Feinberg's notion of a trans movement theoretically creates space for the inclusion of individuals who regard their gender movement – the act of transitioning – as resolvable; those who 'do not seek to queer or destabilize categories of gender but to successfully embody them' (Elliot, 2009: 11). These are traditionally men or women who seek to live permanently in a 'binary' gender role that contrasts with the gender they were coercively assigned at birth, following a physical transition.

Prior to the 1990s, the medical model of transsexualism was the primary form of subjectivity available to 'binary' trans men and women. With the advent of transgender studies, writers such as Prosser (1998), Namaste (2000) and Rubin (2003) sought to create space within poststructuralist and postmodern theory for a transsexual subjectivity defined neither by the conditional demands of the medical literature, nor by the emerging queer language of transgenderism with its focus on perpetual fluidity and change. Namaste (2000: 62) therefore argues – with reference to the work of Feinberg – that trans theory grounded in discourses of movement 'erases transsexual specificity'. For this reason, transsexual theorists sought to account for the individual and social experiences of the transitioned subject, as well as the means by which they might traverse the 'borderlands' between genders to find a gendered 'home' (Prosser, 1998): an embodied sense of belonging and resolution. Trans feminist writer Julia Serano – a biologist by profession – would later build on this work with her account of

the physical and psychological changes wrought by hormone therapy, linking the alleviation of dysphoric feelings through this process to an innate sense of 'subconscious sex' (Serano, 2007). Even as these accounts provided an alternative to the medical literature, they might be understood as grounded in discourses of trans as condition in a similar manner to Prince's models of femiphile transvestism and transgenderism (1973 [2005]; 1978 [2005]). At the same time, they also provide for the possibility of movement – albeit *resolvable* movement – in the 'migration' (Prosser, 1998; Ekins & King, 2006) from one gender role to another. This can also be coupled with a pointed feminist rejection of sexist stereotypes (Namaste, 2000; Serano, 2007).

A substantial debate unfolded during the late 1990s and early 2000s as queer 'transgender' and binary 'transsexual' theorists critiqued one another's accounts of trans possibility and authenticity. Where many transgender theorists argued that transsexual accounts were rooted in a form of biological essentialism, transsexual theorists stated that transgender accounts left little room for the lived experience of transsexual individuals (Halberstam, 1998; 2005; Elliot, 2009). However, even as this debate unfolded, Feinberg's (1992) model of a *collective trans social movement* increasingly informed the approach undertaken by participants in the debate. Both Namaste (2000) and Serano (2007) write of 'transsexual and transgender' experience, while Judith/Jack Halberstam (2005) – positioned within the queer/transgender camp – increasingly sought to acknowledge and account for experiences of lived physical transition. Moreover, ideas of affirmative sexed embodiment as articulated by Prosser (1998) and Serano (2007) have increasingly been taken up by individuals seeking a 'queer' physical transition without a traditional binary resolution, thereby creating a 'home in the borderlands' (Vähäpassi, 2013).

I address a means by which remaining tensions might be resolved in my discussion of 'gender pluralism' (Monro, 2005) in the final substantive section of this chapter.

Trans movement language and activism

The Internet has provided a vital catalyst for the trans social movement to grow and change, as a formerly largely invisible and geographically dispersed population has been empowered to come together and organise. Within communities of marginalised peoples, solitary 'experiences' can be converted into accounts of 'being', 'through the construction of *stories of identity*' (Plummer, 1995: 118, emphasis in original). Whittle (1998) notes that online communities inclusive of a broad range of *trans people*

provide valuable space for the negotiation of Stryker's (1994) 'new modes' and 'different codes' of (trans)gendered possibility. I understand these modes and codes as reproduced through mutual recognition, and an iterative citation of emergent language by community members. Successive studies have built upon Whittle's work to examine how new language and understandings of trans 'being' – including a dizzying array of new gendered identities – have emerged and are reproduced through mutual recognition and iterative citation within online communities (Hegland & Nelson, 2002; Gauthier & Chaudoir, 2004; Shapiro, 2004; Ekins & King, 2010; Pearce, 2012; Horak, 2014; Jenzen & Karl, 2014; Raun, 2015; 2016; Yeadon-Lee, 2016). Writings by Stone (1991), Feinberg (1992) and Stryker (1994) have played a direct role in this broad process of discursive change, having been made available by their authors and/or by others on webpages and in ezines, while more extensive works such as Bornstein (1994) are commonly recommended within community spaces and easily available in online bookstores. However, as access to the Internet has increased and trans communities have grown, the sophistication of *informal* theorisation and the rapid distribution of ideas has increased also. As Natasha Curson (2010: 142) argues: 'some thinking and writing on the nature of gender by trans individuals, often in non-academic contexts, goes beyond the current level of thinking and sophistication in transgender studies itself. I have therefore sought to include and acknowledge the theoretical work of a number of non-academic trans writers (including research participants for this project) in my discussion of research data in following chapters.

Eve Shapiro (2004: 166-167) notes that online connectivity has enabled trans activists to more easily 'educate themselves and others [...], make contacts' and 'foster collective identity'. In the UK context, Christine Burns (2013; 2014) has described how this increased level of education and connectivity intersected with offline activism for trans legal rights by groups such as Press For Change and Liberty, in what Whittle (1998: 393) has described as the 'street-Net-street effect'. Within the UK, trans activists have successfully fought for inclusion within LGBT organisations, the universal provision of trans-specific medical services through the NHS, and legal recognition¹³ in legislation such as the Gender Recognition Act 2004 and Equality Act 2010. The Internet has also facilitated shifts in language, with trans people seeking to create an inclusive terminology for the purposes of community organising and activism (Whittle, 2006; Burns, 2013). The shift from 'transgender' to 'trans' is an example of this. So too is the emergence of non-binary and non-gendered forms of language, which provide a

¹³ Albeit somewhat limited in scope and implementation, as discussed by Davy (2011) and in later chapters of this thesis.

means by which the fluidity Bornstein (1994) sought can be achieved. For instance, in *Trans Liberation* Feinberg describes hir use of gender neutral pronouns in the context of the normative language of binary gender.

I am a human being who would prefer not to be addressed as Ms. or Mr., ma'am or sir. I prefer to use gender-neutral pronouns like *sie* (pronounced like 'see') and *hir* (pronounced like 'here') to describe myself. I am a person who faces almost insurmountable difficulty when instructed to check off an 'F' or an 'M' box on identification papers. [...] I simply do not fit the prevalent Western concepts of what a woman or a man 'should' look like. (Feinberg, 1999: 1, emphasis in original)

The adoption of gender neutral pronouns – in the form *sie/hir* as used by Feinberg, or in other forms such as the singular 'they' used by numerous participants in this project – has limited impact as an individual act. However, the *collective* adoption of new pronoun systems within trans communities on the Internet has provided a means by which new forms of trans language can be first implemented (and experimented with) in affirmative environments.

Interventions such as the introduction of gender neutral pronouns are most commonly undertaken by and for individuals who, like Feinberg, do not consider themselves to be (straightforwardly, exclusively or at all) female *or* male. A myriad of terms have been coined to describe these gendered (and/or non-gendered) possibilities, such as 'agender', 'bi-gender', 'boi', 'enby', 'genderblender', 'genderfluid', 'genderfuck', 'neutrois', and 'polygender'. These sit alongside older identities that predate the contemporary trans movement, but can be incorporated into it, such as the 'transvestites, [...] drag queens and drag kings, cross-dressers, bull-daggers, stone butches, androgynes [and] diesel dykes' described by Feinberg (1992: 206). The most common such terms at the time of writing are 'non-binary' and 'genderqueer', which are also commonly employed as umbrella terms for the wider repertoire of identities described above (Richards et al., 2016). Like Feinberg's interpretation of trans/transgender, and in contrast to the fixity of both traditional medical terminology and social identities such as 'transgenderist', neither 'non-binary' nor 'genderqueer' have an absolute, clearly delineated meaning. Instead, they denote personal and/or collective gendered movement in terms of rejecting binary gendered norms. For instance, the edited collection *Genderqueer* (Nestle et al., 2002) addresses a great number of differently gendered subjectivities belonging to individuals who might previously have been categorised simply as transsexual, as cross-dressers, or as gender

non-conforming gay, lesbian and/or bi people utilising terms such as 'butch' or 'femme'. In this way, space is created within non-binary and genderqueer identity categories for both individuals intending to physically transition, and those who have no desire to do so.¹⁴ Non-binary and genderqueer language therefore creates a means by which collective movement *can* occur – in terms of social understanding and political recognition – even as traditional categorical boundaries are broken down, reassembled, and broken down again. This collective movement is beginning to achieve the political goal of social affirmation through recognition in a number of settings, having successfully campaigned for the inclusion of non-binary identifiers in contexts ranging from United Nations reports to the formal records of the UK's Royal Mail (Richards et al., 2016).

In this way, Feinberg's (1992; 1999) vision of a collective trans movement has been enabled through the wide dissemination of writing by herself and others, academic and non-academic. Trans has become both a 'politicized identity category' and something that people *do* (Enke, 2012: 236).¹⁵ Trans language is forged through interactions of the academic, the political and the everyday, facilitated greatly by the Internet. This collective movement has achieved a number of successes in challenging the hegemonic discourse of binary gender, and in achieving forms of social and legal recognition. Such achievements are intrinsically linked to the advancement of increasing options for movement-oriented identities, providing a basis by which more liberated individual engagements with gender might be rendered possible. In these social and political changes, and in alternatives to condition-oriented models of trans possibility, a wider range of trans lives become liveable.

Naming oppression: transphobia and cisgenderism

Having named 'trans' – along with numerous related possibilities – the trans movement worked to name the means by which trans people find themselves marginalised in various spheres of society, including within the realm of healthcare provision. Two of the most important interventions in this arena are the naming of 'transphobia' and of 'cis' norms.

'Transphobia' resembles related terms such as 'homophobia' in describing prejudicial 'anti-trans sentiments' underpinning acts of violence, harassment, and

¹⁴ It is important to note, however, that whilst all of these non-binary and genderqueer identities can be recognised under the 'trans' umbrella, not all individuals identifying with them necessarily regard themselves as 'trans'.

¹⁵ This assessment reflects West & Zimmerman's (1987) account of 'doing' gender.

discrimination (Hill & Willoughby, 2005). Transphobia can therefore describe an attitude towards the trans subject, but can also represent a wider rejection of gendered movement, thereby denoting 'the fear of the subject in transition' (Prosser, cited in Heyes, 2007: 201). Attempts to name transphobia can be traced to the 1990s, with Bornstein (1994) considering the term, and Feinberg (1992) proposing 'genderphobia'. At the time of writing, 'transphobia' has achieved a discursive stability and social recognition through regular use within trans community spaces and (increasingly) beyond. In this thesis I follow Bettcher (2007: 46) in regarding transphobia as 'any negative attitudes [...] harboured towards transpeople on the basis of our enactments of gender', while also acknowledging that this can intersect complexly with other forms of prejudicial attitude and behaviour, including homophobia, racism and sexism (Koyama, 2004; Bettcher, 2007; Lambie, 2008; Richardson & Monro, 2010).

A more complex genealogy can be attributed to 'cis', a term utilised by trans people for the purpose of 'decentralizing the dominant group' (Koyama, 2002). Cis – along with related words such as cisgender and cissexual – has been attributed with a number of overlapping but separate meanings. Most simply, 'cis' can be regarded as an antonym of 'trans': that is, people who are 'not trans' are 'cis'. Cis may also operate as a means by which non-trans privilege can be named – i.e. if you are not trans, you hold a cis privilege (Koyama, 2002; Serano, 2007) – and/or it can be used to describe the state of 'living a life in congruence with static medico-juridical determinations of one's sex/gender' (Enke, 2012: 236). Biologist Dana Leland Defosse is generally credited with coining 'cisgender' in 1994, within an online discussion around transphobia within university campuses (Enke, 2012: 234); the term was later popularised in the 2000s following the publication of Serano's (2007) influential trans feminist book *Whipping Girl*. Like 'trans', 'cis' is derived from a Latin root; where 'trans-' is a prefix meaning 'across from' or 'on the other side of', 'cis-' is a prefix meaning 'on the same side' as (Ansara & Hegarty, 2012: 152). According to Defosse, the use of 'cis' within the social realm of gender was originally intended to reflect the use of the prefix 'cis-' within scientific disciplines such as molecular biology and organic chemistry (Enke, 2012: 235).

While 'cis' enables nuanced conversations around gender, transition, privilege and hegemony (Serano, 2007), recent critics have noted the risks of creating a trans/cis binary that precludes the possibility of figurative, narrative and social movement both past and present, between and within these categories (Ansara & Hegarty, 2012; Enke, 2012). For example, popular conceptions of cis that position an individual as trans *or*

cis leave little space for an individual to be ‘somewhat’ trans or cis, to ‘become’ trans, or to ‘no longer be’ trans. In creating a binary opposition, trans/cis thereby become binary categories of selfhood where the individual is always (and has always) been one or the other, thereby stripping ‘trans’ of movement. Ironically, the trans/cis binary also poses a challenge for understandings of trans as condition. Enke (2012: 242) describes the example of surgeon and gynaecologist Dr Marci Bowers, who has transitioned in the past but now regards herself simply as ‘a woman’ rather than as ‘a transsexual’, or as ‘a transsexual woman’. In this way, the use of trans/cis as fixed categories does not leave space for trans to be resolvable. Within this thesis, therefore, I seek to address these issues by regarding ‘cis’ – like ‘trans’ – as a broad, unstable category with fluid boundaries, denoting a range of social experiences or modes of moving through the world, rather than any kind of fixed, absolute identity.

The use of ‘cis’ as a contingent category enables a discussion of *cisgenderism* (Serano, 2007; Ansara & Hegarty, 2012; Kennedy, 2013). In Ansara & Hegarty’s (2012: 141) account, cisgenderism – in contrast to transphobia – ‘describes a prejudicial *ideology*, rather than an individual *attitude*, that is systemic, multi-level and reflected in authoritative cultural discourses’. In this sense, it is comparable to terms such as ‘ableism’ and ‘heterosexism’ in denoting a means by which society happens to be organised to privilege particular bodies and behaviours. Cisgenderism thus describes the structuring of social norms and institutions *around the assumption that everyone is cis*, thereby offering a means to analyse ‘the difficulties faced by transgender people in a culture simply not constituted to account for our existence’ (Kennedy, 2013: 3).

‘Transphobia’, ‘cis’ and ‘cisgenderism’ are therefore examples of language that has emerged from the intersection of transgender studies and Internet communities, and in the context of this discussion they are linked to understandings of trans as movement. In this thesis I use ‘transphobia’ to refer to individual acts of prejudice towards trans people in general and trans patients in particular. More prominently, however, I employ ‘cisgenderism’ to describe the social *processes* by which trans people are marginalised.

Movement as condition: towards a more inclusive model of trans health?

I have noted that a small number of health professionals have authored publications within the medical literatures that speak directly to transgender studies. This move reflects calls for increased affirmation of new trans identities from within medical literatures (e.g. Lombardi, 2001; Bockting, 2009b; Serano, 2010; Richards et al., 2015), following years of work from trans movement activists opposed to the paternalism and psychopathologisation of traditional medical models (Vähäpassi, 2013; Hanssmann, 2016). In a similar manner to groups such as women's health campaigners and AIDS patient organisations (e.g. Epstein, 1996; Franklin, 1997), trans activists have sought to establish themselves as 'experts' with access to alternative forms of relevant knowledge. This is accompanied by the growing presence of trans people *within* health professions, a shift noted by Richards & Lenihan (2012) and Richards et al. (2014). Christoph Hanssmann (2016: 125) argues that such 'insider-providers' can drive 'ideological and practical challenges and refigurings'.

The gradual ideological shift signalled by the emergence of insider-providers, along with a growing recognition of trans 'movement' insights, has informed Bockting's (2009a) description of trans health as 'a field in transition'. However, this transition has not necessarily resulted in a move away from discourses of trans as condition within medical practice. Instead, understandings of trans as movement have arguably been *incorporated* into models of trans as condition, particularly in the UK context.

An example of this incorporation of movement into condition can be seen in the increasing recognition of non-binary and genderqueer identities within the medical literatures. For instance, Version 7 of the WPATH *Standards of Care* notes that some individuals 'no longer consider themselves to be either male or female' and that they may therefore 'transcend a male/female binary understanding of gender' (Coleman et al., 2011: 171). Christina Richards and colleagues (2016; forthcoming) build upon this to outline how physical transitions for non-binary and genderqueer people might be managed in clinical settings through the provision of affirmative mental health support, hormone therapies and degendering surgeries. Nevertheless, the provision of this treatment for individuals engaged in movement away from the male/female binary remains linked to the diagnostic category of 'gender dysphoria' within DSM-5 (Richards et al., 2016: 97). A number of commentators (e.g. Richards et al., 2015; Barrett, 2016; Drescher et al. 2016) have argued that this continued adherence to pathologising diagnostic models is essentially a pragmatic move, as 'the healthcare funding systems in many countries are set up in such a way as to make it effectively

impossible to assist trans people with hormones and surgeries if they do not have a diagnosis which relates to those interventions' (Richards et al., 2015: 310).

It is perhaps necessary to regard trans as in some sense resolvable. This can be as much the case for individuals who seek to undertake a non-binary transition – oriented towards movement and fluidity – as it is for those such as Enke's (2012) example of Marci Bowers, who sought to position herself as 'just' a woman. In regarding treatment as a pragmatic move (both in political terms, and in terms of meeting the needs of patients) it is possible to partly reconcile understandings of trans as movement with understandings of trans as condition.

Gender identities and expressions are diverse, and hormones and surgery are just two of many options available to assist people with achieving comfort with self and identity. Thus, transsexual, transgender and gender non-conforming individuals are not inherently disordered. Rather, the distress of gender dysphoria, when present, is the concern that might be diagnosable and for which various treatments are available. (Coleman et al., 2011: 168)

However, in the following chapters of this thesis I shall show that significant tensions remain between trans patients and the health professionals who purportedly embrace the admirable recognition of trans complexities seen in the above quote from the Version 7 WPATH *Standards of Care*. I therefore next outline an alternative means by which discourses of trans as condition and trans as movement might be potentially reconciled: this time, through incorporating understandings of condition into a model of movement.

Condition as movement: towards gender pluralism

Sociological understandings of trans possibility

An increasing number of social researchers have sought to describe and theorise trans lives, particularly since the beginning of the 2000s. Historically, sociological accounts of trans possibility have focused primarily upon uncovering what trans identities and experiences might mean for wider understandings of gendered behaviour and norms (e.g. Garfinkel, 1967; Bolin, 1994; Kessler & McKenna, 2000; Schilt & Connell, 2007). More recently, social researchers have increasingly focused more on the liveable reality of being trans, addressing social experiences of (for instance) transition and gender affirmation as well as processes of marginalisation and

discrimination (e.g. Namaste, 2000; Monro, 2005; Ekins & King, 2006; Hines, 2007; Dewey, 2008; Connell, 2010; Hines & Sanger, 2010; Sanger, 2010; Beemyn & Rankin, 2011; Burke, 2011; Davy, 2011; Pearce, 2012; Kennedy, 2013; Capuzza, 2014; Raun, 2015).

The work of Richard Ekins and Dave King sits between these two approaches. Ekins & King (2006) draw upon three decades of case studies to describe *processes* of 'transgendering' – migrating, oscillating, negating and transcending – and explore the meanings of these processes for trans people. I read this approach as accounting for how trans identities might be rooted in notions of condition *and/or* movement. The authors' account of 'migrating' can be compared to the account of transsexualism provided by writers such as Prosser (1998), Namaste (2000) and Rubin (2003). This process is one of movement through transition, but also of conditional resolution through the notion of a fixed end point to that transition. By contrast, 'oscillation' involves movement back and forth between gendered positions. This may entail a binary 'dual role' approach to gender (in which an individual presents in a relatively normative way as either a man or a woman in different social circumstances), or a more gender fluid approach. 'Negation' describes moves towards a fixed point that is radically different to prominent conditional discourses: that of an *ungendered* subjectivity. This can be done by erasing indicators of assigned sex and gender (through body modification and/or social presentation) in order to create an ambiguous or a 'neutral' appearance. By contrast, 'transcending' gender offers a more flexible shift away from binary gender norms, as exemplified perhaps by individuals such as Bornstein (1994) and Feinberg (1999). Importantly, by focusing on transgendering *processes*, Ekins & King (2006) offer an alternative to the totalising languages of diagnosis and identity. For example, the traditional, condition-oriented medical models of transsexualism and transvestism can be described through the models of 'migration' and 'oscillation' respectively; models that also enable the recognition of a (potentially resolvable) movement. Moreover, non-binary 'transsexual' transitions can be recognised through the negation or even the transcending of normative gender. Ekins & King (2006) therefore provide a means by which identities and experiences grounded in understandings of trans as condition can be incorporated into a wider model of trans as movement. This possibility has been addressed more directly by Monro (2005; 2007; 2010) through her concept of 'gender pluralism'.

Echoing Prosser (1998) and Namaste (2000), Monro draws upon empirical research with trans participants to note that movement-oriented accounts of trans

subjectivity from queer and postmodern theorists such as Butler (1993) and Bornstein (1994) frequently fail to acknowledge transsexual 'experience[s] of sexed embodiment' (Monro, 2005: 10). By seeking to queer *all* approaches to gender, such theorists risk leaving little space for those who seek to 'resolve' their transness and identify within traditional 'binary' categories of female or male. Moreover, a number of trans activists have argued against entirely breaking down definable social categories – such as 'transsexual' – that might provide a basis for specific political action. At the same time, Monro (2005; 2007) states that it is vital to acknowledge the gendered politics and experiences of those who seek to understand gendered subjectivity beyond the male/female binary. She therefore advocates 'gender pluralism' as an approach that can incorporate diverse approaches to trans/gendered possibility while maintaining a strategic incorporation of identity labels.

[T]his involves building models of gender that include gender diversity at every level, not just at the level of representation and discourse, as is the case with postmodernist and poststructuralist approaches. [...] [W]e need a pluralist model of gender that supports intersex, androgynous, gender-fluid, transsexual, cross-dressing, multiply-gendered, and non-male/female people as (1) physical, embodied people, with the biological foundationalism¹⁶ that this implies; (2) social people, who may change genders despite having a fairly static physical appearance; (3) psychological people, who may have an experience of themselves which is different to their social and physical identities and mainstream male/female norms; (4) political actors, who require changes in social structures and institutions to enable them to have basic human rights; (5) academics, who may seek to critique current gender theory and develop pluralist alternatives. (Monro, 2005: 14)

Gender pluralism understands the social reality of gender as constructed, but also offers space for individuals to feel a deep-seated need to physically transition and find a 'home' (Prosser, 1998) in their transitioned body. As trans activist Roz Kaveney (cited in Monro, 2005: 13) argues, 'we are caught in a contradiction – and must embrace this'. Gender pluralism provides a frame by which the political movement envisaged by Feinberg (1992; 1999) might be understood as theoretically coherent *through* its embrace of contradiction. In this way, Monro's account provides for an

¹⁶ In Monro's discussion of 'biological foundationalism' she draws upon the accounts of research participants who describe sexed 'bodymaps' in a manner similar to Serano's (2007) later theorising of 'subconscious sex' to account for the desire to physically transition.

incorporation of condition-oriented identities into a model of *social movement* that itself draws upon understandings of trans *as* movement, incorporating transitions and diversities both physical and social in many forms. This approach is enacted in edited collections such as Nestle et al. (2002) and Bornstein & Bergman (2010), which bring together a large array of trans, non-binary and/or genderqueer perspectives on gendered subjectivity, as well as in the inclusive approach of many contemporary trans activist groups. It is here that I also locate my own work, writing from a poststructuralist, constructivist perspective while also seeking to acknowledge the diverse lived and embodied realities of trans people.

Qualitative accounts of trans health

Gender pluralist models of trans diversity have informed the relatively scarce literature of trans health within the UK. Within the discipline of sociology, the majority of work in this area has been undertaken by Zowie Davy, through her examination of trans medico-legal embodiment, and by Sally Hines, as a part of her account of trans 'communities of care'. Hines' (2007: 31) 'queer sociology of transgender' follows Monro in aiming to simultaneously 'extend the notion of "queer" to a range of non-normative subject positions (gendered, sexual and embodied), and to bring materiality and corporality to poststructuralist analyses'. Davy's work similarly recognises the diversity of gendered possibilities in the 'agentic practices of transpeople living a gender that suits them better, whether within the binary gender system, or beyond it' (Davy, 2015: 1169). Both have conducted qualitative studies with trans people residing in the UK.

Davy (2010; 2011; 2015) describes how the concept of 'gender dysphoria' remains central to the management of trans healthcare provision, to wider forms of social and legal recognition, and to individual subjectivity. The accounts of her research participants 'show how their desire for body modification and legal recognition needs to be negotiated through medical discourses, and requires working "with" doctors and psychiatrists when approaching the services in relation to bodily modification and legal recognition that constitute them' (Davy, 2010: 107). Echoing Stone (1991), Hines (2007) argues that trans patients are most likely to successfully negotiate these medical discourses through conforming to practitioners' notions of an appropriate trans subject. This appropriate – 'trans enough' (Catalano, 2015; Nicolazzo, 2015) – subject is typically constructed as binary-identified, and transitioning. Moreover, 'those who conform to medical understandings by articulating the "condition" of "gender

dysphoria” are granted gender reassignment, while those who question medical discourse, and/or articulate more ambiguous and complex gender identities and presentations are denied [treatment]’ (Hines, 2007: 169). For this reason, both Davy (2010; 2011) and Hines (2007; 2013) describe the negotiation of gender identity services as a *difficult* and often negative experience for trans patients; this is also briefly discussed by Tam Sanger (2010) in her work on trans partnerships. This difficulty of negotiating gender identity services can be compounded by misgendering practices (such as those described by Ansara & Hegarty, 2012) in the assessment and management of patients seeking a diagnosis of gender dysphoria. Davy (2011: 129) describes how, beyond representing a ‘simple lack of respect’, this can ‘inflict a grievous wound, saddling people with crippling self-hatred’.

Numerous participants in studies undertaken by Davy (2010; 2011), Hines (2007; 2013) and Sanger (2010) – as well as Ekins & King (2006) – also describe the potential *affirmative* value of gender identity services, particularly when strong and inclusive support is available from health professionals. This support is impossible to guarantee, however, due to the prevalence of misgendering practices and a lack of recognition for diversity and movement within the diagnosis of ‘gender dysphoria’. Affirmative treatment is therefore frequently regarded by trans patients as a matter of ‘luck’, or as something that can only be guaranteed through private providers.

[E]xperiences of accessing body modification technologies can be both positive and negative, experience of which is contingent on whether they were taken seriously or not by the GIC¹⁷ and GPs. Both quality and opportunity of treatment depended on the ‘luck of the draw’ or a ‘postcode lottery’ for the participants in this research in relation to both GPs and psychiatrists. ‘Luck’ was often replaced by agency and respect if the participant was fortunate enough to have the capital to fund their body modifications privately, indicating that trans experiences are situated within a class system. (Davy, 2010: 123)

However, both Davy (2010; 2011) and Sanger (2010) also note that discourses of trans as movement have begun to very gradually enable a greater recognition of trans/gendered possibilities within healthcare settings, reflecting the claims of

¹⁷ The acronym ‘GIC’ is commonly used to refer to ‘gender identity clinics’ within a UK context, as in this quote and others throughout this thesis. However, I generally refer instead to ‘gender clinics’ within my own writing. I do so in order to reduce my use of acronyms, but also to reduce confusion as ‘GIC’ is often also used to refer to the proposed, forthcoming ICD-11 diagnosis of ‘gender incongruence in childhood’ within the international literature of trans health (Winter et al., 2016).

practitioners such as Richards et al. (2016). This can be seen, for example, in the publication of reports and guidance that acknowledge a wider range of trans subjectivities than encompassed within the traditional transsexual narrative, commissioned by and for public health bodies (e.g. Fish, 2007; Burns, 2008; NHS England, 2015a; 2015b). In this way, ‘the governance of trans individuals has seemingly become less stringent with greater recognition of diversity emerging’ (Sanger, 2010: 12).

The recognition (or otherwise) of trans subjectivities by medical authorities plays an important role in *legal recognition* due to the design of legislation such as the Gender Recognition Act 2004. This law was groundbreaking in that it enabled (in theory, at least¹⁸) the legal recognition of acquired trans genders *without* recipients first having to undergo genital surgeries. However, the Act also remains grounded in conditional, binary medical understandings of trans that do not fully acknowledge transsexual diversities, let alone non-binary or genderqueer genders (Hines, 2007; 2010; 2013; Davy, 2010; 2011). This can be seen in the Act’s recognition of just female and male genders, in line with binary norms, and in the role of health professionals in its enactment. In order to obtain formal gender recognition, trans people must demonstrate – *with evidence from medical practitioners* – that they have undergone a permanent change of gender. This evidence is submitted for approval to a Gender Recognition Panel, whose membership includes practitioners from gender clinics.¹⁹ In this way, health professionals play an important role in ‘enabling – or disabling – recognition’ within both healthcare and legal settings (Hines, 2013: 58).

Hines (2007) also looks beyond gender identity services in her wider account of trans ‘communities of care’. Noting that provisions for – and the recognition of – trans people is often lacking in primary healthcare settings and social care services alike, she outlines how trans communities can offer alternative forms of care through mutual support and advice on matters related to identity, transition and mental health. There is, therefore, an alternative to affirmation through medical recognition to be found within everyday *collective* acts of solidarity within trans community settings.

¹⁸ A number of participants in this study described encountering difficulties in obtaining a Gender Recognition Certificate (GRC) without having first undergone surgical interventions.

¹⁹ Several participants stated that the gender identity specialists overseeing their treatment refused to support their application for a GRC prior to surgery. In (at least) one of these instances, the specialist in question also sat on the Gender Recognition Panel.

Quantitative and mixed-methods accounts of trans health

The qualitative evidence base described above has been bolstered in recent years by a number of surveys that examine trans patients' reported experiences of healthcare service provision. While these studies often do not engage directly with sociological theory, I regard them as gender pluralist in that they draw upon a wide, inclusive understanding of 'trans' possibility in assessing the provision of healthcare services. They typically prioritise quantitative accounts of trans experience, but only three have provided statistically significant findings grounded in a large and diverse set of specifically UK-based respondents: the *Engendered Penalties* report (Whittle et al., 2007), the *Trans Mental Health Study* (McNeil et al., 2012; Ellis et al., 2015), and Kristensen & Broome's (2015) account of autism within trans populations. The first two studies are both examples of action research, undertaken by trans activist groups in collaboration with social researchers. Each produced a complex picture of trans health, reflecting Davy's (2010) assessment of the role of 'luck' in accessing trans-affirming care. Trans patient experiences of discrimination, harassment and misgendering are shown to be relatively common in all areas of healthcare provision, including the trans-specific, transition-oriented setting of the gender clinic. However, misunderstandings between practitioners and patients are more common still, as is ignorance from otherwise well-meaning health professionals.

Similar findings were reported from smaller investigations undertaken by trans individuals and organisations (e.g. Bishop, 2013; Belcher, 2014), public health bodies (e.g. Schonfield & Gardner, 2008), practitioners (e.g. Hunt, 2014) and the UK Government/Parliament (Home Office, 2011a; Women and Equalities Committee, 2016). By contrast, a survey undertaken by gender identity specialists indicates high levels of patient satisfaction at their clinics (Davies et al., 2013).²⁰ As these studies provide the majority of evidence on healthcare provision for trans people in the UK – reflecting the wider dearth of evidence described by Meads et al. (2009) as well as Mitchell & Howarth (2009) – I refer to their indicative findings, where relevant, throughout this thesis.

²⁰ Davy (2015: 1169) argues that trans patients' adherence to 'correct' medical narratives for the purposes of ensuring access to treatment might distort the findings of research undertaken by gender clinics.

Conclusion: negotiating medical discourse

In two recently-published interventions written (or co-written) by health professionals working at the UK's Charing Cross and Nottingham gender clinics, the authors propose that sociological accounts of trans health focus too much on constructing a rigid and overwhelmingly negative account of 'medical discourse' (Richards & Lenihan, 2012; Richards et al., 2014). They argue that terms such as "the medical approach to/discourse of" trans' work to create 'a straw figure, whereby any [negative] reported experiences of trans healthcare, or views of one professional, is presented as a monolithic' (Richards et al., 2014: 254). They further note that contemporary gender clinics are diverse spaces with multidisciplinary teams and trans employees, 'dedicated to providing quality, pragmatically useful, care for trans people' (Richards & Lenihan, 2012), with clinicians 'rarely relish[ing] the *exercise of power*, or the role of "gatekeeper"' (Richards et al., 2014: 255, emphasis mine).

Some past accounts of 'medical discourse' from sociologists have perhaps indeed been guilty of flattening complexity; as, indeed, have past accounts of 'trans' from medical practitioners, radical feminists, and trans people themselves both within and without these groups. In this chapter I have therefore sought to instead recognise the multiplicity of discourse. In referring to multiple, complexly overlapping discourses, and to discursive *repertoires* of trans possibility, I account for the ongoing negotiation of manifold understandings of 'trans'. In categorising these discourses according to an orientation towards 'condition' and/or 'movement', I aim to observe similarities and comparisons between ideas both within and beyond the medical literatures, while continuing to acknowledge difference and diversity. This is particularly important because the evolution of 'trans' language has not resulted in one paradigm neatly replacing another. Instead, multiple understandings of trans possibility remain relevant to this day.

The *story* that these collective discourses tell, however, does suggest that the somewhat rosy picture of trans-affirming healthcare service provision presented by Richards & Lenihan (2012), Davies et al. (2013) and Richards et al. (2014) is somewhat misleading. This is not because health practitioners are power-hungry or uncaring (although undoubtedly a minority engage in unprofessional or deeply inappropriate behaviour, as described by Ansara & Hegarty, 2012). Rather, it is because the historical and contemporary discursive *processes* by which trans possibilities have been negotiated ultimately centre practitioner expertise and credibility in a way that often works to sideline or silence patient perspectives. This can be seen in the creation of

categories such as transvestite and transsexual (Hirschfeld, 1910 [1991]; Cauldwell, 1949; Benjamin, 1966), in the establishment of related diagnoses in the DSM and ICD as well as the WPATH *Standards of Care*, and in the continuing impact of these concepts within healthcare settings and beyond, as described by social researchers such as Monro (2005; 2007; 2010), Hines (2007; 2010; 2013) and Davy (2010; 2011; 2015).

The progress of medical science – like all science – is not neutral (Foucault, 1978; Collins & Pinch, 1998; Hess, 2004). While some trans people have been involved in the creation of categories of diagnosis (Meyerowitz, 2002; Rubin, 2003), and while these categories have undoubtedly played an important role in making many trans lives *liveable* through the provision of gender identity services, they ultimately work to interpellate²¹ health professionals as ‘expert’; not simply in matters of service provision, but also in matters of *gendered possibility*. This has granted an enormous amount of power to the health professions over the past century, resulting in a discursive power differential that has only been significantly challenged following the emergence of the post-1990s trans movement. Importantly, even critiques of – and suggested alternatives to – medical models have ultimately been *defined against them*. This can be seen in interventions from both cis radical feminists (e.g. Raymond, 1979) and trans theorists (e.g. Prince, 1978 [2005]; Stone, 1991). It is for this reason that transgender studies scholars – including sociologists – seek to critically engage with medical discourses, and to interrogate health professionals’ exercise of power through diagnosis and discourse alike. In doing so, they reflect and draw upon similar critiques of medical discourse (e.g. Epstein, 1996; Franklin, 1997; Jain, 2007; Steinberg, 2015a; Steinberg, 2015b) that have emerged from feminist and queer theory and activism (Hanssmann, 2016).

The following chapters of this thesis therefore offer a timely empirical account of the *ongoing* negotiation of discourses of trans health at a time of both continuity and change. I build on the work of Hines (2007; 2010; 2013) and Davy (2010; 2011; 2015) in examining, in-depth, how discourses of trans health have been understood, contested and reimagined through the interaction of patients, activists and practitioners over a six-year period, within both gender identity services and the wider healthcare context. I follow Monro (2005; 2007; 2010) in taking a gender pluralist approach to understanding and acknowledging trans possibility, reflecting an overarching concern with centring the *liveability of trans lives* (Vähäpassi, 2013) rather

²¹ Interpellation ‘refers to the ways in which we are, on the one hand, inserted into discourse [...] and, on the other, insert ourselves into discourse (Steinberg, 2015b: 138).

than debates over authenticity or transgression. In this way, I broadly subscribe to a model of trans as movement; however, in doing so, I also seek also to acknowledge and affirm relevant trans participants' own understandings of trans as condition.

3

Trans Health in Practice Conditions of care, 2010-2016

[I]t is clear from our inquiry that trans people encounter significant problems in using general NHS services due to the attitude of some clinicians and other staff when providing care for trans patients. This is attributable to lack of knowledge and understanding – and even in some cases to out-and-out prejudice.

- House of Commons Women and Equalities Committee (2016)

As a result of rigid and strict procedures around gender presentation within GICs, many of our respondents found their experiences in these clinics quite traumatic.

- Sonja Ellis and colleagues (2015)

Not worth the trouble?

A couple of years ago I switched GP practice. Looking back on it, I wonder why it took me so long to do so.

The first signs of trouble were subtle. Appointments with my GP felt short and sharp. I assumed he was just a busy man, pressured by the demands of his job. I initially went to see him about being trans, as it happened. I registered with his practice around the time of my second appointment at Charing Cross gender clinic, at which I received a formal diagnosis of transsexualism. At this point I had transitioned socially and had been living ‘full time’ as a woman for over a year. Having already changed my name and received a new NHS card, I joined the practice as ‘Ruth’, with a female gender marker on my records.

My GP followed the instructions of the Charing Cross clinicians to the letter, at least in terms of signing off on my oestrogen prescription. However, it rapidly became apparent that he wasn’t particularly interested in monitoring my health once I was on hormones. The regular blood tests required by the endocrinologist at Charing Cross didn’t happen; my GP argued that he ‘wouldn’t understand what the results meant’ and refused to speak to the rest of his team, ask for help or look up guidance on the matter.

I never pursued the issue. 'It isn't worth the trouble', I felt; moreover, I didn't feel like I had the power to challenge my doctor. I wasn't aware at the time that I could seek support from patient advocacy bodies such as the NHS Patient Advice and Liaison Service.

During my recovery from surgery my GP signed me off as 'fit to work' at a point where I could still barely stand. I considered challenging this, but again thought it 'wasn't worth it'. I didn't know how or where I might have recourse against his decision.

Matters finally came (quietly) to a head when I sought help with a mental health referral following the untimely death of a housemate and good friend. Again, my GP's response felt quite unhelpful. As I sat there in his office, something in my patient notes (displayed on his computer screen) caught my eye. My GP referred to me entirely with male pronouns in the notes. 'Ah', I thought. He clearly did not respect that I was a woman, or that I was trans. Did this inform his more general attitude of dismissiveness towards me? I didn't dare directly accuse him of transphobia and was exhausted by the grief of my recent loss. I quietly registered with a different practice, and never saw him again.

My experience is in no way unusual. As noted in the opening chapters of this thesis, trans patients face numerous challenges in accessing healthcare services. In this chapter, I unpack the context of these challenges. Having provided a broad account of Western discourses of 'trans' in Chapter 2, this chapter describes the material conditions of trans health in the UK at the time this project was undertaken, from 2010 to 2016. It has been a time of both continuity and change, shaped on the one hand by deeply entrenched modes of practice and cisgenderist norms, and on the other by political forces such as activism and legislation. In this chapter I focus primarily on setting the scene for the analysis that follows in later parts of this thesis. I look at the context of healthcare provision, examining the conditions that trans patients have experienced and the challenges that they continue to face in attempting to access care that is affirming of their identities and/or experiences.

Firstly, I look at the issues that trans patients can face within general healthcare services. I build on the above vignette to show how the *power* associated with professional capital might lead trans patients to feel *powerless* to oppose instances of ignorance and/or discrimination, even in the wake of legislation such as the Equality Act 2010.

Secondly, I explore the clinical pathway(s) available to trans people who want to undergo a medically-mediated physical transition. At the heart of this account is a description of the patient journey from referral to treatment. Power is once again a key theme here: specifically, the manner in which UK gender identity services are characterised by the operation of control and judgement on the part of health professionals. I also look at the role of binary logic within the diagnostic process, plus the persistence of lengthy waits for treatment.

Throughout this chapter, I draw largely upon examples and evidence from social studies of trans health, clinical guidance and protocols, minutes, reports and legislation. However, at times I also touch briefly upon qualitative findings from my fieldwork. I return to these findings with a more analytic lens in later chapters.

The wider context of trans health

A considerable number of trans people face challenges accessing general health services; a matter that is particularly troubling given the high prevalence of mental and sexual health issues, substance abuse and experiences of violence amongst the trans population (Reisner et al., 2016). These challenges can frequently be attributed to a lack of knowledge pertaining to trans people amongst non-specialist health professionals. In the previous chapter of this thesis, I showed that a new language of trans has emerged and developed to account for and accommodate gender variant peoples' desires, interests and needs. However, the ideas and knowledges associated with this language have not necessarily been adopted extensively beyond trans community spaces; this is due in part to the continued hegemony of cisgenderist norms. Furthermore, transphobic prejudice and discrimination remain all too common within a range of health settings.

One in five participants in the *Engendered Penalties* study described their GP as 'not trans friendly' (Whittle et al., 2007: 44). More recently, Jay McNeil and colleagues (2012: 45) found that a majority of trans people had experienced at least one form of negative interaction within general health services. These findings are reflected in my own data; inappropriate behaviour from practitioners was frequently discussed within community forums and activist spaces. Sometimes – as with my own experiences with my GP – this behaviour involved the quiet denial of services and/or transphobic microaggressions (Nordmarken, 2014). In extreme but not uncommon cases,

inappropriate behaviour could entail explicit abuse, harassment or violence towards patients.

Non-specialist health professionals providing treatment for trans patients often lack relevant knowledge of trans issues (Whittle et al., 2007; Schonfield & Gardner, 2008; Bishop, 2013; Hunt, 2014; Women and Equalities Committee, 2016). Trans people frequently find themselves having to educate healthcare providers about any trans-specific health needs they might have, as well as more general etiquette surrounding (for instance) the use of their correct name and appropriate gendered pronouns. These issues are underpinned by a lack of training in trans issues for health professionals, both in medical schools and in terms of continuing professional development (Women and Equalities Committee, 2016). A significant minority of health professionals also engage in direct acts of discrimination against trans patients (McNeil et al., 2012; Belcher, 2014; NHS England, 2015a; Barrett, 2016). Such acts can be attributed to the circulation of 'enduring and mistaken and highly offensive stereotypes about trans people among the public at large' (cliniQ, cited in Women and Equalities Committee, 2016: 36).

Ignorance, prejudice and discrimination towards trans patients is underpinned by – and feeds into – an institutional resistance to change. This can be seen in the work of Louis Bailey and Jay McNeil (2013), who report on a project that was commissioned by NHS North West. The researchers intended to work with GP surgeries to generate a better evidence base for understanding trans health, and to improve access to primary care for trans people. However, they 'encountered a series of barriers which proved both insurmountable and demoralising', most often from practice managers and administrators (Bailey & McNeil, 2013: 4). Barriers included: information being withheld from researchers, 'a lack of awareness or understanding about trans people', and in some cases explicitly 'negative attitudes towards trans people' (5-6). GP surgeries were also resistant to the distribution of posters designed to both show support for trans patients and signpost relevant services (24). This lack of co-operation severely undermined the project and limited the extent of its impact (3).

Both the dearth of knowledge and the prevalence of prejudice around trans issues amongst healthcare practitioners and managers can have severe consequences for the provision of both specialist and general healthcare in the UK. For example, ignorance of trans health needs can lead some practitioners to unnecessarily connect irrelevant health issues to a patient's trans status. This can lead to trans patients being denied treatment. Moreover, the commonality of problems in accessing healthcare services

can foster a sense of mistrust amongst trans patients (Schonfield & Gardner, 2008: 42). I further explore the background to these issues and their consequences, with reference to my fieldwork, in Chapters 5 and 6.

An important characteristic of these problems is that trans patients and their advocates can feel powerless to challenge inappropriate care. Health practitioners hold a great deal of professional capital that makes it difficult for trans patients to feel able to challenge instances of ignorance or discrimination; like myself, many participants in this study felt that it 'wasn't worth' doing so. Trans rights advocate Helen Belcher (2014) attempted to tackle this issue by collecting accounts of alleged medical malpractice. These accounts included 'allegations of sexual abuse, physical abuse, verbal abuse, inappropriate and sometimes damaging treatment, treatment withheld, threats of withholding treatment, poor administration, and acting against patients' best interests' (Women and Equalities Committee, 2016: 41). A dossier of 98 such cases was presented to the General Medical Council (GMC) by Belcher. The GMC later confirmed that at least three of these were eventually formally submitted as complaints, but all were dismissed. In a submission to the House of Commons Women and Equalities Committee's *Transgender Equality Inquiry*, representatives of the GMC explained that:

For us to pursue a complaint, we will also usually need the patient to identify themselves and to consent to disclosure of their complaint to the doctor. This is an unavoidable part of due legal process, but we acknowledge it may be a disincentive to some to pursue complaints. (GMC, cited in Women and Equalities Committee, 2016: 42).

Challenging inappropriate care through formal channels can be an adversarial pursuit; one that many patients are unwilling to take. This situation is no doubt compounded by the high prevalence of mental health issues and economic marginalisation amongst the trans patient population (McNeil et al., 2012; Reisner et al., 2016). Moreover, attempts by action researchers such as Bailey & McNeil (2013) to advocate on *behalf* of trans patients can similarly result in an adversarial relationship between advocates and providers due to the barrier of entrenched cisgenderism and transphobia.

A right to good care?

While negative experiences were more commonly discussed, many participants in this project were also keen to recount *good* experiences of treatment. Furthermore, the NHS was generally very well-regarded, with a great number of individuals describing how they value both the organisation itself and the principle of health care being free at the point of delivery. Much of the positive feeling towards health service providers was no doubt due to the helpful and professional attitude of the practitioners in question. However, participants' positive experiences were also shaped by a growing body of professional guidance and laws written to support practitioners and/or protect the rights of trans patients.

The 2000s and 2010s saw the publication of numerous documents that aimed to help providers meet the general needs of trans patients, many of which were written by (or in collaboration with) trans professionals or activists (e.g. Fish, 2007; Burns, 2008; Curtis et al., 2008; NIGB, 2011; Ahmad et al., 2013). This period also saw the passage of three key pieces of equalities legislation. The Gender Recognition Act 2004 (commonly known amongst trans groups as 'the GRA') enabled trans people to change their birth certificate, on the condition that they intended this change to be permanent, and could prove that they had been living 'full time' in their preferred gender for at least two years with some form of medical supervision. The Sex Discrimination (Amendment of Legislation) Regulations 2008 prohibited discrimination against individuals with the protected characteristic of 'gender reassignment'²² in the provision of goods and services (including health services). The Equality Act 2010 reinforced this prohibition, and added a legal duty for public sector bodies in England, Wales and Scotland to eliminate discrimination, harassment and victimisation on the grounds of gender reassignment. All of this provides an environment in which public health providers have (in theory) some information on trans issues available to them, healthcare managers are charged with taking action to ensure that trans people do not face discrimination, and healthcare providers can (again, in theory) face legal proceedings if discrimination *does* occur.

²² As of 2010, an individual 'has the protected characteristic of gender reassignment if the person is proposing to undergo, is undergoing or has undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attributes of sex' (Equality Act 2010: Chapter 1, Section 7). Importantly, whilst this definition conflates 'sex' with 'gender' and has been widely interpreted as relevant only to 'binary' trans people, it *in theory* leaves space for the 'reassignment' of 'sex' to take place along non-binary lines (Whittle, 2016). Moreover, there is no requirement for medical supervision in order for an individual to have the protected characteristic.

The continuing prevalence of ignorance and prejudice within healthcare settings show that NHS guidance and legal protections are not sufficient to overcome institutional cisgenderism and transphobia. Trans patients (and patient advocates) still face the problem of challenging cisgenderism and transphobia due to the entrenched nature of these problems on an institutional level, and the adversarial manner of the formal channels by which individual acts of malpractice might be addressed. Nevertheless, they can be linked to a shift in power from service providers to patients; patients now have stronger grounds to oppose anything they might perceive as inappropriate treatment. In Chapter 7 I touch on how these guidelines and laws helped to provide trans patients with a sense that they *deserved* better and could challenge the power of healthcare professionals and institutions alike.

Gender identity services: the patient journey

I now look at how trans patients might typically navigate the UK's 'gender identity' services. I begin with a look at the diagnostic criteria that shape this patient journey, and explain how these criteria empower gender identity specialists as *gatekeepers*, controlling access to treatment such as hormone therapy and surgeries. I then examine the treatment pathway that NHS patients might expect to follow, before exploring two main alternatives to this pathway: private care, and the self-management of hormone therapy through self-medication.

Diagnostic criteria

In the UK, access both to gender identity services and to legal recognition through the GRA is typically predicated on a diagnosis 'of or relating to Gender Dysphoria' (Ahmad et al., 2013: 176), provided by mental health professionals at a gender clinic. For the past two decades, this has most typically taken the form of a diagnosis of 'Transsexualism' according to the 10th edition of the International Classification of Diseases (ICD-10):

A desire to live and be accepted as a member of the opposite sex, usually accompanied by a sense of discomfort with, or inappropriateness of, one's anatomic sex, and a wish to have surgery and hormonal treatment to make one's body as congruent as possible with one's preferred sex. (World Health Organization, 1992: F64.0)

This diagnosis also requires that the ‘transsexual identity [is] present persistently for at least two years’, and that it is ‘not a symptom of another mental disorder or a chromosomal abnormality’. Other gender-oriented diagnoses available to participants in this project have included ‘Dual-role transvestitism’ and ‘Fetishistic transvestitism’ from ICD-10, ‘Gender Identity Disorder’ and Transvestic Fetishism’ in DSM-IV and (from 2013) ‘Gender Dysphoria’ in DSM-5.

Assessment procedures for these diagnoses have historically been built upon a prescriptive assumption that transitions can/should take place within the gender binary, with the only imaginable and desirable outcomes being a permanent transition from male to female, or vice-versa (Davy, 2011; Ellis et al., 2015). This assumption is encoded in the binarist language of the ICD – which relies upon binary concepts such as ‘opposite sex’ (within the diagnosis of transsexualism, which generally allows for physical transition) and ‘dual role’ (within the diagnosis of dual role transvestism, which generally does not) – as well as in the DSM (Davy, 2015). Moreover, health professionals such as Barrett (2007) frequently insist that appropriate patient behaviour involves aiming to be ‘read’ by others as male or as female. In this way, the diagnostic power of the gender specialists can effectively reinforce a binary model of gender (NHS England, 2015b). As a result, many patients withhold ‘any level of ambivalence or uncertainty about their gender’ from practitioners (Ellis et al., 2015: 12).

In the previous chapter I noted that while gender identity specialists ‘rarely relish the exercise of power, or the role of “gatekeeper”’ (Richards et al., 2014: 255), the continuing emphasis on assessment and diagnosis within gender identity services nevertheless works to ensure that they *do* play this gatekeeping role, thereby *exercising power* as experts in gender. Transitioning individuals can, of course, act without guidance from such practitioners; as I described in the opening vignette of this chapter, I myself transitioned socially prior to my arrival at a gender clinic. However, gatekeepers within gender identity services effectively control access to forms of treatment such as hormone therapy and surgeries. This means that they have the power to determine what constitutes an appropriate or ‘trans enough’ patient for the purposes of specialist care. I propose that the operation of this power relies upon two binary distinctions. The first is the not-trans/trans distinction, which relies upon the presupposition that ‘trans’ is a conditional category that can be defined and delineated. The second is the male/female binary, which enables health professionals to conceptualise treatment in terms of a transition from one gender to the ‘opposite’.

NHS gender identity services: a linear pathway?

The majority of medically-supervised transitioning individuals in the UK access diagnosis and treatment through NHS gender clinics. Treatment regimens can vary considerably between the individual clinics, but are typically based upon a somewhat conservative interpretation of the WPATH *Standards of Care* (Coleman et al., 2011). It is important to note that the *Standards of Care* do not necessarily require that medical supervision of transitioning individuals be managed through one of these centralised institutions: indeed, treatment can in theory be managed by a family doctor. However, the *Standards* do state that a range of expert knowledges are required to oversee various aspects of transition. These must include a mental health assessment and/or screening from a mental health professional (typically a psychologist or psychiatrist, but this can also be a suitably qualified counsellor or therapist), and can also include hormone management by an endocrinologist and/or relevant operations undertaken by a surgeon (Coleman et al., 2011). While some countries (such as Canada) offer decentralised, collaborative approaches to the management of publicly funded gender identity services (Goldberg, 2006), the UK has typically seen a ‘clustering of expertise’ (Barrett, 2007: 4) within the institution of the gender clinic. This institutional approach is often seen as preferable by UK gender specialists (Barrett, 2007); as I shall show in my discussion of private care, alternative approaches to treatment have faced censure backed by practitioners based at the gender clinics.

Prior to 2012, gender identity services provided through the NHS tended to be provided according to a linear pathway. Assuming that a patient successfully obtained funding from their local PCT (Primary Care Trust), Board or Trust, they would normally take the following steps during transition:

- 1) Referral from GP to local mental health service (or directly to a gender clinic in Scotland).
- 2) Referral from local mental health service to gender clinic.
- 3) Assessment by (at least) two clinicians (or one in Scotland).
- 4) ‘Real Life Experience’ (RLE; often – but not always – undertaken concurrently with hormone therapy).
- 5) Hormone therapy and other interventions such as speech therapy or hair removal.
- 6) Assessment for surgeries.
- 7) Surgery/surgeries.

This pathway is generally subdivided into two parallel routes: a ‘masculinising’ route (involving treatments such as testosterone supplements and chest reconstruction) and a ‘feminising’ route (involving treatments such as oestrogen supplements and facial hair removal) (NHS England, 2015c). In this way, even treatment for non-binary and genderqueer patients (where provided) is conceptualised in binary terms.

Any given individual might ‘finish’ their transition after taking only a given number of these steps: for example, a patient might choose not to have surgery,²³ or alternatively they might be refused hormone therapy by practitioners who felt that they did not adequately follow the requirements for RLE. In cases where an individual was denied a referral and/or treatment from a particular provider and still sought to transition through the NHS, they generally had to start again from the beginning of the pathway.

During recent years the NHS pathways for most gender identity services have become somewhat more flexible. This is due to the implementation of a new national protocol for Scotland in 2012, coupled with legal changes in England and Wales that were implemented in 2013. I discuss these changes toward the end of the chapter.

Referral and waiting

At the time of writing there are twelve NHS gender clinics for adults in the UK and three for children and adolescents; the number fluctuated somewhat during fieldwork as some clinics closed and others opened. A majority of these are based in England. The clinic with the largest capacity by a considerable margin is the West London Mental Health Trust Gender Identity Clinic, which is more commonly known amongst patients and clinicians alike as ‘Charing Cross’ due to its proximity and historic links to Charing Cross Hospital. Charing Cross’ patients number in the thousands; by comparison, patients at the UK’s other gender clinics typically number in the dozens or the hundreds (UK Trans Info, 2016). Other notably large clinics include the Nottingham Centre for Gender Dysphoria, and Glasgow’s Sandyford Clinic.

The NHS has a legal requirement to provide patients with an initial appointment within a maximum of 18 weeks from referral to a service. However, the relevance of

²³ Sometimes, however, gender identity specialists could be troubled by the prospect of a patient obtaining hormones without also intending to undertake surgery. I explore the rationale for (and consequences of) this perspective in Chapter 5, *(Re)defining Trans*.

this to gender clinics has long been ambiguous and contested.²⁴ In reality, waiting list lengths for gender identity services are considerable, with the current average wait being 42 weeks for adult services, or 21 weeks for child and adolescent services (UK Trans Info, 2016). One of the longest waiting lists encountered during fieldwork was for the (now defunct) York gender clinic, which had a waiting time of four-and-a-half years in 2010; at present, the longest waiting list (for Leeds Gender Identity Service) is four years (UK Trans Info, 2016).

These long waits are due in part to 'financial uncertainties' (including issues with funding) as well as 'retirements and closures' (Combs et al., 2008: 1-2). However, they have also been shaped by the changing landscape of trans possibility following the emergence of the trans movement in the 1990s. Growing public awareness, coupled with some decrease in the stigmatisation of trans people (as now codified in law) has arguably made it 'easier' to be trans. This has resulted in an exponential increase in the visible trans population over the last decade, leading in turn to an enormous growth in patient numbers (Combs et al., 2008; Reed et al., 2009; Davies et al., 2013; UK Trans Info, 2016). Ryan Combs and colleagues (2008: 30) describe Charing Cross' 'max capacity' as 2500. By October 2015, 3645 patients were on the books at Charing Cross, with an additional 1728 people waiting for their first appointment (UK Trans Info, 2016).

In the years leading to 2013, patients based in England, Wales and Northern Ireland typically required two referrals²⁵ in order to access gender clinic waiting lists in the first place: the first being a referral from a GP to a local mental health practitioner, and the second being a referral from the local mental health practitioner to the gender clinic (Barrett, 2007). In each instance, patients had to wait (sometimes for weeks or months) for a referral letter to arrive before being placed on a formal waiting list for the requested service. The situation differed somewhat in Scotland, where patients seeking treatment at gender clinics in Edinburgh and Glasgow could self-refer, or be referred by a GP. As of 2013, trans patients in the rest of the UK can also be referred to a gender clinic by their GP.

²⁴ For many years a number of NHS bodies (including a number of gender clinics) claimed that the 18-week requirement was not applicable to gender identity services. However, following a campaign by trans organisation UK Trans Info, a letter from NHS England's Director of Commissioning Specialised Services to Healthwatch England's Chief Executive in January 2015 confirmed that the 18-week requirement *is* in fact applicable in this case. Since this time, some efforts have been made (with mixed success) to reduce gender clinic waiting lists (NHS England, 2015c).

²⁵ In practice, some patients were referred back-and-forth between local mental health services before finally receiving a referral to a GIC.

Prior to 2013, *some* patients in England and Wales would be referred to a gender clinic almost immediately following an appointment with their local mental health service; others would be expected to attend appointments for several months. According to Charing Cross lead clinician James Barrett (2007: 9), the role of local mental health practitioners was *not* to offer or refuse a diagnosis of or related to transsexualism, but instead to screen out individuals for whom an appointment at a gender clinic might be inappropriate, such as 'bemused but otherwise contented transvestites, lesbians, gay men and acutely psychotic people'. However, many local practitioners took it on themselves to assess patients, sometimes refusing a gender clinic referral to individuals with an avowed trans identity. To this day, patients might also find that referrals are refused or delayed by GPs (Davy, 2010; Barrett, 2016). In this way – and contrary to the intentions of the gender clinics (Barrett, 2016) – even *non-specialists* have the power to block access to treatment.

A number of patients have also historically found themselves unable to access services due to geographic and/or funding issues. Funding for patients wishing to attend a gender clinic was acquired through their local PCT, NHS Board or Trust prior to 2013. While these bodies were technically required to fund medical transition, some refused to do so, or placed caps on patient numbers (Combs et al., 2008; McNeil et al., 2012). This situation was particularly severe for Welsh patients. Wales does not have a gender clinic; patients there are instead typically referred to Charing Cross in London. A blanket ban in Wales on funding for gender identity services – imposed by commissioners in order to save money – prevented many people from transitioning through the NHS in the late 2000s. This caused a considerable patient backlog of Welsh referrals to Charing Cross for some years after the ban was lifted (Combs et al., 2008).

Waits within the system: assessment, diagnosis and Real Life Experience

Further waits are encountered once a patient is registered at an NHS gender clinic. There are a number of waiting periods built into the WPATH *Standards of Care*: for example, it is recommended that patients are assessed for gender dysphoria and any coexisting mental health conditions and provided with relevant information prior to hormone therapy, and that they 'engage in 12 continuous months of living in a gender role that is congruent with their gender identity' prior to any genital surgeries (Coleman et al., 2011: 202).

These waits are compounded by UK-specific clinical pathway requirements. Transitioning patients in the UK are typically required to obtain a diagnosis from at least two gender identity specialists²⁶ and undergo ‘Real Life Experience’²⁷ – also known as the ‘Real Life Test’ – in order to access treatments such as hormone therapy, speech therapy, facial hair removal and surgeries. The diagnoses are made on the basis of assessments undertaken on two or more²⁸ separate occasions, usually several weeks or months apart. Some gender clinics, such as the Nottingham Centre for Gender Dysphoria and Exeter’s ‘The Laurels’, require patients to attend three or more initial assessment appointments prior to diagnosis (NHS England, 2015c).

Assessment typically involves interviews of between 30 and 90 minutes, in which the patient is asked about their gendered feelings, their past and present experiences of gender presentation, their relationship with their body, and (often) sexual fantasies and experiences (Barrett, 2007; Speer, 2013; NHS England, 2015c). Sometimes additional requirements are made of patients as part of the assessment process. For instance, the Nottingham Centre for Gender Dysphoria asks patients to keep a diary of their gendered experiences, and requires patients to bring a friend or member of their family to one of their appointments. Specialists working at Nottingham argue that these measures help to assess the level of support that transitioning patients will receive from people close to them (NHS England, 2015c); however, numerous participants in this study stated that the family/friend appointment in particular was used by health professionals to ‘corroborate’ their account.²⁹ Following an initial diagnosis, patients at Nottingham are then required to sit before a clinical panel who decide whether or not to offer hormone therapy.

Real Life Experience (RLE) requires the patient to spend a period of time living in their new ‘gender role’: presenting socially in their preferred gender, changing their name and identification documents, coming out to friends, family and work colleagues. Evidence of this must typically be provided to practitioners. This is intended to show

²⁶ Versions 6 and 7 of the Standards of Care require the approval of just one mental health professional for the provision of hormone therapy and/or chest surgeries. This standard is followed in Scotland (NHS Scotland, 2012).

²⁷ The requirement of Real Life Experience for the purpose of hormone therapy was removed from the Standards of Care with the publication of Version 7 in 2011. This did not, however, have any immediate effect upon practice in many UK gender clinics.

²⁸ Some patients undergo assessment for several months or years before receiving a diagnosis. In some cases, this reflects their desire to explore their gender identity in depth and be sure that they are making the correct decision (NHS England, 2015c). In other cases, participants in this study argued that this extended period of assessment was the result of their refusing or being unable to meet the expectations of clinicians.

²⁹ I unpack the context of this claim in Chapter 6: *Trans Temporalities*.

‘whether [or not] the patient has demonstrated a satisfactory adjustment to a new gender role in a real-life setting’ (Barrett, 2007: 71). ‘Success’ in RLE tends to be judged in terms of ‘occupational, sexual, relationship and psychological stability’, with patients being treated as a member of their preferred gender category by others (Barrett, 2007: 72-73) on a *full time basis*. A number of gender identity specialists regard it as essential that patients have an ‘occupation’ as part of this process: that is, a job, a government training scheme, or an education course (Barrett, 2007: 72).³⁰ In this way, the power of the gender identity specialist can effectively extend beyond the management of gendered presentation alone.

Policies on diagnosis, RLE and the provision of treatment can therefore vary considerably between (and within) gender clinics (NHS England, 2015c). This is due largely to their historical development as independent entities, with national protocols only very recently implemented in Scotland and England (NHS Scotland, 2012; NHS England, 2013). However, a feature common to most UK clinics is the positioning of the health professionals as qualified to *decide whether or not a patient is trans* (whether or not they are ‘trans enough’). The requirement for at least two diagnoses demonstrates that, at least outside of Scotland, these assessments are not simply a matter of screening for troublesome co-morbidities, creating a care plan and ensuring that patients provide informed consent in line with the *Standards of Care* (Coleman et al., 2011). Instead, the assessment procedure is one in which practitioners exercise their *judgement* as to whether or not a patient should receive treatment, with the second (or third) opinion in place to ensure that the ‘wrong decision’ is not made (Barrett, 2007: 4). The severity of this decision is underpinned by the notion that transition represents a *permanent* move from male to female or from female to male. Health professionals working in gender clinics frequently highlight the importance of their role in reducing the *risk* of an inappropriate transition, which may result in regret over irreversible physical changes as well as possibly social consequences such as the loss of friends, family and/or work (Barrett, 2007; Richards & Lenihan, 2012; Richards et al., 2014).

In 2011, a patient satisfaction survey was undertaken at the Charing Cross and Nottingham gender clinics, with the findings published in the name of a number of gender identity specialists (Davies et al., 2013). In responding to the survey, a

³⁰ Barrett (2007: 72) argues that some occupations are ‘unacceptable’ for the purposes of RLE, including ‘work in a purely transvestite or transsexual environment’, and ‘prostitution’. His logic is that these occupations enable individuals to work *as transsexuals*, meaning that they cannot demonstrate their ability to survive in a new gender role for the purposes of RLE.

considerable majority of patients reported satisfaction with their gender clinic experience. However, in other research and in consultations, many trans people have also described their experience of stringent assessment procedures as demeaning, invasive and disempowering (Ellis et al., 2015; NHS England, 2015a; Women and Equalities Committee, 2016). Participants in a recent consultation argued that mental health professionals ‘have too much power around decisions of people within the trans community, both medically and legally’ (NHS England, 2015a). A patient quoted by Sonja Ellis and colleagues (2015: 11) describes how questions asked during their assessment were ‘were overly irrelevant, prying and sexual’, leading them to feel ‘utterly powerless and infantilised in my dealings with them’. In this way, the power held by health professionals within gender clinics is reflected in a *lack of power* experienced by patients in regards to managing their own identity and health. This, too, has its risks: Ellis et al. (2015: 13) note that ‘[a] number of participants [...] reported feeling that they had been pressured into doing things they did not want to do in order to “prove” their gender to professionals in GICs’, such as conforming to a particularly masculine or feminine gender role. Moreover, over half of the respondents in their study ‘reported having felt emotionally distressed or worried about their mental health while attending a GIC’ (Ellis et al., 2015: 14), and did not feel able to discuss this with practitioners.

Hormones and surgery

If hormone therapy is approved by the NHS gender clinic, the patient’s GP is written to with instructions regarding the prescription of hormones. The wait for this letter is typically several weeks, but can sometimes amount to several months due to administrative issues at gender clinics (Pearse, 2012). Upon receipt of instructions, the patient’s GP is expected to regularly prescribe appropriate hormone supplements and/or hormone blockers. Patients are asked to undergo blood tests at their GP practice at regular intervals to monitor this treatment, with endocrinologists at the gender clinic recommending continued or changed dosages as appropriate. Usually dosage is increased gradually over time, meaning that the resulting physical changes occur more rapidly the longer an individual has been undergoing hormone therapy.

Trans women might also be offered vocal training or hair removal treatment (through laser or electrolysis), although prior to 2013 these were usually not funded through the local PCT, Board or Trust outside of Scotland. Some patients engaged in lengthy administrative battles for access to these services, with mixed levels of success.

Gender clinic patients can be referred for surgeries (e.g. chest surgeries, genital reconstruction surgeries, vocal feminisation surgery) following a period of time undergoing RLE. Barrett explains that this period might vary from patient to patient, as:

suitability for gender reassignment surgery is not determined solely by the length of time the patient has attended a gender identity clinic – although a certain minimum time must apply. Rather, it depends on whether the patient has been seen to be or has become a *suitable candidate* in the time that they have attended. (Barrett, 2007: 71, emphasis mine)

For genital reconstruction surgery, the *Standards of Care* recommend a ‘minimum time’ of one year in a congruent gender role prior to a referral (Coleman et al., 2011:202); UK gender clinics typically require patients to wait for 12-24 months (Barrett, 2007; NHS Scotland, 2012; NHS England, 2013). UK gender clinics typically follow the Standards of Care in requiring two mental health professionals to formally approve a referral for genital surgeries.

These requirements once again demonstrate the power of clinical oversight and judgement held by NHS gender identity specialists. Moreover, they show how trans patients are treated quite differently to cis patients: for instance, cis patients requesting reconstructive surgery for either medical or cosmetic purposes are not expected to demonstrate a consistent commitment to the treatment through means such as RLE. Drawing upon the example of orchidectomy (removal of the testicles) Bouman et al. (2014: 380) note that, in contrast to a trans woman seeking the same intervention, ‘a cisgender male with chronic scrotal pain does not require any written psychiatric opinion for an orchidectomy nor does he have to be in pain or distress for a minimum of one year before surgery can take place’. It is clear therefore that while some aspects of patient management (such as regular blood tests) are necessary for the purposes of ensuring that treatment goes smoothly and that transitioning individuals are safe, other aspects are based upon an ideological and moral assumption that health professionals should take full responsibility for ensuring that transitioning patients are making the ‘right’ decisions.

Private pathways and the politics of provision

I now examine alternatives to the NHS gender clinics. There are four major private providers offering gender identity services in the UK: two in London, England, one in Edinburgh/Aberdeen, Scotland, and a recently established clinic in Abergavenny, Wales, which opened in 2015. All of these private providers offer a faster route to treatment: waiting times are short, patients can self-refer, and requirements for RLE tend to be less demanding. Moreover, non-binary diversity in terms of gender identity and expression is more widely recognised by private practitioners. Participants in this study generally considered the private route to offer a great deal more agency to those who could afford it, reflecting Davy's (2010: 123) finding that 'quality and opportunity of treatment' could be guaranteed through private treatment. However, some of these clinics have been criticised by NHS specialists for allegedly failing to conform to the *Standards of Care* (Burns, 2006; Bouman et al., 2014).

The most high-profile private clinic is Transhealth, overseen by Richard Curtis. Curtis has long been widely known for being considerably less strict and rigid in his management of patients than the NHS gender clinics. This has led to some controversy in the media as well as within professional and trans community spaces, as it has been suggested that Curtis' approach puts patients at risk of being allowed to make the 'wrong' decision about their care. However, a considerable number of participants in this study held Curtis in very high regard, and he had a good reputation amongst the wider patient body as well as amongst his own clients.

Curtis is widely seen as the heir to former private practitioner Russell Reid, having worked with him and inherited his practice. Reid – who was also very popular within trans community spaces (Burns, 2006) – retired after he was found to be engaging in 'serious professional misconduct' by a General Medical Council (GMC) 'Fitness to Practice Panel' in 2007 (Bouman et al., 2014). Numerous complaints about Reid were submitted to the GMC by four Charing Cross practitioners, including James Barrett (Burns, 2006). Barrett (2007) argues that Reid was not strict enough in managing his patients. He states that the GMC findings can be linked to Reid's failure to follow the (Version 6) *Standards of Care* (Meyer et al., 2001), by: 'administer[ing] hormonal treatment after one consultation in circumstances where patients had neither lived in their desired gender role nor undergone three months of psychotherapy'; 'giv[ing] support for the provision of gender reassignment surgery despite patients not having lived in their desired gender role for what would be regarded as a sufficient length of time'; failing to seek an appropriate second referral for gender reassignment surgery;

and making ‘no attempt to verify patients’ claims’ that they had been undertaking RLE (Barrett, 2007: 287). Notably, most – if not all – of these complaints describe deviations from the standard approach taken by NHS gender clinics, including Charing Cross.

David Hess (2004: 705) describes how medical ‘researchers in [...] dominant networks have tended to engage in a wide variety of suppression tactics aimed at activists, clinicians and researchers who have departed from the dominant research programmes’. The suppression of Reid’s practice would seem to be an instance of this, albeit in the context of medical practice rather than research. While Barrett (2007) argues that Reid’s approach to treatment constituted a risk to patients, his crime is perhaps better understood as a departure from the dominant paradigm, particularly as Reid’s approach arguably *does* meet the standards of the more flexible Version 7 *Standards of Care*, published in 2011. As such, the complaints against him were historically contingent: they reflect a clinical consensus that has since begun to disintegrate somewhat.

Curtis, too, faced investigation from the GMC following similar allegations of professional misconduct in 2011. This prompted a popular outcry within trans community and activist spaces, particularly following the publication of an article about the case in newspaper *The Guardian*. An important consequence of this outcry was the creation of the #transdocfail hashtag on Twitter, which saw thousands of contributions from individuals arguing that widespread ignorance, prejudice and malpractice within health services should be the subject of popular scrutiny, rather than any alleged failings on the part of Curtis. #transdocfail forms a key fieldwork site for this project.³¹

The GMC case against Curtis was eventually dismissed in 2015; however, in the intervening years he made a number of changes to his service that meant they more closely resembled the NHS gender clinics pathways. These included the requirement for a second diagnosis for his patients from an additional health professional, as well as more extensive evidence regarding his patients’ dedication to living full-time in their acquired gender role. In recent months a new private provider has emerged with reputation for providing very flexible treatment: Welsh practitioner Helen Webberley, of the ‘Gender GP’ Online Transgender Medical Clinic. In a message posted to a trans group on Reddit, Webberley states that a complaint to the GMC was made against her, too, by ‘[o]ne of the other private gender specialists’, but this complaint was

³¹ I provide in-depth analyses of #transdocfail in Chapters 6 and 7.

dismissed.³² She goes on to argue that the GMC now seem to be taking the position that more dedicated gender specialists are required due to the large waiting lists.

Self-medication

Another option available to individuals wishing to physically transition is self-medication, with hormones acquired outside of a formal medical context. Like private care, self-medication offers trans people more control over their own transition. Dutch consultant Henk Asscheman (cited in Morgan, 2016: 208) notes that ‘self-medication has always existed and is not related to legal restrictions [...] it is related to waiting lists and difficulties in obtaining treatment’. In addition to highlighting the impact of long waits for treatment, Asscheman’s comments suggest that strict approaches to the assessment and management of transitioning patients might lead many to self-medicate if they are denied treatment (or fear being denied treatment) by an NHS gender clinic and cannot afford private care.

Some individuals buy hormones through one of a number of Internet-based pharmacies that exploit loopholes³³ in UK law, while others are provided spare pills, patches, gel or needles by trans friends. A number of patients educate themselves extensively regarding the management of their own hormone regime, drawing on evidence from scientific papers and/or a myriad of trans websites offering (sometimes contradictory) advice on the matter. Self-medication is a highly contested practice within many trans spaces: some participants in this research advocated for the self-management of transition, while others argued that supervision by trained medical professionals is required for safety. Within the professional literature, it is generally agreed that hormone therapy is safest under clinical supervision, where relevant aspects of patient health such as liver function and blood pressure can be monitored by trained endocrinologists (Coleman et al., 2011; Weinand & Safer, 2015).

There have been no studies looking specifically at self-medication in the UK. However, it is likely that the number of trans people who self-medicate is rising as information on the topic becomes more widely available and waiting lists grow longer

³²https://www.reddit.com/r/transgenderUK/comments/4i03lt/is_dr_webberley_safe_legitimate_etc_has_anyone/ (accessed 04/07/16)

³³ It is illegal to *sell* certain drugs (including oestrogen and testosterone supplements) *in* the UK if a patient does not have a doctor’s prescription. However, it is not illegal for patients to *buy* these drugs. There are a number of Internet drugs shops that are based *outside* of the UK, meaning it is technically legal for UK consumers to buy prescription medication from them without the stated approval of a health professional.

in many parts of the country. According to Jules Morgan (2016: 207), 'Leighton Seal, consultant endocrinologist at the Gender Identity Clinic in London, UK, says that about 40% of his patients are self-medicating before being seen at the clinic'. If this number is similar across the national patient population, then self-medicating trans people in the UK must number in the thousands.

Gaming the system?

A number of patients traverse both public and private health pathways. This is usually done in order to speed up the process of transition as much as possible while minimising the financial impact of doing so. Some individuals seek quick access to hormones through private means while waiting to be seen at an NHS gender clinic. Others ask GP to provide a *repeat* prescription through the NHS (along with blood monitoring for safety), after they have gained an initial hormone prescription from a private clinic, or begun self-medicating. There is some disparity between NHS gender clinics and gender identity specialists in their response to this: while it is increasingly standard practice for gender clinics to allow patients to continue their pre-existing hormone regimes during initial assessments (NHS England, 2015c), some practitioners write to GPs to insist that patients be taken off hormones until they have met the requirements of the gender clinic regarding RLE.

A contemporary point of political contention between and within a number of UK medical professions is the possible provision of 'bridging hormones' by GPs while trans patients are waiting to be seen at a gender clinic. WPATH (Coleman et al., 2011), the Royal College of Psychiatrists (2013) and the General Medical Council (2016) recommend that hormones can be provided directly by GPs prior to a gender clinic appointment if a patient is already self-medicating: this recommendation is intended to reduce the possibility of harm to trans patients, as the mental health implications of stopping hormone therapy can be profound. This has led to some concern from GPs who fear that they do not have the appropriate expertise to provide this care. However, a number of trans activists are pushing for 'bridging' hormones to be provided by GPs regardless of whether or not a patient is self-medicating,³⁴ thereby replacing the current system of assessment with a new approach that centres trans patient decisions rather than professional judgement.

³⁴ For instance, at the time of writing a petition entitled *Make bridging hormone prescriptions easier to obtain for transgender people* has received almost 2000 signatures on the UK Government and Parliament petition website.

Reform and austerity: 2012-2016

The landscape of trans health has shifted somewhat since 2012. This is due in part to wider legal, structural and financial changes within the NHS. However, there have also been changes made specifically in the provision of gender identity services. In this final section, I discuss how these changes have taken place, and note a range of impacts upon transitioning patients.

Changes in Scotland

As previously noted, the Scottish gender clinics have long taken a less strict approach to assessment, referral and RLE in comparison to much of the rest of the UK. In July 2012 this was extended and codified in a formal Gender Reassignment Protocol for NHS Scotland (NHS Scotland, 2012), which also reflected changes between Versions 6 and 7 of the WPATH Standards of Care and wider shifts towards ‘patient centred care’ (Davies et al., 2013) within the NHS. Key features of the Protocol included only one assessment being required for hormone therapy, speech therapy, hair removal and ‘female-to-male’ chest surgeries; no requirement for RLE prior to these treatments; and only one year of RLE being needed prior to genital reconstruction surgeries (which still requires two assessments). Moreover, a less linear approach to treatment was instituted, in which treatment pathways can more flexibly meet the stated needs and desires of patients: for instance, it is now possible for masculinising chest surgery to take place without patients having first undergone hormone therapy.

Abolition of PCTs

The Health and Social Care Act 2012 transformed the structure of the NHS in England and Wales on its implementation in April 2013. One of the major changes instituted by the Health and Social Care Act was the abolition of PCTs in England. They were replaced with new, more localised, GP-led commissioning consortia – the Clinical Commissioning Groups (CCGs) – as well as a new national body overseeing budgeting, planning and commissioning, known as NHS England.

While the establishment of the CCGs had significant implications for the bureaucracy of public health as well as for private and third sector investment in the NHS, it had relatively little day-to-day impact upon *primary* care services theoretically available to trans people in their local area. However, a number of gains made by trans

activists in the pre-2013 period were lost. For instance, numerous documents issued by PCTs and other bodies with guidance on dealing with trans patients were rendered obsolete, leading to an effective abolition of trans-friendly policies – such as for changing name and gender on GP records (NIGB, 2011) – in many parts of the country.

NHS England: national funding and a new protocol for England and Wales

The implementation of the Health and Social Care Act has had a considerably more important impact on gender identity services. Responsibility for commissioning specialist services has shifted from the local level (through the PCTs or Health Boards) to the national (through NHS England). This means that transitioning patients in England and Wales are now far less likely to be denied funding for treatment. Moreover, this has also led to the emergence of a coherent national approach to oversight of English gender clinic policies for the first time. A number of new Clinical Reference Groups (CRGs) were created under the guidance of NHS England in order to develop clinical strategies for specialist services: one of these took explicit responsibility for gender identity services.

In May 2013, the Gender Identity Services CRG wrote a letter to stakeholders announcing that elements of the Scottish Gender Reassignment Protocol would be adopted for England and Wales.³⁵ This represented a shift towards a less strict and less rigid management of transitioning patients in England and Wales, as well as increased oversight of gender clinic policies on the part of NHS England.

An official NHS England Interim Gender Protocol followed in July 2013, coming into force³⁶ during October. This protocol instituted a number of important changes in England and Wales regarding access to gender identity services:

- GPs are now able to refer patients directly to GICs.
- Laser and electrolysis services for hair removal are made available for MTF patients, funded through NHS England.

³⁵ I explore the political backdrop to this decision in detail in Chapter 7, *Changing Trans Health*.

³⁶ However, a number of GICs have continued to follow their old, individual pathways, effectively ignoring parts of the protocol that didn't fit with the clinic's philosophy. For instance, as recently as 2015 the Nottingham Centre for Gender Dysphoria website stated that clinicians followed the 'Harry Benjamin Standards of Care' (i.e. Version 6), despite these having been superseded by the WPATH *Standards of Care* (Version 7) in 2011. This indicates a continued adherence to a more strict oversight of transitioning patients at gender clinics such as Nottingham.

- Only *one* assessment was now necessary for a speech therapy, hormone therapy or chest reconstruction surgery referral.
- Chest reconstruction for FTM patients can be offered 6 months after a first appointment (with RLE *not* necessarily required).
- 12-24 months of RLE is required prior to genital reconstruction surgeries.
- Adult services are now available to patients from the age of 17.

Additionally, a number of English GICs began to oversee a small number of ‘test case’ non-binary transitions from 2014 onwards. While many non-binary and genderqueer patients did, in fact, gain access to gender identity services through the NHS prior to 2014, this tended to entail misrepresenting their gender identity to clinicians in order to negotiate the assessment procedure. Now, for the first time, non-binary and genderqueer patients were permitted to transition openly through the NHS, on the condition that they participated in a study looking at the long-term impact of treatment.³⁷ Furthermore, UK gender specialists such as Christina Richards and colleagues (2016) have begun to publish on approaches for managing the care of non-binary and genderqueer patients. However, some UK gender clinics – such as the Northamptonshire Gender Dysphoria Service – continue to explicitly deny treatment to non-binary and genderqueer patients at the time of writing.

The overall shifts that have taken place provide more flexibility for English and Welsh patients undergoing physical transition (albeit not as much as in Scotland), with greater scope for gendered expression, plus fewer waiting times and referrals built into the system. As in Scotland, these shifts reflect changes that took place between Versions 6 and 7 of the WPATH Standards of Care, as well as a wider push for ‘patient-centred’ care within the NHS. However, they do not change the essential nature of gender identity services, in which clinical judgement remains key in assessing whether or not any given patient is (appropriately) trans.

Waiting times

Ironically, formal waiting lists for many gender identity services increased in length even as waits *within* the system largely decreased in line with the new English and Scottish protocols. The austerity programme launched by the 2010-2015 Conservative/Liberal Democrat Coalition Government had a significant impact upon

³⁷ The context of this is discussed in Chapter 7.

funding for public health (Roberts, 2015). This in turn has contributed to the financial squeeze on gender identity services, which do not receive funding that fully reflects the continuing exponential growth in patient numbers (NHS England, 2015c). As of late 2015, only two smaller adult gender clinics met the NHS 18-week referral standard: Northamptonshire Gender Dysphoria Service, and the Brackenburn Clinic in Belfast (UK Trans Info, 2016). A simultaneous crisis in the provision of feminising genital reconstruction surgeries – triggered by the retirement of a senior surgeon and the lack of training for a suitable replacement – means that most patients transitioning from ‘male to female’ can be expected to wait 1-2 years for surgery (UK Trans Info, 2015).

Conclusion: characterising care

The overall picture of trans health in the UK is a complex one, but with a number of important features that have persisted over time. Trans patients tend to value the existence of the public health system and the provision of both trans-specific and more general services; however, challenges must frequently be negotiated.

Within the wider health service, some practitioners openly discriminate against trans people; many more are ignorant of the best ways to help trans patients even if they have good intentions. Institutional attempts at reform have met with mixed success, with a great deal of formal guidance rendered obsolete by the 2013 restructure of the NHS, and GP practices often refusing to engage with trans inclusion programmes (Bailey & McNeil, 2013).

Within gender identity services, specialist practitioners act as gatekeepers and wield a great deal of power over patients. Waiting times are typically long, with patients frequently waiting months or years to access initial appointments, and then many months more in order to access interventions such as hormone therapy and surgery (UK Trans Info, 2016). Assessment procedures – which vary greatly from clinic to clinic – can be seen as unnecessarily demanding by patients (Ellis et al., 2015). The combination of long waiting times and strict assessment procedures leads many patients to seek private services or to self-medicate (Morgan, 2016). Recent changes have seen rules and guidelines relaxed somewhat – particularly in Scotland – but the essential nature of the system has not changed.

A key feature of both specialist services and wider health services is that trans patients are likely to feel disempowered. The professional capital of healthcare providers means that it is difficult to challenge practices that are experienced by

patients as unfair, inappropriate or discriminatory. I understand this as a *power differential* between practitioners and patients, which works to shape patient expectations and perspectives on trans health. In later chapters of this thesis, I explore the impact of this power differential – as well as waiting times and binary logics of definition – upon discourses of trans health. I also examine how trans activists have sought to draw upon legal and clinical frameworks such as the Equality Act 2010 and the Version 7 WPATH *Standards of Care* to push for greater change.

4

Evoking the Field

Methodological and ethical considerations

Sylvia begins to cry. I touch her shoulder and hand her a Kleenex. We sit silently for a while, sadness connecting us. 'Do you still want to continue this project?' I ask gently. 'Or is it too painful?'

'Oh, no, I have to continue it,' she responds forcefully though her voice shakes. 'What I'm experiencing is important to me.'

- Carolyn Ellis (1999)

At the heart of the matter

In her 1999 article *Heartful Autoethnography*, Carolyn Ellis explores the emotional difficulty, pain and vulnerability that can accompany academic work on deeply personal matters. The article takes a narrative form, in which Ellis weaves her analysis through an evocative account of various methodological discussions that she engaged in with Sylvia, a PhD student. Sylvia was a survivor of cancer who gradually developed ideas for a project that looked at both her own experiences of recovery, and those of other women. With Ellis' guidance, she learned to build a deep sociological and emotional connection with her experiences for the purpose of research.

This project departs considerably from the primarily narrative-oriented form of 'evocative autoethnography' (Ellis et al., 2011) that Ellis is known for. However, the description of her encounters with Sylvia touched me deeply, and helped me to reflect upon my own positionality as a qualitative researcher. Conducting this project was a deeply emotional and frequently difficult experience, one that forced me to come to terms with my own experiences as I explored those of my participants. As I began to work on the final drafts of this thesis, I began to pay closer attention to the 'heart' (Ellis, 1999) of the work, examining what it *means* to be a trans academic analysing the complex social, clinical and political investments of trans health in the context of the Internet.

In this chapter I focus on these meanings through an account of the relationship between researcher and research. I first explain how and why I planned and characterise my project as an 'online ethnography', looking at the methodological and epistemological decisions that informed this. I provide relevant context by unpacking the social construction of the Internet, exploring how it is shaped by (and in turn, shapes) modes of community, sensemaking (Markham, 2003) and intersubjective temporality. I then examine my positionality and the considerable ethical issues raised by this project, and discuss how I sought to acknowledge and account for my relationship to the field as well as how I took measures to prevent harm coming to research participants. Finally, I examine an issue that I was not adequately prepared for prior to fieldwork: the ethical responsibility towards *myself*.

Epistemological considerations

My research was conducted from a broadly poststructuralist, constructivist perspective. In using the term poststructuralist, I refer to the position that 'discourse constructs meaning' (Hines, 2007: 22). I consider social phenomena – and with them, social reality as understood and experienced by social agents – to be intersubjectively constructed through the discursive interaction of said agents. This informed my selection of qualitative methodological tools for the observation and analysis of data relating to the discursive construction and negotiation of 'trans' possibilities and 'trans health'.

This is an ethnographic study, key features of which include immersion and participant observation in a social setting, engagement with group conversations and the collection of related documents, with the aim of understanding and providing an account of the culture and behaviour within this setting (Bryman, 2004: 293). My fieldwork was conducted on the Internet; I follow Christine Hine (2000: 65) in regarding online ethnography as an 'adaptive ethnography which sets out to suit itself to the conditions in which it finds itself'. For this reason, I reflect a great deal upon the opportunities and challenges of Internet research in this chapter. However, I do not consider online ethnography to be analytically distinct from more traditional, 'offline' forms of ethnography, being in agreement with Tom Boellstorff and colleagues (2012: 4) that 'ethnographic methodology translates elegantly and fluidly to virtual worlds [...], the ethnography research paradigm does not undergo fundamental transformation or distortion in its journey to the virtual arenas'.

I do not regard ethnography as a means to ‘authority’ regarding the material nature of the world (Bryman, 2004: 499); after all, the data in this project broadly represents what *is said* about trans health. Instead, I work from the foundational assumption that ‘[l]anguage and speech do not mirror experience; they *create* experience’ (Denzin, 1994: 296, emphasis in original). In conducting an ethnographic study, I therefore set out to uncover how ‘trans health’ is constructed *through* discussion and representation, in both everyday and institutional contexts.

However, this focus on discourse is not intended to detract from the *embodied* experience of trans health. As Stryker (2006: 9) notes, theoretical issues such as ‘what bodies mean, how representation works, and what counts as legitimate knowledge’ have ‘material consequences for the quality of transgender lives’. I therefore follow MacDonald (1998), Hines (2007) and Davy (2011) by working within the frame of a materially *grounded* poststructuralism, recognising that the intersubjective social reality of trans health is ‘corporally experienced’ (Hines, 2007: 33).

I myself am present in this ethnography, through my interaction with the field as researcher, my creation of meaning through analysis of data, and my own experiences as a trans woman who has accessed a range of healthcare services in the UK. In drawing personal, narrative accounts and analytic insights from the latter point in particular, this thesis is also autoethnographic. Autoethnography combines ‘ethnography’ with ‘autobiography’, thereby drawing upon personal experience to understand the social world (Ellis et al., 2011). There are two main approaches to autoethnography: the ‘evocative’ approach favoured by writers such as Carolyn Ellis, and the ‘analytic’ approach favoured by writers such as Leon Anderson (2006). Like Heewon Chang (2016), I seek to combine the artful, emotive insight of ‘evocative’ autoethnography with a committedly ‘analytic’ engagement with the social world. I thus position myself as a full participant in the research setting, becoming visible as such by highlighting where my own narratives are under discussion (such as through the use of vignettes) while dedicating this autoethnographic insight towards improving theoretical (and, by extension, material) understandings of social phenomena (Anderson, 2006).

Locating discourse online

The research questions for this project ask how ‘trans’ meanings and possibilities are produced, reified and legitimated through health discourses and practices, and how discourses of *trans health* are negotiated within and between trans community groups, trans activists, and health professionals. These are questions that seek to understand discourse and material experience alike, unpicking the range of stories that are written onto trans bodies (Stryker, 1994), the implementation of policies and practices on the basis of these stories, and the contestation of policy, practice and story alike. In order to explore the implications of these questions, I needed to access the stories told by and for trans people and the health professionals who work with them. For this, I turned to the Internet.

The Internet as a repository of trans stories

As Ekins & King (2010: 27) note, the Internet has become a major medium for the telling of ‘stories of all kinds’, not just trans stories. However, to this day the Internet remains a primary (if not the only) means by which many trans people are able to regularly connect, converse and organise with others like them. For this reason, many qualitative researchers looking at trans populations have located ethnographic, narrative and/or discursive analytic research projects entirely online (Whittle, 1998; Hegland & Nelson, 2002; Gauthier & Chaudoir, 2004; Shapiro, 2004; Ekins & King, 2010; Pearce, 2012; Horak, 2014; Raun, 2015; 2016; Yeadon-Lee, 2016).

I noted in Chapter 2, *Condition or Movement?*, that Western trans cultures and communities have a long-standing connection to the Internet. While vibrant and active communities of gender variant people certainly existed prior to the widespread availability of online communication, the arrival of easy Internet access brought about changes that fundamentally (re)shaped how trans people identify, socialise and organise (Stryker, 2008). Community spaces on the Internet enable geographically diverse individuals to engage in regular social interaction: ‘no matter how small a minority you belong to, you could at least find your community’ (Ekins & King, 2010: 28).

Unprecedented opportunities for communication around gender variant experience and activism beyond the local (and, indeed, the national) level provided the catalyst for a rapid evolution in understandings of gender(ed) difference, accompanied by changes in language and other ‘new modes’/‘different codes’ of self/group expression (Stryker,

1994; Whittle, 1998). Whittle (1998: 393) attributes this to the possibility of trans *authenticity* in an environment where users can be who they want to be: '[i]t is the virtual self, the node of communication in cyberspace, that has allowed an actual self to be recognised, and become the primary organizing centre of activism'. Eve Shapiro (2004) additionally notes the importance of the Internet as *infrastructure*.

The use of Web sites, listserves, and online communities have provided a critical mass of information, guidance, and space where trans people can connect [...] the use of the Internet as both a tool to communicate, reduce costs, and distribute information and as a space to organize activism, network, and foster collective identity has been revolutionary within the trans movement. (Shapiro, 2004: 167)

These online spaces are relatively common and available at every hour of every day. They have historically offered a means by which private, anonymous communication can be facilitated (Ekins & King, 2010), but with the growth of social media the Internet can also enable visibility (Horak, 2014; Raun, 2016).

While a growing number of trans social groups, organisations and events do exist in UK, these can still be inaccessible to those who have not managed to make the right connections and/or individuals not fortunate enough to reside in (the right) large urban centres. Moreover, there are few (if any) permanent *spaces* available for trans community and activism: those that exist tend to be multi-purpose LGBT centres in large cities such as Birmingham, temporary large-scale events such as Trans Pride in Brighton and Sparkle in Manchester, or queer club nights such as London's Bar Wotever. By contrast, online spaces offer a permanent means by which a relatively small population can regularly converse (as 'communities') and organise (as 'activists') around issues such as health.

Professional discourses of health are also increasingly visible online. The ongoing negotiation of ideas and meanings can be seen within and between gender clinic websites, meeting minutes, reports and guidance documents. Together, these form an enormous archive of ideas: one that draws on and also feeds into trans community and activist discussions. Moreover, some health practitioners have begun to participate in trans communities online, engaging in discussion and debate through blogs and on platforms such as Facebook, Twitter and Reddit.

We see therefore that the Internet is a key site for the creation and negotiation of trans discourse. Online spaces do not simply provide a place for trans community to

exist: they are instead sites for the constant (re)creation of patient and practitioner identities, experiences and activism through the dissemination and negotiation of stories and ideas. In this way the Internet provides a rich network of texts – a *hypertext* (Nelson, 1981) – which is ideal for exploring discourses of trans health. As a trans person who came out in the early 2000s, this hypertextual discursive and electronic space forms a central part of my own everyday life and personal history, informing my experience and knowledge of trans community and activism.

The Internet as social reality

Communities do not (just) have to be physically located, but may instead be ‘imagined’: constituted of distinct cultural practices coupled with a sense of shared history and belonging (Anderson, 1991). While Anderson originally wrote about nations in his account of ‘imagined communities’, online networks can also facilitate ‘a strong symbolic or “imagined” sense of group identity, [...] intense and intimate communication among participants and resolute commitment to coherent sets of values and norms’ (Hodkinson, 2007: 635). Indeed, in Chapter 2 I showed how ‘trans’ values and norms can emerge (and evolve over time) within online spaces.

Such communal spaces are frequently characterised as ‘virtual communities’, as they enable members to interact in a supposedly non-physical – ‘virtual’ – space (Rheingold, 1993).³⁸ Within this project, however, I reject any dualistic characterisation of social interactions as ‘virtual’ or ‘real’. As Wellman & Gulia (1999: 170) note, the Internet ‘is not a separate reality’: individuals ‘bring to their on-line interactions such baggage as their gender, stage in the life-cycle, cultural milieu, socioeconomic status, and off-line connections with others’. This social reality is compounded by technological change. The broadly text-based medium explored within early Internet studies undertaken by researchers such as Rheingold (1993), Turkle (1995) and Kendall (2002) has been largely superseded by more flexible, multimedia spaces. The growing popularity of ‘nomadic’ online access through technologies such as mobile phones, tablets and laptops ensures that Internet sites are no longer necessarily mediated by the static screen of the personal computer (Hills, 2009). This media convergence changes ‘our experience of media spaces, making a nonsense of any

³⁸ Rheingold’s conceptualisation of *virtual* space (as distinct from what many Internet users refer to as ‘irl’: ‘in real life’) rapidly achieved discursive hegemony within academic accounts of Internet community. A quick search of research databases reveals thousands of papers using terminology such as ‘virtual ethnography’ and ‘virtual community’. For instance, a search for ‘virtual ethnography’ on Google Scholar in July 2016 yielded 6,180 results.

lingering distinction between the “real” and the “virtual” (Bell, 2009: 36). I therefore regard social reality to be constructed as authentically through interactions and discourse online as it is offline.

The Internet as ‘space’: three spheres

Annette Markham (2003) outlines how the Internet is constructed and constituted through metaphorical sensemaking, arguing that it is variously framed as a ‘tool’ (as prosthesis, conduit or container for accessing, sharing and/or storing information), a ‘place’ (as digital architecture that can be explored, with shifting borders/boundaries), or a ‘way of being’ (as cyborg meeting of human and machine, or hyperconnected global network). I draw implicitly upon all three of Markham’s sensemaking elements in my use of the term *space* to describe both digital frameworks and the social interactions they host.

The online spaces I visited for fieldwork operate as ‘container’ (‘tool’) and ‘architecture’ (‘place’) both electronically and metaphorically. They typically have a fixed ‘location’ (a Uniform Resource Locator, or URL) in which particular functions (e.g. discussion) take place, for which purpose they are visited regularly by users. An archive of this usage is usually automatically stored by the software. In this way, the social and technological meet to ‘provide a [...] vivid sense of “place”’ (Kendall, 2002: 6). For some users – particularly younger individuals utilising social media platforms – Internet usage has indeed become a ‘way of being’ (Markham, 2003) or integral extension of the everyday, but one that nevertheless usually takes place within a contained visual space: both in terms of the screens through which the Internet is viewed, and the aesthetics of the given site or platform.

For the purposes of discussion and analysis, I have divided the areas in which fieldwork took place into three broad sub-‘spheres’ from within what I regard as a wider ‘transphere’ of online spaces. These are the ‘activist’ sphere, the ‘community’ sphere and the ‘practitioner’ sphere. I do not intend to claim that there is any *necessary* distinction between either individuals or text within these three areas; indeed, there are plenty of activists who participate in community groups or wrote documentation as/for practitioners. Instead, I use these overarching groupings to make sense of broad trends and some of the ways in which particular spaces and platforms might facilitate particular activities at a particular point in time.

I use the metaphor of the sphere to capture these topic groupings in order to imagine an abstract 'container' (Markham, 2003: 5-6), with a substantial volume: a space that might expand or contract over time while maintaining basic properties, or intersect/overlap with other spheres in a manner similar to a digital polyhedra. I also draw upon existing uses of 'sphere' to describe social worlds-within-worlds online, such as within the commonly used compound term 'blogosphere', which refers collectively to blogs as distinct from the wider Internet.

The activist sphere consisted of social media space and blog/media articles created with the explicit intention of discussing political issues for trans people and/or organising action. For the purposes of this project, the field included seven Facebook groups, the Twitter hashtag #transdocfail (along with related hashtags such as #transdocwin), and numerous individual articles written for blogs and media organisations. A wide range of political tactics were discussed and/or implemented by individuals organising within these spaces, including protests/pickets, letter-writing campaigns, petitions, information/awareness drives, event disruption, and the lobbying of politicians.

The second sphere I describe as community-oriented. For this area of my research, I looked into discussions taking place on two Internet forums (also known as message boards). Some of the activist spaces discussed in the previous section were also arguably communities in their own right (or one constituent part of a larger community). However, I use 'community' in this context to refer to the manner in which the forums visited for fieldwork primarily operated as social spaces: their purpose was *specifically* to provide a basis for community in terms of people with a shared experience being able to gather and talk. This differed from the more purposeful, action-oriented nature of spaces within the activist sphere.

The 'practitioner' sphere consisted of information written both by and/or for medical practitioners on the subject of trans health. I encountered relatively little public discussion involving practitioners. Within this sphere I therefore focused largely on informative websites and documents addressing issues around trans health from the perspective of health professionals within the UK. These included guidance and advice documents for NHS staff and patients, clinical guidance and protocols, gender clinic websites, and information on public consultations. The majority of this material was, therefore, written by cis professionals working with trans people. However, there were a number of key documents written and/or influenced by trans professionals and activists.

I name and briefly describe the specific Internet spaces visited within the various spheres of the field in an appendix to this thesis.

The Internet as material encounter

The offline world does, of course, remain present in my research. Internet browsing does not take place on some abstracted plane: the experience of using physical interface devices such as screens, mice, trackpads and keyboards is *embodied* (Gies, 2008; Postill & Pink, 2012).³⁹ Experiences and discourses developed largely offline inform a large proportion of the literature discussed within the first two chapters of this thesis. Similarly, the very online conversations, articles and documents that form this project's data corpus are largely written in response to – and with the intention of influencing – encounters, experiences, policies and suchlike from the offline world, in what Whittle (1998: 393) refers to as the 'street-Net-street effect'.

Exploring the field

Data collection for this ethnographic project entailed immersion in the field and a subsequent capture of text(s) – as well as my own thoughts, feelings and initial insights – for later analysis. I visited relevant spaces on the Internet for hours at a time: reading conversations, articles and documents, following links from one website to another. I announced my presence within every social space I visited, explicitly asking permission to conduct research. However, much of my participation from thereon in consisted of 'lurking': that is, reading interactions without generally adding my own comment. This meant that I was often 'invisible' to others in the field (Murthy, 2008: 845). I wrote regular accounts of my experiences in my fieldwork diary, reflecting upon what I'd seen, learned and felt. I also copied images and text directly from websites using browser plugin NCapture, which formats them for use within qualitative analysis software NVivo. The formal period of fieldwork took place between 2013 and 2015, although I also delved into archived forum conversations dating from as far back as 2010. However, I continued to keep abreast of current affairs within the realm of trans health well into 2016; moreover, the process of meaning-making through autoethnographic reflection continued through the writing of this thesis.

³⁹ Internet servers are also physical devices residing in the offline world (Herrera, 2007).

Defining the scope of the field

In her discussion of online ethnographic method, Markham (2008: 265) notes that: ‘while the analysis may indeed emerge from the data, *the researcher determines a priori what constitutes data in the first place*’ (emphasis in original). While my approach to analysis (which I discuss more fully later in this chapter) was broadly inductive, I made a number of decisions that significantly shaped the process of fieldwork, and informed the kind of data that was available.

The Internet is vast. Even relatively small networks – such as spaces that are oriented specifically around trans issues – are liable to contain huge quantities of information, the smallest fraction of which can be realistically drawn upon in an ethnographic project. As I planned this study, I asked myself: how could I possibly choose research sites within this huge, socially-constituted hypertext in a manner that was not simply arbitrary? How could I define the scope of the field without subjecting myself to information overload?

I answered this question by reflecting on my own relationship to the field as an ethnographer. With ethnography requiring immersive participation on the part of the researcher (Bryman, 2004: 293) I sought to acquire data in a manner informed by the networked nature of the Internet: specifically, the connections that *could* be made by any individual navigating trans spaces online. In their discussion of social media ethnographies, John Postill and Sarah Pink argue that researchers working online should not limit themselves to a single space.

Social media ethnography [...] does not mean doing fieldwork in or about one particular social media platform – such as Facebook, Twitter or YouTube. While [this] is possible, it is complicated by the fact that most internet users constantly criss-cross a range of platforms through aggregators, search engines, hyperlinks and other devices. (Postill & Pink: 2012: 133)

As a situated individual within a hypertextual field, I therefore allowed myself to also encounter new sites and spaces as I followed links from one to another. In contrast to the rigid sampling techniques typically used within quantitative ‘big data’ exercises, this is a form of intentionally *human* mediation, reflecting the ‘messiness’ of everyday social interaction (Postill & Pink, 2012; Lohman, 2015). In this sense, my behaviour as researcher was shaped by my role as a *participant* in trans spaces and discourses; a situation both aided and complicated by my pre-existing connections to trans

communities. I used one primary criterion to prevent information overload and ensure focus in my findings: I focused on posts, comments, articles and documents that related specifically to *healthcare provision* for trans people, in terms of the provision of medical services by a public or private individual or institution.

A number of sites and spaces operated as 'starting points' for my navigation of the transphere. Two of these were the community forums, which I selected from the first page of results displayed by a search engine. I also started my fieldwork from a small number of Facebook activist groups in which I was already a member. In order to ensure a range of voices and perspectives from across the trans spectrum this original selection included forums and groups that, together, hosted a diverse range of trans users. In particular, I aimed to ensure that a wide range of gender identities were represented, as individual trans community sites are frequently gendered, catering specifically for transfeminine, transmasculine or non-binary experiences.

From these starting points, I acquired links to the additional activist Facebook groups, Twitter feeds, blog posts, media articles, NHS websites, reports and documents that would constitute the wider field for the purposes of this project. This dataset includes blog posts and articles written by *myself* at points in the past, sampled in instances where they were linked to by other participants. In line with the autoethnographic thread of this project, my own writings were analysed alongside similar fieldwork material.

Finally, I include a number of personal reflections in this thesis, most prominently in the form of the vignettes that open a number of chapters. These are drawn largely from my experiences in the offline world. However, in summarising these experiences and using them to produce a textual narrative, I draw upon my everyday emotional life and memories in a similar manner to many of the 'community' and 'activist' discussions conducted online.

The 'field' within this project thereby incorporates a very large number of conversations, writings, documents and reflections from across a wide range of spaces and times, but is also centred upon the idea of everyday engagement. Ultimately, I sought to explore discourses of trans health that any interested individual might encounter in exploring the transphere.

Digital notetaking

I used the web browser plug-in 'NCapture' to acquire digital images of the majority of web pages visited during the fieldwork process. Through 'capturing' images in this way, I was able to obtain a full record not only of the written discussions that are central to my analysis, but also of the visual architecture of pages, thereby retaining a feel of the *visual impact* of visiting any given space. I did not conduct a formal semiotic analysis of this imagery, but the approach did enable me to re-immense myself in the 'feel' of the spaces when later reflecting analytically upon the discussion that took place there, reminding myself of features such as colour schemes, company logos, fonts and advertising.

I made an exception for data from Facebook groups visited during the fieldwork process. Instead of using NCapture for fieldwork on Facebook, I took detailed notes in my fieldwork diary (which took the form of a Microsoft Word document) every day after reading the latest activity. This mediation of the field was performed out of respect for the very private nature of the majority of these groups, and the sensitivity of conversations that took place on them. In line with Facebook policy, most group users utilised their everyday, 'offline' name rather than a pseudonym: this means that directly collected data could make it very easy to identify individuals from my research. I have also changed the name of closed and secret groups used within this research in order to respect the private nature of these spaces. A full discussion of these issues can be found in my later discussion of anonymisation.

Temporal features of the field

Social interactions online constitute social reality, just as they do offline. However, as Gilbert Garza (2002: 190) argues, 'there can be little doubt that the Internet radically alters the constraints and live meanings of space and time'. I have previously noted that the Internet can collapse physical distance through the provision of platforms for discussion amongst a geographically dispersed range of users. Similarly, conversations and records on the Internet deviate from the Kantian notion of 'linear time' that typically underpins everyday Western understandings of temporality; as Susan Leong and colleagues (2009: 1280) note, 'the entire assemblage of constantly re-deployed technical mediations holds together not one isochrony but a multitude of timings'.

The Internet exists across time zones, meaning that a conversation might take place simultaneously in the morning and evening. Conversations between Internet users may

also take place asynchronously, meaning that a response might be posted minutes, hours, days, months or even years after the conversation has begun. The 'past' is ever-'present': most spaces (particularly those oriented around social interaction) automatically save 'old' content in an archive that can easily be searched by users. Even comments, posts or websites that have been deleted may be saved in screenshots, search engine caches, and/or archival projects such as non-profit digital library The Internet Archive. In these ways and more, the social and technological structures of the Internet complicate narrative and linear ideas of time, as well as clear distinctions between past, present and future.

These temporal features of Internet sociality have important consequences for online ethnography. The social spaces visited for my fieldwork sat on a spectrum of asynchronicity, meaning that social interactions typically took place 'over time' rather than 'in the moment'.⁴⁰ In the case of some conversations within the Internet forums I visited, topics would often be discussed over weeks or months, with some topics being picked up again by users after a long lull. In this way, the archiving of a conversation is not necessarily permanent, as many discussion threads can be shifted from 'past' to 'present' on an individual level (through personal engagement with old threads) and a community level (through a pinned link to an old discussion).⁴¹ This meant that I was able to follow the development of ideas and themes over time, observing community members interacting with 'old' topics as well as older ideas. Moreover, it enabled me to conduct a form of retroactive fieldwork in some cases, following discussions some years *after* they originally occurred in a manner comparable to a new user browsing a site's archive. For instance, I was able to read forum conversations from 2012 when conducting fieldwork in 2014. As a result, my findings reflect the field at the time of engagement: effectively a snapshot (or a series of snapshots!) of discursive themes at a moment (or moments) in time.

⁴⁰ This situation is complicated by the possibility of effectively instantaneous conversation should two users engaged in discussion happen to be online at the same time. This is more likely to happen on social media platforms such as Facebook and Twitter – the architectures of which encourage short, concise posts – rather than in the more lengthy engagements typically associated with forums.

⁴¹ I discuss how this element of online interaction informed the continued circulation of 'outdated' narratives in Chapter 6, *Trans Temporalities*.

'When' did the fieldwork take place?

I used two key legislative events within the UK to bookend the period from which the majority of data from the activist and community spheres *originates*: April 2010 to July 2013. The first of these is the passage of the Equality Act in April 2010. The second is the implementation of the Health and Social Care Act 2012 during the spring and summer of 2013. This latter Act led to a massive re-organisation of the NHS, meaning that new bodies were responsible for commissioning, providing and scrutinising various aspects of public health. The 2010-2013 period was therefore a distinct, important era in the social history of trans healthcare provision in the UK. In focusing upon this period, I seek to provide a snapshot of the social processes by which discourses of trans health are negotiated across different spaces under particular circumstances. Moreover, this 2010-2013 data corpus is augmented by documents I collected and fieldwork notes I took on developments that occurred in the three years that followed the close of this primary data collection period. This offers me a perspective on long-term trends and effects, providing some insight into how key debates and issues from the 2010-2013 period informed discursive negotiation and patient narratives into 2016.

I undertook the majority of fieldwork during two periods: from January 2013 to October 2013, and from August 2014 to April 2015 (I discuss the reasons for the break between these periods in my discussion on ethics later in this chapter). The first period involved a contemporaneous engagement with the field: I concerned myself mostly with events as they occurred and writings as they emerged, particularly within the activist sphere. During the last four months of this first period I began a retrospective process of data collection from archived discussions and documents across the field; a process that reflected the asynchronous temporal features of social interaction common to many of these spaces. This retrospective, archival element was completed during the second period of data collection.

Engaging in analysis

Thoughts, ideas and observations arising during the research process were noted in my fieldwork diary. These constituted an initial, informal stage of analysis, which informed my later thinking and the design of the more structured thematic analysis that followed.

Thematic analysis entails ‘searching across a data set [...] to find repeated patterns of meaning’ (Braun & Clarke, 2006: 91). For the purposes of this project, data from social media, forums, blogs, news articles and various documents, as well as the fieldwork diary itself, were fed into NVivo 10, a computer programme designed for qualitative data processing and analysis. I used NVivo to create a database that brought together material from across the data corpus; this material was then organised for both ease of access and thematic analysis. A key feature of NVivo is the creation of ‘nodes’, which facilitate the thematic coding of qualitative data. Any section of text can be coded as part of a node: I used this function to identify discursive themes across the data corpus.⁴² NVivo has a number of features that enable some form of automated analysis, but I eschewed these in favour of using the program to *facilitate* a manual process of coding. This decision was taken in part because I feel that these automated processes lose some nuance, but it also because it enabled me to maintain an immersive, feeling-based connection to the data many months after I completed the primary fieldwork.

Virginia Braun and Victoria Clarke (2006: 85) state that thematic analysis can be ‘an essentialist or realist method, which reports experiences, meanings and the reality of participants, or it can be a constructionist method, which examines the ways in which events, realities, meanings, experiences and so on are the effects of a range of discourses operating within society’. Mindful of the epistemological commitments that underpin this project, I sought specifically to identify the (re)production, dissemination and negotiation of ideas, assumptions and meanings associated with ‘trans health’ during the coding process. The themes I identified – and the connections between them – form the basis of my findings.

⁴² Nodes ‘are not actual segments of data, but *references* to the exact location of the text you coded in the source document’ (Bazeley & Jackson, 2013: 75, emphasis in original); this meant that I was able to organise thematically linked sections of text together in one place, whilst retaining the ability to look back at any given snippet of text in its original context.

Positionality: my relation to the field

Social research is not value neutral (Ellis, 1999). As with any researcher, my life experience – as a white, abled, bisexual trans woman in her late 20s, with a middle-class British background – impacts my approach to research and interactions with the field. In this section, I explore how my identity and experiences have impacted on the research process, and how I sought to address and account for this in my methods and analysis.

Centring trans voices

As a trans feminist researcher writing within the tradition of transgender studies, I aim to centre the voices of those individuals whose words form the core of this study, and create work that might ultimately be of benefit to them. In the context of my research questions, this means that I am concerned with amplifying trans voices and promoting trans agency as well as understanding the professional context of trans health. In the words of Stryker (2006: 12): '[t]ransgender studies considers the embodied experience of the speaking subject, who claims constative knowledge of the referent topic, to be a proper – indeed essential – component of the analysis of transgender phenomenon'. As a trans woman, I have drawn upon my familiarity with trans discourses, trans spaces and trans debates in order to plan, execute and contextualise an ethnographic project that puts trans voices at its heart.

Furthermore, writing *as* a trans woman within a cisgenderist and frequently transphobic academic world remains an important radical act. As Stone (1991) notes in her foundational transgender studies text, trans people have been historically written *about* at great length within medical, feminist and sociological literatures. While trans voices are finally gaining legitimacy within the realms of medicine, academia and media, cis writing about trans lives continues to contribute to an often violent erasure of trans bodies and subjectivities (Ansara & Hegarty, 2012; Serano, 2013; cárdenas, 2016; Gupta, forthcoming). Additionally, there are gender imbalances even within transgender studies: for instance, there is a dearth of in-depth empirical social research published by trans women (Namaste, 2000; Whittle, 2006: xiv).

Numerous trans scholars have highlighted the revolutionary value of writing as openly trans (Stone, 1991; Bornstein, 1994; Feinberg, 1999; Namaste, 2000). Being 'read' as trans – even within academic writing – makes me feel vulnerable, means I *am* vulnerable (Shultz & Shultz, 2016). However, like Ellis (1999) and her student Sylvia, I

also feel that this vulnerability grants me strength: my monstrosity as ‘outsider’ and ‘other’ provides me with energy, inspiration and insight (Stryker, 1994; Rose, 2007). In writing *as* a trans woman as well as *about* trans discourse, I follow the example of trans writers before me in challenging cis hegemony within the academic world and beyond, and aim to inspire other trans academics to follow in turn.

‘Insider’ status? Turning a critical lens on myself

In critical social research, being an ‘insider’ member of a social group is increasingly recognised as advantageous for understanding particular social phenomena relevant within and to that group. For instance, in their introduction to the US-based empirical work *The Lives of Transgender People*, Genny Beemyn and Susan Rankin argue that:

Detractors may contend that we lack adequate critical distance or are biased by virtue of our memberships in transgender/queer communities, yet we feel that our positions give us insights that have been absent from much of the literature on transgender lives, which has been largely written by cisgender [...] researchers. Our connections to the communities that we are studying also enabled us to involve many transgender people in the research who otherwise would have been reluctant to participate for fear of further mistreatment by academics. (Beemyn & Rankin, 2011: 6)

In many respects, I approached fieldwork as a classic insider. As a woman who was coercively assigned male at birth, I am immediately familiar with specifically trans experiences of sexual dysphoria, social and medical transition, harassment and fear, hope and fulfilment. This enabled me to empathise with trans experiences and ask pertinent questions of my findings; it also ensured that I was hyper-aware of ethical issues as they arose. As Hines (2007: 194) notes in positioning herself as a ‘*non-transgender researcher*’ (emphasis mine), *trans* academics may benefit from both insider knowledge and a basis from which ‘to build trust with potential participants’.

Prior to fieldwork, I was already well-acquainted with many of the social spaces within which I conducted this study. As a lonely trans teenager in the early 2000s, I spent a great deal of time on community forums, seeking company and support from

others with similar experiences.⁴³ As a result, both forums visited for fieldwork felt immediately familiar upon arrival: I recognised their electronic architecture, the terminology used by members, topics of conversation and many of the experiences discussed. In a similar way, a personal involvement in campaigns around legislative change during the drafting of the Equality Act 2010 led to my involvement in a number of activist groups on Facebook, as well as frequent engagement with the trans blogosphere, mainstream media articles, and official government and NHS documentation. This means that my ethnographic engagement with these spaces and texts drew upon a deep understanding of cultural, historical and political context, developed over the course of my adult life. It also means that I had the relevant connections and cultural capital to quickly gain access to new groups for the purposes of fieldwork.

I therefore benefited from a significant level of insider insight in conducting this project. However, it is important to acknowledge that insider/outsider positions are not necessarily as distinct as they might seem. For instance, in her discussion of Bulgarian maritime workers, Milena Kremakova (2014) develops the concept of the 'returning outsider': a researcher who has personal and historical ties to a community, but has been absent for a period of time as they develop external ties to the academy. This concept can be applied to my own interactions with trans forums; I have not simply 'been away', but have also developed different ideas and perspectives in the meantime, particularly within the academic context. I am also 'returning' to spaces similar but also different to those I visited as a teenager.

Moreover, there is no one way to be trans. In many ways, my identity and experience fit neatly into a certain established *transsexual* narrative, but it differs radically from the identities and experiences of any given sissy maid, drag king or non-transitioning genderqueer person. In their discussion of qualitative methods in research centred upon race, Miri Song and David Parker (1995: 243) argue that the cultural identities of supposedly 'insider' researchers can complicate interactions with others from a *shared* racial background: 'the dual categories of 'black/white' as well as 'insider/outsider', have not only tended to obscure the diversity of experiences and viewpoints between and within various groups, but these categories have also obscured the diversity of experiences which can occur between the researcher and the researched'. This can be complicated further through intersectional analysis, which

⁴³ Social and technological shifts mean that, at the time of writing, younger trans people are now more likely to use newer social media platforms such as Twitter, Tumblr and Youtube than the forums that were more popular during my own youth (Jenzen & Karl, 2014).

more widely addresses 'difference *within* groups' (Crenshaw, 1991: 1242, emphasis in original) as well as differences between groups. For instance, because I am racialised and privileged as white, my experience of being trans is different to that of a trans person of colour (Vidal-Ortiz, 2014). In this way, the identity, familiarity and understanding that come with group belonging are not one-dimensional.

To illustrate these issues more deeply, I describe my emotional and analytic response to Zev Al-Walid's (2010) personal account of pilgrimage in Mecca. Upon reading his account, I was at once empathically struck by the differences and similarities between our lives. As a trans woman and a non-Muslim, I will never share anything like Al-Walid's experience of negotiating participation in the Umrah as a trans man of colour who passes for a cis woman. This example highlights the risks of assuming 'expert knowledge' on the basis of shared identity: I am not *just* trans *but* also a white, agnostic woman. To extend the example: Al-Walid's difficulty with passport control at the airport (where staff were confused by the apparent difference between his physical appearance and the gender marker on his documentation) felt intimately, painfully familiar. However, when I found myself in a similar situation to Al-Walid at airports in Western countries, prior to obtaining a passport with a 'female' gender marker, I did not fear being racially and religiously profiled as a potential terrorist in the same way. Parallel stories could be told about my relation to the experiences of trans people from different socio-economic backgrounds, trans people of a different age and so forth. In this way, 'trans' is something that marks both difference and similarity between myself, Al-Wahid and others. We are insiders/outsideers to one another in terms of shared/divergence identity, experience, privilege and marginalisation.

It is therefore important to acknowledge commonalities between researchers and members of the communities they engage with, but not overemphasise them (Hines, 2007: 194). I thus consider my insider status to be of benefit to me as a researcher, but have also sought to avoid sweeping assumptions about the experiences, perspectives and discursive modes present within my findings. Instead I take a reflexive approach, regarding the amplification of trans voices and the analysis of a wide range of discursive themes as an *active*, never-complete process of continual negotiation.

Ethical considerations

In the final section of this chapter, I discuss ethical concerns relevant to the undertaking of this project. In particular, it is important to consider the impact that social research might have on the individuals and communities it engages with: '[i]n a very real sense, every method decision is an ethics decision, in that these decisions have very real consequences for not just research design but also the identity of the participants, the outcomes of our studies, and the character of knowledge which inevitably grows from our work in the field' (Markham, 2008: 251). Researchers have the power to define the terms of engagement with those they study, and disseminate information about them; we therefore 'have a responsibility to ensure that the physical, social and psychological well-being of research participants is not adversely affected by the research' (British Sociological Association, 2002: 2). In the final part of this section I discuss self-care, in terms of my ethical responsibility towards *myself* as researcher, as well as my institution's responsibility towards me.

Responsibility to participants

My methodological approach raises a number of important ethical considerations. These include issues of consent, privacy, and authorship. The British Sociological Association (2002) has a number of recommendations about gaining consent from participants and anonymising their identities in order to protect their interests. Such considerations are particularly important in research involving trans participants for two central reasons. Firstly, even trans people who are 'out' on the Internet may be closeted or 'stealth'⁴⁴ in the offline world for a variety of reasons. Any action that might unwittingly 'out' a trans individual to family, friends, work colleagues or peers is likely to place undue stress upon their mental health and leave them open to discrimination and abuse (McNeil et al., 2012). Secondly, trans people are regularly misrepresented, misgendered and othered within research (Namaste, 2000; Serano, 2007; Ansara & Hegarty, 2012). As a result, trans people may be particularly wary of researchers' aims and intentions.⁴⁵ This, coupled with the relative vulnerability of trans participants – as

⁴⁴ 'Stealth' trans people seek to move through the world without their trans status being apparent.

⁴⁵ A blog post I saw shared on several occasions is *Fuck You and Your Fucking Thesis: Why I Will Not Participate in Trans Studies*. In the post, author Anne Tagonist (2009) argues that the majority of researchers looking at trans issues are 'self-serving' and cisgenderist, and that their research interests do not typically align with trans people's needs. The post – along with a heated debate in the attached comments thread – reflects both the frequency with which trans

evidenced by exceptionally high rates of depression, self-harm, suicide ideation and attempted suicide (Whittle et al., 2007; McNeil et al., 2012) – means that researchers should be particularly sensitive to the privacy of trans populations.

At the same time, it is important to explicitly acknowledge the contribution of trans writers. Namaste (2000) argues that successive generations of trans people have effectively been silenced by social research: in contrast, I hope to amplify trans voices. I have therefore sought to openly name participants in instances where they have explicitly sought a public audience. This need not necessarily contradict a commitment to privacy: in the context of Internet research, a key issue for ethical consideration is whether or not any given text was conceived of by its author as private or as public.

I therefore adopted the following broad guiding principles for ethical engagement during fieldwork and the writing of this thesis.

- I would seek permission to acquire data from private spaces (including member-only communities such as the community forums, and secret Facebook groups).
- I would anonymise all data from these private spaces.
- I would *not* anonymise data from public spaces within the activist sphere (such as public blogs); instead, I would acknowledge each writer openly as the author of their work, in recognition of the public statement they sought to make through writing.
- I would *not* anonymise data from the practitioner sphere, as these documents and websites were produced *as* public discourse.

In practice, implementing the first two of these principles in particular was a complex process. As noted by the British Sociological Association (2002: 5), '[e]liciting informed consent, negotiating access agreements, assessing the boundaries between the public and the private, and ensuring the security of data transmissions are all problematic in Internet research'. This led to three issues that required careful consideration.

Firstly, while some spaces were very explicitly member-only or secret, and others were explicitly aimed at a wide public audience, the distinction between 'public' and 'private' was not always clear, particularly within the activist and community spheres.

community spaces are approached by privileged, thoughtless and/or underprepared researchers, and the distrust that can arise from this.

For example, some of the sub-forums within a particular message board were specified as 'public', meaning that anyone could read content or post anonymously. Others required a membership profile with the forum in order for a user to read and post on them. This raised questions about the extent to which forum users paid close attention to which sub-forum they were posting on, and how best I could anonymise or acknowledge writers in different parts of the forum. Similarly, tweets to #transdocfail were visible to anyone who clicked on the hashtag – a matter that regular Twitter users would be aware of – but contributors were unlikely to expect their tweet to be picked up by a researcher. As Markham (2008: 274) notes: '[s]ome users perceive publicly accessible discourse sites as private'.

Secondly, anonymisation within social research typically entails changing the reported name of participants in order to protect their identity (Bryman, 2004). It is possible to argue that even this is not always necessary online, as Internet users frequently create pseudonyms when registering for membership of various spaces in order to manage their own privacy. However, there is a danger that any direct quotation from a social space online might attract undue attention regardless of pseudonym use, as readers can often uncover even 'private' locations in which conversations originally took place by copying the quote (or a section thereof) into a search engine (Kendall, 2002).

Thirdly, there were issues with consent. Seeking consent was complicated by the fluid membership and shifting activities of users within fieldwork sites in the activist and community spheres: '[o]nline discussion sites can be highly transient [...] Researchers gaining access permission in June may not be studying the same population in July' (Markham, 2008: 274). This, combined with the temporal peculiarities of the spaces in question, along with the sheer number of users present across multiple spaces within the field, rendered it impractical to directly seek permission from every individual whose writing is present in the data corpus for this project.

My solution to the above issues was to treat spaces with a *predominantly private* function (such as the forums) as private, and spaces with a *predominantly public* function (such as Twitter) as public. I further implemented a number of additional measures to seek consent and protect the identity of users.

I explicitly sought permission to conduct research within every private space visited for fieldwork. I posted on the forums and Facebook groups to state that I hoped

to conduct research within the space. I linked to a website created for the purpose of providing information on myself, my research aims and methods,⁴⁶ provided my institutional contact details, and offered to answer any questions that potential participants might have. No-one took exception to my proposal to conduct research and I was not denied permission to conduct research in any of the spaces; however, I waited for permission from forum or group administrators before commencing data collection. In one of the two forums I was asked to restrict data collection to 'public' areas, so I limited my activities accordingly; I nevertheless continued to regard this data as 'private' due to the predominantly private function of the space.

I also sought explicit consent to reproduce all quotes from social spaces (e.g. forums, Twitter) that I use for illustrative purposes within this thesis (and within related external publications), *regardless* of whether or not I otherwise regarded that space as 'public' or 'private'. This ensured that I addressed the important methodological issues raised by Markham (2008) regarding public discourse and shifting populations. I sent direct private messages or emails to relevant individuals in order to ask if they would be interested in participating in this project. If permission was denied or I did not hear back from the individuals in question, I did not use anything they had written.

I did not seek permission to quote from public blogs or media articles. However, I follow blogosphere etiquette – and seek to amplify trans visibility, where relevant – by openly naming writers and providing links to their articles in the bibliography of this thesis. I also provide a list of blogs in the appendix.

Where this thesis quotes from public spaces, I use the name or pseudonym chosen by the author. In this way, I aim to respect the choice made by the author in selecting a username that may have an important personal meaning. Where this thesis quotes from private spaces, I use a pseudonym selected by myself to protect the identity of the author. Some quotes (particularly those from public areas of spaces I have treated as private) have undergone small edits – with permission from the participant – in order to protect the author from discovery via search engine. When taking this step, I have sought to retain the intent, spirit and 'feel' of the original quote.⁴⁷

I therefore sought to adopt a nuanced approach to the sensitive ethical issues that arose from my methodological approach. Applying a single, inflexible principle in

⁴⁶ <https://transhealth.wordpress.com/>

⁴⁷ I am particularly grateful to Dr Karen Throsby for her advice on implementing this measure.

matters of consent, privacy and authorship might have served to undermine the privacy and/or autonomy of participants. Instead, I adapted and responded to specific circumstances within different spaces in the field.

Responsibility to self

I spent a great deal of time contemplating the aforementioned ethical issues relevant to *participants* during the planning stages of this project, the fieldwork process, and the writing of this thesis. However, I would have benefited from better considering my ethical responsibilities to *myself* before entering the field. I would also have benefited from better institutional support at these times. I encountered a number of challenges that impacted significantly on my mental (and, to a lesser extent, physical) health during this project; challenges that in retrospect could have been better anticipated and addressed. I discuss this as an important methodological issue, but also aim to break the widespread 'silence' regarding mental health issues within university environments (Wynaden et al., 2014).

The British Sociological Association (2002: 2) guidelines state that: '[s]ocial researchers face a range of potential risks to their safety', but there is no mention of the mental health of sociologists. There is a recommendation that '[m]embers [...] consider carefully the possibility that the research experience may be a disturbing one' (4), but the onus is upon the impact that this might have on participants.

There is, however, some discussion of these issues within feminist literatures. Sevaste Chatzifotiou interviewed participants resident in Greek women's shelters for a project that looked at personal experiences of domestic violence, abuse and rape. She felt under-prepared for the impact that this had upon her *own* mental health. Her paper explains that the experience of data collection was stressful due to the empathy she felt for participants: '[l]istening to women's traumatic stories made me feel anxious and depressed' (Chatzifotiou, 2000: 8.3). By contrast, Ellis (1999) carefully prepared Sylvia for the emotional difficulties of conducting research with other cancer survivors. In acknowledging the 'pain' that the project would entail and the 'vulnerability' it would require, Sylvia was empowered to carefully plan a study that accounted for these factors.

While coding my fieldwork diary, I was struck by the impact of the research on my own mental health. I was engaging on a daily basis with stories of transphobia and cisgenderism from medical providers and the mainstream media, as well as narratives

of hardship, anguish and internalised transphobia from research participants. The very act of managing my feelings while entering the field, analysing my data and attending research events became an increasingly difficult form of emotional labour (Hochschild, 1983), only compounded by my desire to maintain a 'professional' approach. These issues are illustrated by the following quotes from my fieldwork diary.

Just finished writing about the Trans* Health Matters⁴⁸ stuff [...] I feel slightly sick and wanted to cry at various points. I might do so now.
(Fieldwork diary: 14/03/13)

I'm finding the process of this research extremely stressful simply because I keep having to confront and digest distressing stories on a daily basis. I'm considering [...] accessing counselling for the [duration] of my fieldwork. If I don't have a way of handling the negative emotions I'm experiencing as a result of this I feel like I could cause myself a fair amount of harm.
(Fieldwork diary: 25/03/13)

I found the overall experience of reading this conversation to be a distressing, upsetting one (Fieldwork diary: 26/06/13)

My 'insider' familiarity with the subject matter and the field meant that I empathised easily with participants' stories. The topic of trans health was very 'close' to me as I began fieldwork, but feels even 'closer' at the time of writing. As this project unfolded, I myself changed GP practice following years of misgendering, and have seen numerous trans friends denied access to medical services, grow frustrated with waiting lists, and/or be refused trans-specific treatment. In particular, two trans friends (one of whom I lived with at the time) took their own lives. These experiences meant that posts written by distressed individuals within the community sphere were particularly hard to read.

When I'm already feeling emotionally vulnerable, the sheer level of anguish experienced by the people on the message board I'm looking at hits hard. I frequently shout at my computer or want to cry. There are some good stories but so much pain. I'm just reading a post by someone who is having a lot of trouble finding out what's happening with his surgery referrals and is so worried by it all that he's becoming physically ill. It all feels horribly familiar. I've already retreated to my bed and cried a couple of times today.
(Fieldwork diary: 22/09/14)

⁴⁸ This was a conference held in London, hosted by holistic trans sexual health centre cliniQ.

I eventually became severely depressed, anxious and prone to panic attacks. In the wake of my housemate's death in November 2013, I took several months off the project to focus on recovery. While I found my supervisor and a number of other individuals in my department (particularly other PhD students) to be very supportive, I felt isolated by the impersonal structures of the wider university institution, which are not well-adapted to support the mental health of academics. Chatzifotou (2000: 8.4) recommends that researchers dealing with difficult, emotional fieldwork and analysis participate 'in sessions providing professional counselling'. However, I could not afford private counselling and was offered only three appointments by the university's in-house service. There was no clear point of contact within my department for me to discuss emotional issues arising directly from my work.

I eventually gained access to counselling through a local charity in the spring of 2014, which helped me process both my bereavement and the wider mental health issues related to my work. Through these sessions, I also had the opportunity to consider the support that my institution could have offered. My counsellor informed me that she was expected to discuss issues of emotion and vulnerability arising from her work with her clinical supervisor. She expressed a great deal of surprise that the university did not have similar procedures in place for social researchers conducting ethnographies and/or qualitative interviews in the course of their professional duties. It was ultimately left to me to realise that I required mental health support, and arrange access to these services. Following a formal withdrawal from my studies, I eventually resumed fieldwork in the summer of 2014. Being more aware of my own vulnerability, I eased myself back into the project gradually. However, I still faced a number of emotional challenges, as evidenced in the above quote from my fieldwork diary dated September 2014.

It is also worth briefly examining the physical impact of the PhD on my body. I have previously noted how the Internet extends into the physical medium through the devices with which we access the online world. Regular use of these devices (for Internet use or simply for writing) without appropriate exercise and self-care can result in injury. Many of my PhD student colleagues swapped stories about back, wrist and neck problems due to frequent computer use. In particular, I strongly recall having to leave a departmental seminar on embodied research in the context of cross-Channel swimming due to the sudden, agonising onset of shooting pains in my lower arms; a consequence of many weeks of typing without adequate exercise.

I fear that the negative impact of this project upon my mental and physical health will be permanent. While I recovered from depression, I have experienced crippling anxiety on numerous occasions since this time. I also need to regularly monitor my computer usage and stretch my wrists in order to avoid pain in my hands and lower arms. Moreover, the emotional difficulties I encountered in undertaking this project ultimately worked to considerably delay the fieldwork process. In retrospect I could have paid better heed to issues of self-care during the planning stages of my PhD. I could have better acknowledged how 'close' I would be to participants' negative experiences, assigned more time to the fieldwork process so I could spend fewer hours immersed in the field on an everyday basis, and accessed counselling services sooner. I also could have considered accessing physiotherapy.

However, I also believe that universities need to take greater responsibility for the wellbeing of researchers. Upon re-reading my PhD 'Upgrade Document',⁴⁹ I note that there is no discussion of any ethical responsibility to myself. This omission was not remarked upon by the members of academic staff who scrutinised and interviewed me about the document. In an environment where the majority of academics report being stressed (Kinman & Wray, 2013), and with substantial anecdotal evidence pointing to endemic mental health issues amongst postgraduate researchers in particular (JC, 2011; Anonymous, 2014; Else, 2015), this seems to be an inappropriate omission. I propose that matters of mental and physical health be properly addressed in postgraduate research training programmes. Researchers should be informed of the mental and physical issues they might face, and offered support and guidance in addressing and managing these issues before they become a problem. In particular, qualitative researchers proposing to engage in work that entails vulnerability should be invited to prepare for this emotional challenge, and offered mental health support (for instance, through a named non-academic mentor and/or counselling services) as a matter of course.

⁴⁹ Within my department, PhD students are asked to prepare an Upgrade Document at the end of their first or second year. This document is effectively an in-depth research proposal, incorporating a short literature review and an extensive methodological discussion. It is used to determine whether or not research students are adequately prepared for further study (and, where relevant, empirical fieldwork).

Conclusion: state of the heart

Ethnographic research is frequently described as ‘immersive’ (Bryman, 2004). In this chapter, I have shown how deep this immersion can go.

Every ethnographic project must be adapted according to context (Boellstorff et al., 2012). For this project, I was required to make numerous methodological decisions in order to account for the particulars of Internet research and research with trans populations. This entailed ontological considerations regarding the intersubjective metaphorical construction of the Internet as ‘space’ (Markham, 2003). I therefore conceptualised online networks as temporally asynchronous ‘spheres’, which in turn informed the planning of my methods and means of thematic qualitative analysis. The context of this project further required a very careful consideration of the intersecting ethical issues that arise from undertaking Internet research with trans populations.

This chapter also turned a critical lens on my own subjectivity, through a discussion of my position in relation to the field as a simultaneously privileged and marginalised trans researcher. If I am to analyse and comment upon deeply personal aspects of the lives and experiences of others, it seems reasonable to offer myself up to similar scrutiny. Moreover, my own ‘insider’ status and intimate, long-standing connection to the field means that there was much to be learned both emotionally and analytically from incorporating an autoethnographic element into my approach (Anderson, 2006; Ellis et al., 2011).

Finally, this chapter offered an account of my own vulnerabilities, one that can be linked both to my discussion of ethics and my commitment to ‘heartful’ autoethnographic insight (Ellis, 1999). This was one of the most difficult parts of the thesis to write. However, like Carolyn Ellis’ student Sylvia, I recognise my pain as deeply important, personally *and* analytically. If individuals from marginalised groups are to undertake qualitative research projects that delve deep into heart of the problems found within our own communities, we require two important commitments. Firstly, *we* must be committed to ourselves and to other people like us. We must be committed to acknowledging our differences and similarities, our vulnerabilities and strengths; and committed moreover to a project of positive change. Secondly, *the institutions* in which we work and our peers in these institutions must be committed to acknowledging the mental and physical toll that research can take, and providing the necessary preparation and support for this.

5

(Re)Defining Trans

Intersecting possibilities of being

I could not ask a transsexual for anything more inconceivable than to forgo passing, to be consciously 'read', to read oneself aloud - and by this troubling and productive reading, to begin to write oneself into the discourses by which one has been written[.]

- Sandy Stone (1991)

Cisgenderism and the bounds of possibility

Trans possibilities are defined, *redefined* and reified through processes of expert recognition in healthcare and community settings. I draw upon three loose models to understand how trans possibilities are shaped and negotiated in the context of trans health: the discursive repertoires of 'trans as condition' and 'trans as movement', plus the concept of 'cisgenderism' (Ansara & Hegarty, 2012; Kennedy, 2013). Trans possibilities oriented towards condition *or* movement can work to counteract cisgenderist norms, providing a means by which trans lives and bodies can be interpellated as *real*; but they can also feed into cisgenderist norms and assumptions. I position the 'real' as a social construct, linked to the mediation of discourse through the operation of recognition as well as power. In doing so, I draw upon Deborah Lynn Steinberg's description of reality,

as a filter, as a *field of intelligibility* that reciprocally imbricates what is *material* (our senses, our experiences, our mutual publics composed of laws, institutions and place) with what is *understood* - as much a projection as it is a consequence of fact. Thus, what is real is both consequential *to* and a consequence *of* what is seen, and not only that, but what is *sought*. (Steinberg, 2015a: 153, emphasis in original)

In her concluding remarks to *The Empire Strikes Back: A Posttranssexual Manifesto*, Stone (1991) reflects upon the cultural and medical imperative that transsexual people 'disappear' following transition, through 'passing' as cis men or women. This prescriptive approach to trans possibility arose from the traditional transsexual model, by which transitions were historically managed within Western gender clinics. Within

the traditional transsexual model, trans people are encouraged to move through the world, to be *seen*, as 'real' women or men. In this context, both reality and intelligibility are tied up in cis gender norms. Passing was to be achieved through a careful management of the transsexual person's gender presentation and the construction of 'a plausible history' in line with their preferred gender (Stone, 1991: 230). This approach relies upon a systemic binary division of gender and erasure of visible trans possibility, with the 'highest purpose of the transsexual' being 'to erase him/herself, to fade into the "normal" population as soon as possible' (ibid). In this sense, the traditional transsexual model operates as a cisgenderist imperative, even as it can be reinforced by transsexual community narratives that position the 'fully' transitioned (post-operative, passing) transsexual at the top of a hierarchy of gender variance (Bornstein, 1994). At the same time, the traditional transsexual model provides a (conditional) means by which trans people can access reality within a cisgenderist world.

The historic *unreality* and *impossibility* of trans visibility is grounded in cultural and professional cisgenderist norms. Cisgenderism 'represents a systemic erasure and problematising of trans people, an essentialising of gender as binary, biologically determined, fixed at birth, immutable, natural and externally imposed on the individual' (Kennedy, 2013: 4). Within a cisgenderist context, trans lives and bodies represent an impossible deviation from the necessary alignment of assigned gender, social gender role, gender identity and sexed body: an alignment described by Butler (1990) as the 'heterosexual matrix'.

Cultural cisgenderism exhibits a low discursive saturation; it is predominantly held and communicated in a tacit or implicit manner (Kennedy, 2013). Natacha Kennedy draws upon the example of gender variant children to illustrate the impact of cultural cisgenderism on notions of the possible. She notes that: '[t]rans children, like other children, understand that it is usually likely to be socially unacceptable to adopt certain behaviour[s], preferences or appearance[s], particularly those that are outside the social norms of their gendered community of practice' (Kennedy, 2013: 7). Such children therefore learn to conceal or suppress non-conforming gendered feelings (Kennedy & Hellen, 2010).

Professional cisgenderism exhibits a high discursive saturation; it can be seen explicitly expressed in professional discourse (Kennedy, 2013). This form of cisgenderism is described by Ansara & Hegarty (2012: 141) as 'a prejudicial *ideology* [...] that is systematic, multi-level and reflected in authoritative cultural discourses' (emphasis in original). Ansara & Hegarty (2012) illustrate the impact of professional

cisgenderism by drawing upon academic literature from an ‘invisible college’ within the field of psychology. Cisgenderist language – such as misgendering, which actively ignores the self-ascribed gender of patients – is intentionally employed by members of the invisible college in accordance with their ideological views on gender. This language works to ‘dehumanise, silence and erase’ all of those who fail to meet normative gender expectations (Ansara & Hegarty, 2012: 152).

Both cultural and professional cisgenderism therefore work to deny the *possibility* of gender variance by delineating the bounds of the real. The children described by Kennedy (2013) learn from the discursive saturation of binary gender norms that it is not *really* possible to be gender variant. They therefore hide or amend their behaviour in a manner that serves to reinforce this social reality by keeping alternative possibilities out of sight. The psychologists described by Ansara & Hegarty (2012) render trans gender identities unreal and impossible in a professional setting through actively refusing to acknowledge them, thereby implying that individuals who hold these identities are somehow deluded. Within cisgenderist discourses, only ‘cis’ genders are therefore real and possible. It is for this reason that the traditional transsexual narrative offers gender variant people an opportunity to effectively *become* socially cis through the erasure of their transness.

Consequently, both trans patients and gender clinics have historically faced significant challenges in establishing trans experiences and bodies as possible and real within the UK’s public health system. For example, patient access to gender identity services through the NHS only became an entitlement following a legal ruling in 1999.⁵⁰ Numerous commissioning bodies attempted to circumvent this in the decade that followed, often due to concerns about being ‘publicly seen to be supporting or “advocating” gender reassignment’; this resulted in a number of de facto local bans on gender identity services (Combs et al., 2008: 19). More recently, Bailey & McNeil (2013) showed how GP practices in the North West of England were disinclined to put up freely provided, NHS-branded posters promoting trans health and/or record the number of registered trans patients. One practice manager told the researchers that their project was irrelevant, stating that ‘[t]here aren’t many around here in Cumbria because they’d stick out like a sore thumb’ (Bailey & McNeil, 2013: 22). This comment provides evidence of assumptions about how trans people might look or be perceived, but also actively works to deny the *possibility* of trans patients at the practice.

⁵⁰ AD & G v North West Lancashire Health Authority, Court of Appeal, 1999.

This chapter examines how both health professionals and patients have therefore sought to (re)define trans identities and experiences as both possible and real, 'reading' trans 'aloud' (Stone, 1991: 232) through discourses of trans as condition and/or movement. I examine the interplay and intersection of these discursive repertoires, looking at how they can variously work to counter or reinforce cisgenderist norms and assumptions. Drawing on material from across all three spheres of my data corpus, I illustrate points of similarity, difference and influence, looking particularly at how various understandings and definitions of trans possibility might shape expectations of treatment amongst practitioners and patients alike.

I begin with a closer examination of the traditional transsexual narrative, showing how it emerged to reflect the cultural and ideological investments of trans patients as well as medical practitioners. This provides background for an explanation of the various 'posttranssexual' redefinitions of trans possibility that have emerged in the wake of Stone's (1991) intervention, as trans people have sought to write themselves 'into the discourses by which [they have] been written', resulting in a 'gender pluralist' (Monro, 2005) spectrum of possibilities. I then turn to my research findings to look at how discourses of trans as condition can shape medical practice and trans perceptions of self. In particular, I show how understandings of trans as transition can limit the availability of information on trans health, and how gatekeeping processes work to define the scope of trans/gendered possibility. I then examine discourses of trans as movement, showing how they can be drawn upon to provide discursive alternatives to trans as condition within the realms of both personal identity and gender pluralist community. Finally, I explore the difficult consequences of discursive clashes within healthcare settings, in which cisgenderist norms and differing understandings of trans as condition or movement have separately shaped the respective perspectives of practitioners and patients.

Transsexual histories and posttranssexual possibilities

Stone (1991) concludes her essay with a call to arms, arguing for the creation and exploration of 'posttranssexual' potentialities. In contrast to the traditional transsexual, the posttranssexual would 'read oneself aloud' and 'write oneself into the [medical, feminist, transsexual] discourses by which one has been written' (Stone, 1991: 232). Stone's account recognises the social and historical contingency of transsexual identity

and experience, created through patients' interactions with medical literatures and health institutions.

This does not mean that transsexual people were (or are) without agency, nor does it mean that they were (or are) necessarily dupes of the medical establishment. As Stone (1991: 228) herself notes, transsexual patients historically took the seemingly necessary steps required to access treatment; for instance, through describing an experience of 'being in the "wrong" body' in line with Harry Benjamin Standards of Care. Joanne Meyerowitz (2002) argues that patient demands for treatment were a key factor in the emergence of the transsexual medical model in the first place. Such demands could involve active efforts to educate health professionals. Patients sought to explain themselves through drawing emotively upon personal accounts and discursively upon the authoritative languages of psychology, religion and biology. For example, Meyerowitz (2002: 368) describes how many patients 'portrayed themselves as intersex,^[51] hoping perhaps, as one psychiatrist phrased it, to "substantiate a biological basis for their condition[""]'.

As I showed in Chapter 2, the discourse of transsexualism not only offered gender variant people access to hormones or surgery; it also offered an identity and an explanation for otherwise inexplicable feelings of dysphoria. As Rubin argues in his account of female-to-male transitions:

As much as these claims [to transsexual identity] substantiate the logic of treatment and provide a rhetorical justification for treatments, they also represent [transsexuals'] attempts to theorize the circumstances that confront them, to put their enigmatic existence into words, and to relieve themselves of the constant queries about who and what they are. (Rubin, 2003: 498)

Transsexual identities can therefore be described as constructed in collaboration between trans people and health professionals (Ekins & King, 2006). The traditional transsexual narrative represented a move by gender variant people to write

⁵¹ Intersex people are born with chromosomes, genitals, gonads and/or hormonal conditions that do not meet the expected binary male/female norms of the sexed body. Whilst intersex and trans communities and activisms are frequently entwined within the Global South, they tend to remain somewhat more separate within the Western world. This is due to a range of factors, including the different social issues faced by intersex people – such as coercive surgery upon infants in some instances (Hird, 2003) – and the common appropriation of intersex issues by trans activists (Clune-Taylor, 2016). As such, discussion of intersex issues is beyond the scope of this thesis, except where intersex discourse intersects with trans discourse, and where intersex individuals also identify as trans.

themselves into the available condition-oriented discourses of gendered possibility. Transsexualism offered such individuals the opportunity to counter cultural cisgenderism by explaining their existence to themselves *and* to the health professionals who might be able to help them transition. However, this was not the only vision of gender variant possibility that emerged during the 20th Century. In Chapter 2 I also showed how discourses of *trans* identity and embodiment offered a vision of posttranssexual possibility from the 1990s onward, with Feinberg (1992; 1999) envisaging ‘trans’ as a broad *movement* of gender diverse minority groups uniting around shared oppressions. I also conceptualised the growing range of non-binary or genderqueer identities – which emphasise fluidity, complexity and the multiplication of possibilities – as bound up in discourses of trans as movement.

The fragile alliance of disparate groups under the banner of ‘trans’ has resulted in numerous disagreements and conflicts over language and the boundaries of identity, but has also worked to create more space for diversity and difference *within* as well as between the constituent categories. Of particular note to this project is the fact that shifts in language and community, shaped by the growing possibilities of trans as movement, have broken down the monolith of restricted transsexual possibility described by Stone. In the 21st Century, a self-ascribed transsexual might transition socially but not physically; they may choose to undergo some medical procedures but not others; or they may seek to transition into a non-binary role instead of endeavouring to live as a woman or as a man. Moreover, a desire for physical transition does not necessarily entail a ‘transsexual’ identity, with some transitioning individuals describing themselves as (for instance) genderqueer, transgender, or simply trans as well as, or instead of, transsexual. Some trans people continue to ‘fade into the “normal” population’ (Stone, 1991: 230) – a course of action known as ‘going stealth’ – but the increasing ubiquity of the Internet and growth in the number of local trans groups means that it is possible to do this while retaining contact with trans communities. In this way, new understandings of physical transition allow for *both* the expansion of existing ‘female’ and ‘male’ categories, and movements beyond the gender binary altogether (Monro, 2007). Trans communities that offer space for a diversity of perspectives and experiences regarding transition can be described as ‘gender pluralist’ (Monro, 2005; 2007). All of these possibilities represent a complex interaction between the discursive repertoires of trans as condition and trans as movement, in which trans people draw upon a range of ideas in order to understand

and explain themselves; to write themselves into the discourses by which they have been written.

Conditional possibilities

A considerable majority of participants from the activist and community spheres draw in some way upon discourses of trans as condition in describing their gendered identities and/or interactions with healthcare services. This is particularly the case amongst individuals who are undergoing, have undergone, or intend to undergo a physical transition. Similarly, all but a small number of the materials sampled within the practitioner sphere conceptualise trans as condition. These materials focus upon matters of gatekeeping, diagnosis and the treatment of gender disorders or dysphoria, representing a professional engagement with trans possibilities in a manner that prioritises medically-mediated transition. I shall show that condition-oriented definitions of 'trans' within all three spheres of the field operated to limit the scope of trans possibilities, thereby rendering 'trans' *conditional*.

Discourses of trans as condition can be utilised by both trans patients and health professionals to a range of ends. In this section I explore a number of these, unpacking how different discourses can be utilised in order to explain and justify modes of treatment as well as the bounds of gendered possibility. I begin with a look at modes of possibility within the practitioner sphere. A considerable range of positions are apparent in the materials from this area of the data corpus. However, two patterns were observed. Firstly, an overwhelming majority of sources focus on issues of diagnosis and treatment for transitioning patients, to the extent that other issues concerning trans health remain largely unaddressed; this derives from and feeds into an understanding of trans *as transition*. Secondly, accounts of diagnosis and treatment position health professionals as *gatekeepers* in relation to trans healthcare provision, with the power and responsibility to shape notions of what appropriate trans lives, trans bodies and transitions might look like. Having examined these patterns, I then draw upon data from the activist and community spheres to show how discourses of trans as condition can be used by transitioning patients to rationalise personal experiences of dysphoria and explain trans issues to the wider cisgenderist world.

Trans as transition

With the transition process almost⁵² unique to trans people, it is inevitable that much of the discussion around trans health will centre upon this form of trans-specific care. Nevertheless, there is a disproportionate dearth of services and public documentation addressing wider issues around trans health. I attribute this to a pervasive understanding of *trans as transition*, which works to erase wider conceptualisations of trans health.

Very few of the materials sampled from the practitioner sphere specifically address trans health issues other than gender dysphoria and transition. The majority of those that do were acquired from a website belonging to one small institution: the London-based holistic sexual health service cliniQ. The cliniQ website provides a range of health information for trans patients, plus links to guides on trans sexual health created by external bodies such as HIV/AIDS charity The Terrence Higgins Trust and trans youth group Gendered Intelligence. I found only three other publications relevant to trans health more widely within the practitioner sphere during fieldwork. Two of these were administrative documents outlining a process by which trans patients can change their name and gender marker on NHS health records. The other was a guide for trans victims of domestic violence published by NHS Barking and Dagenham. This compares to a great number of consultation documents, formal letters, guidance for health professionals and patients, position papers, protocols, meeting minutes, blogs and websites available that relate to transition-specific care in the UK.

The lack of information on wider issues of trans health arises in part from the paucity of formal evidence on the matter (Meads et al., 2009; Mitchell & Howarth, 2009). The difficulty of generating an evidence base within the realm of primary health is also powerfully illustrated by Bailey & McNeil (2013) in their description of barriers to engagement from GP practices. However, a number of studies *do* indicate that trans people have health needs and concerns beyond dysphoria and transition that require specific attention. Julie Fish (2007: 4) draws on large US studies and small UK action research projects to argue that trans individuals are at particular risk of ‘alcohol abuse, depression, suicide, self-harm, violence, substance abuse and HIV’; similar findings are reported by Reisner et al. (2016) in their review of international evidence. Findings on the disproportionate prevalence of mental health issues, suicide ideation and suicide

⁵² Many intersex people also have reason to undergo treatments such as hormone replacement therapies, surgeries and hair removal for the purposes of alleviating dysphoria with respect to gender and/or the sexed body.

attempts amongst trans people are reported by Whittle et al. (2007), McNeil et al. (2012) and Ellis et al. (2015). Furthermore, recent research indicates a significantly higher prevalence of autistic spectrum conditions amongst trans people than within the general population⁵³ (Van Der Miesen et al., 2016); this is particularly the case amongst non-binary and genderqueer people (Kristensen & Broome, 2015; Valentine, 2016).

I previously noted that concrete engagement with the issues outlined above is almost entirely absent within the practitioner sphere. This has wider consequences for the provision of public information around trans health. For example, at the time of writing the NHS Choices web page *Transgender health* – part of the ‘Live Well’ series on healthy living – provides no information on trans health issues beyond those related to transition.⁵⁴ Most of the resources linked to from the page provide personal accounts of transition from the perspective of trans individuals, as well as from the perspective of trans people’s partners and parents. All of these stories rely in some sense on binary logic, with the narratives present on the page all drawing on the language and imagery of (exclusively white) masculine or feminine possibilities for gendered expression. Information on gender dysphoria and NHS gender clinics is also provided. This singular focus contrasts notably with other pages dedicated to minority health within the ‘Live Well’ series, such as the *Gay health* page (which provides information on sexual health, mental health, reproductive health and access to services) and the *Black health* page (which provides information on diabetes, sickle cell anaemia, prostate cancer, blood pressure, skin lightening and mental health).

It is therefore apparent that wider issues of trans health are effectively erased within the practitioner sphere through a focus specifically upon transition. This has some basis in the paucity of available research on wider issues of trans health in the

⁵³ A range of biological, neurological, psychological and/or psychiatric hypotheses have been proposed to explain the common co-morbidity of autism and gender dysphoria. However, social explanations for this phenomenon have also been proposed. Kennedy (2013) argues that autistic spectrum children may be less likely to acknowledge the cisgenderist social norms that limit gender identity and expression, while Kristensen & Broome (2015) suggest that binary gender expectations are more likely to be seen as irrational and inconsistent by individuals with a ‘systematising’ view of the world. Both of these social explanations imply that autistic spectrum conditions are actually no more common amongst the trans population than the cis population, but autistic individuals are *more likely* to be ‘out’ as trans.

⁵⁴ The limited content of the NHS Choices *Transgender Health* page has been highlighted on numerous occasions and in a range of contexts. For example, the Conservative/Liberal Democrat Coalition Government’s *Transgender Action Plan* tasked the Department of Health to ‘[u]pdate the NHS Choices website and add information on transgender health, including sexual health and links to other useful websites’ (Home Office, 2011b: 11). The failure of the government to meet this commitment was highlighted in a number of activist Facebook groups during 2013, showing that it was regarded as an ongoing concern.

UK; however, the information that *does* exist is not generally reflected in the available resources. A consequence of this is the perpetuation of a discourse of trans *as* (binary, white) *transition*, in which gender variant identity and experience is necessarily linked to very particular, conditional form of trans possibility. Through the discourse of trans *as* transition, Stone's (1991) posttranssexual vision is largely unfulfilled; *some* trans people are *partially* visible in the public eye, through the public dissemination of information regarding *one aspect* of their health; trans possibility is grounded in cisgenderist norms and linked to the traditional transsexual narrative. In this way, the dearth of information related to wider issues of trans health does not simply mean that vital concerns regarding trans wellbeing are not publicised; it also limits the discursive possibilities available to trans people seeking to write themselves into being.

Gatekeeping: the gender experts

Public health providers play a further role in defining trans possibility through controlling access to treatment for those who do wish to transition. In Chapter 3, *Trans Health in Practice*, I showed how gatekeeping operates through assessment and diagnosis as well as through processes of long-term management such as Real Life Experience (RLE). In assessing patients for diagnosis and managing their treatment, health professionals draw on and promulgate particular ideas regarding the behaviours and bodies that might be considered appropriate (or 'trans enough', in the words of some participants) for transition.

The gatekeeping process relies upon an understanding of health professionals as *experts*. Their expertise is grounded in a learned knowledge of assessment processes and available treatments, tied to diagnostic criteria and institutional protocols. This knowledge is typically framed within the practitioner sphere as authoritative and unbiased, as can be seen in the following excerpt from a draft clinical commissioning policy for the NHS England Gender Identity CRG.

[I]t should be remembered that the overarching aim of treatment for gender dysphoria is 'to enable affected persons to achieve lasting personal comfort with their gendered selves, in order to maximize their overall health, psychological well-being, and self-fulfilment.' The range of interventions described in this commissioning policy [...] are recommended as components of a comprehensive, need-related package of care in all relevant, *authoritative* clinical guidelines. All these interventions must be available to all patients within the care pathway, on the basis of their

individual clinical need (but not their personal social preference), as assessed by [gender identity service] clinicians[.] (Draft⁵⁵ document for consultation: *Clinical Commissioning Policy: [Gender Identity Services]*, NHS England, 24/03/15, emphasis mine)

The language of the draft clinical commissioning policy works to underline the *authority* of gender specialists' expertise. This is set against an implied *lack* of authoritative expertise from two groups: detractors within the NHS, and trans patients themselves.

The first group is present implicitly within the document. As Combs et al. (2008) describe, gender identity services have an 'image problem' within the NHS, reflecting cultural cisgenderist norms and transphobic prejudices within wider society. Physical transition is often seen as the unnecessary disruption of a 'healthy body' by health professionals without relevant expertise. From this perspective, trans accounts of dysphoria are unreal, arising from delusion rather than medical need. This perception is reinforced by media accounts of transition as a waste of public money, which only compounds the ideological, financial and resource pressures upon 'those working in the field and [in] commissioning services' (Combs et al., 2008: i). The draft clinical commissioning policy responds to these concerns with an in-depth review of medical literature to demonstrate the benefits of gender identity services to transitioning patients. The 'definitions' section of the document opens with a quote from the ICD-10 section on 'transsexualism', thereby tying the policy's authority to international clinical consensus. The document's authors take care to employ language that reinforces the medical rigour of gender identity services, as seen in the contextual use of terms such as 'need' and 'authority' in the quoted passage.

The language used within the draft clinical commissioning policy to reinforce the medical necessity of gender identity services has consequences for the second group with an implied lack of expertise, which is more explicitly present within the document: transitioning patients themselves. It is the expert knowledge of gender identity specialists that is invested with the authority to provide transitioning patients 'personal comfort with their gendered selves, [...] overall health, psychological well-being, and self-fulfilment', *rather than* the patient's 'personal social preference[s]'. A stated respect for this authority can often be seen within trans spaces, particularly within the community sphere. An example can be found in the following comment from

⁵⁵ At the time of writing, this draft document has not yet been superseded by a final public version.

a community forum, which was made in response to a post by someone seeking to better understand their gendered feelings and explore the possibility of defining as trans.

Have you had any appointments with gender specialists, psychiatrists or at the Gender Identity Clinic? Their job is to help us question the way we feel and *decide what's right for us objectively*, so maybe they'd have better advice than anything I can offer. (Aiden, emphasis mine)

In this way, the authority of professional knowledge leads Aiden to invest in their expertise, and encourage other trans people to do so also. I return to this theme shortly.

In managing their patients' transitions, gender specialists frequently go beyond simply making a medical judgement on the basis of diagnostic criteria. Through their interpretation of guidelines (from WPATH, the NHS and/or the individual gender clinics) these practitioners hold the power to determine what constitutes an acceptable form of gendered behaviour and embodiment for the purposes of transition. For instance, on the Nottingham Centre for Gender Dysphoria website, the *What we do* page⁵⁶ describes practitioners' role in overseeing RLE, through which patients are expected to 'get used to living in their preferred gender role in all aspects of their life'. The page states that patients will need to provide appropriate evidence of their participation in RLE, stating that: '[t]he *gender experts* at the clinic will need to make sure that you are out and about in your new gender role' (emphasis mine). It is therefore up to these 'gender experts' to decide what constitutes appropriate conformity to the patient's preferred gender role. Patients who do not appropriately conform to these requirements may face censure.

Gave GIC evidence for RLE for a year stating I was presenting as male despite also having a gender neutral title (on 3 items). Told I had to change to Mr or be discharged. (TransDocFailAnon)⁵⁷

In the above example from the #transdocfail Twitter stream, a contributor highlights how conformity to the gender binary was demanded by their gender clinic as a condition of continued treatment. As Stone (1991: 228) comments in her description of

⁵⁶ The web page in question was directly accessed twice for this project, on 08/11/14 and 30/11/15. At the time of writing it is no longer available.

⁵⁷ TransDocFailAnon is a Twitter account that enabled individuals to anonymously contribute to the #transdocfail hashtag through a third party. I discuss the context and importance of this account in the next chapter.

treatment criteria for transsexual people: '*at the site of their enactment we can locate an actual instance of the apparatus of production of gender*' (emphasis in original). This form of gatekeeping can be understood as a 'border patrol' (Steinberg et al., 1997) that polices the boundaries of the possible. Steinberg (1997) describes how the notion of a 'fit family' can be used to police the borders of heterosexuality in the realm of reproductive health, thereby upholding heterosexist norms. Similarly, the gender experts' 'objective' judgements of appropriate behaviour work to police the borders of gender. Within local mental health settings and in gender clinics, this border patrol is a form of professional cisgenderism (Ansara & Hegarty, 2012; Kennedy, 2013), in that it arises from formal policies and practices that prioritise the expertise of a (largely cis) profession over the lived experiences of patients.

A further example follows regarding the expert production of gender through a professional cisgenderist policing of gender borders. In the example, a health professional from Leicester's gender clinic expresses his concerns about trans patients who decide not to 'fully' transition. His comment was made during a meeting of gender identity specialists from a number of different UK clinics.

[Dr Deenesh Khoosal] spoke to the group about the issue of unintentionally creating 'she-men': patients who have breasts and are on hormones but don't have final surgery as they don't want to go any further. These patients continue to live full time as female but with male genitalia. Many of the services present at the meeting had examples of this happening. (Document: *G3 - Gender Governance Group: Minutes of meeting held on Wednesday 25 March 2009*)⁵⁸

The reference to Dr Khoosal's *intentions* highlights his role in overseeing and controlling gendered embodiment in his patients' respective transitions. The fact that he raises an *unintentional* consequence of treatment with the group in order to ask for advice on the matter, along with his use of the derogatory term 'she-men', strongly suggests that he is concerned about this outcome as it runs contrary to his intentions. There are two important binary discourses implicit within these apparent concerns, which I shall unpack with reference to Monro's (2007) terminology of gender diversity. Firstly, Khoosal's story effectively refers to the expansion of the social categorisation 'female'. In describing this expansion as 'unintentional', he appeals to cisgenderist norms of appropriate sexed embodiment. A number of Khoosal's patients 'live full time

⁵⁸ These meeting minutes were acquired by trans activists and published online following a Freedom of Information Request by blogger Emma Brownbill.

as female', exhibiting various secondary sexual characteristics normatively regarded as 'female' (such as breasts) even as they retain a body part that is normatively regarded as 'male' (the penis). In this way, some of Khoosal's patients are effectively threatening to re-define what it *means* to be 'female' through living contentedly as women with penises. Secondly, Khoosal's apparent concerns are relevant to the possibility of movements beyond the gender binary altogether: while some of the patients he describes will see themselves as women, others might prefer to describe themselves in non-binary terms. In referring to his *intentions* in these matters, Khoosal perpetuates the professional cisgenderist discourse of practitioner as gender expert, gatekeeping not only access to treatment, but the very borders of sex and gender.

The particular form of gatekeeping seen in Khoosal's description of his patients was not universal to the practitioner sphere. My findings provided evidence of a wide range of attitudes towards gender and trans possibility amongst health professionals, including those that focused more on meeting the stated desires of transitioning patients. Furthermore, there were significant changes in professional discourse over time, with the aforementioned 2015 draft clinical commissioning policy explicitly stating that patients with gender dysphoria might seek some medical interventions but not others, and/or undergo a non-binary transition.⁵⁹ Nevertheless, the cisgenderist status of practitioner as 'gender expert' and border patrol within a professional context largely remains. The role of gender identity specialist continues to entail a pronouncement on the trans status of any given patient, with UK professional consensus providing an authoritative, conditional basis for medical definitions of trans/gendered possibility.

Reifying identity through medical discourse

I now examine how trans people themselves can understand trans as condition. As in Meyerowitz's (2002) historical observations, and Davy's (2011) account of how trans embodiment is framed in terms of pathologisation by a number of trans people and cis allies, some participants in this project appealed to a range of discourses of condition – including those arising from psychiatry and neurology as well as clinical praxis – in order to conceptualise their respective relationships to gender and to the sexed body. Such conceptualisations are most often used to rationalise personal experiences of dysphoria, but can also be employed strategically in justifying trans

⁵⁹ I explore the background to this in Chapter 7.

identity to friends, family members and work colleagues, as well as in attempting to gain access to services. In all such instances, there is an agential claim being made about the *reality* of trans experience in response to cultural cisgenderism, rendering transness possible through the employment of medical discourse.

A number of participants describe their trans experiences as arising from a ‘medical condition’. These accounts implicitly reference the diagnoses present within classificatory systems such as ICD-10 and DSM-IV/5. In making such connections, the participants in question draw upon the *authority* of clinical consensus in a similar manner to the aforementioned NHS England draft commissioning policy. Descriptions of trans as condition therefore serve to imbue trans experiences with a sense of authoritative weight and seriousness. Two examples follow:

An individual [...] posted about troubles she is having changing her name and pronoun with her GP surgery [...]. The author of this post states that [the practice's inaction] breaches her right to privacy in regards to people knowing about her ‘medical condition’. (Fieldwork diary: 14/5/13, quotation marks indicate terminology used by the post author)

[...] we have a condition that we were born with, that causes sufficient distress/ dis ease⁶⁰ for a large number of us to try to take our own lives[.] (Shannon)

Both of these accounts represent a move on the part of their respective authors to explain and validate their trans experiences. In the first instance, the author sets the discursive weight of ‘medical condition’ against the dismissive actions of her GP practice, thereby portraying the practice as failing in duty of care *in its own terms*. In the second instance, Shannon draws upon the high prevalence of poor mental health and suicide within the trans population to reinforce the seriousness of the dysphoric ‘condition’. In this way, trans experiences can be interpellated as *real* through claims to discursive authority in medicalised language.

Within the above examples it does not really matter *what* the ‘condition’ is, only that the individual in question has it; however, other participants sought to provide a more grounded medicalised account of being. For instance, some people sought personal validation through a specific diagnosis of transsexualism or gender dysphoria. Like the broader notion of a ‘medical condition’, the specific conditions spelled out in documents such as the ICD and DSM provide an alternative to the internalisation of

⁶⁰ This was an intentional play on language by Shannon rather than a mistake.

cultural cisgenderist discourses that render trans unreal. An example of this can be found in the account of Chris, who writes about a forthcoming assessment appointment.

[...] I'm going to know whether I have [gender identity disorder] or not on friday when I go to see the psych [to find out] if I do have it and I suspect that I do[.] (Chris)

This post positions the 'psych' as an expert who can effectively determine whether or not Chris is trans. Chris 'suspects' that this is the case, but seeks external confirmation. A second forum user replies to argue that it is not the role of the medical practitioner to determine anyone's gender. Chris offers an ambivalent response:

I know that it's not dependant on the shrink, it's just I'd like a name to put on why I'm feeling the way I do if that makes sense. (Chris)

Chris' perspective demonstrates the powerful validating potential of medical diagnosis. He is in touch with his gendered feelings and doesn't feel that the practitioner has an absolute say on the matter, but nevertheless hopes for a diagnosis. A medical 'name' for Chris' feelings would provide an authoritative claim to an experience that might otherwise be concealed or suppressed (Kennedy & Hellen, 2010), if not regarded as somehow unreal or impossible. This demonstrates an *agential* engagement with medical expertise by Chris, who – like the trans patients described by Meyerowitz (2002) and Rubin (2003) – is actively seeking to define himself with reference to an established authority on the matter.

Medical discourse can also be used to persuade *others* that transness is real and possible. For example, a number of younger participants refer to the benefit of professional support in persuading parents and/or schools to take trans feelings seriously. In the below examples, Brian and Aiden offer advice to other young trans people.

It might be useful to have the backing of a person in the medical profession when talking to your parents because they will be more inclined to take you seriously[.] (Brian)

I don't know the formal route for this mate but I'd recommend getting your doctor to write you a note [for school] about having gender dysphoria (have you been to see a psych who has 'officially' confirmed this?) (Aiden)

Similarly, Ellie describes drawing upon medical discourse in order to explain her existence to people who question her gender.

Although my voice is better I still get read [as transsexual] on the phone at least 4 times out of 5. If I get any trouble for this, I just tell the truth - I was born male and am an MTF transsexual in the care of Charing Cross - London[.] (Ellie)

In the three above instances, participants recommend that others employ the authoritative weight of professional acknowledgement to persuade others that their gender is real and valid, thereby countering cultural cisgenderism. This can be regarded as a strategic move, rather than one grounded in any actual special knowledge held by practitioners rather than trans patients. For instance, Aiden's use of quotation marks around the word 'officially', indicates the contingency of the 'official' position.⁶¹ Regardless, the value of diagnosis is that practitioners are more likely to be regarded as 'experts' than ordinary trans people, due to practitioners' professional standing as well as wider cultural cisgenderist attitudes towards trans authenticity. This means that within normative settings, an appeal to medical expertise is effectively an appeal to a higher discursive authority. The discourse of professional expertise is therefore self-perpetuating: as trans people take advantage of this socially legitimated expertise, they work to reinforce that legitimisation through prioritising the informed opinion of health professionals over their own experiences.

One consequence of the perceived expertise of health professionals in regards to trans issues is that they are called upon to support trans people's legal claims to gendered identity and civil rights in a range of contexts. Sometimes this is legally required: for example, a doctor's letter is necessary for a change of gender marker on a passport. Similarly, an individual typically needs the support of a gender identity specialist before any application for a Gender Recognition Certificate is submitted to the Gender Recognition Panel. On other occasions, participants noted that the support of a health professional could be beneficial even when not technically required, such as in applying for a change of name at a GP practice or in the workplace. The perceived expertise of the health professional in question is also of relevance.

[S]ome new comments on the long [Facebook] thread about changing gender/titles with GPs. An individual draws upon passport name change guidance to recommend that people get a psychiatrist's letter confirming

⁶¹ This also reflects a shift in Aiden's own perspectives on the authority of gender clinicians, which occurred over time after he and other forum users faced challenges in accessing services.

that their gender change will be permanent ('this will be a permanent change') in order to update their passport (passports were mentioned in passing by an individual on an earlier occasion). She also states that her PCT stopped using [inappropriately] gendered pronouns and that they now use the right name and pronouns for her. (Fieldwork diary: 03/06/13)

The above quote from my fieldwork diary highlights how getting a letter specifically from a *mental health* practitioner can help trans people more efficiently change name and gender in a variety of contexts, even though in some cases (such as for passports) any medical practitioner will do, while in other cases (such as for NHS records) no medical approval is required. This shows the existence of a perceived hierarchy of gender expertise, with knowledge specific to gender identity services prioritised in a range of social contexts.

In contrast to quests for personal and social validation through mental health diagnosis, some participants instead regard dysphoric feelings as a condition of the body. This reflects Meyerowitz's (2002) observation that many trans people have historically sought a biological basis for their experience, effectively positioning transsexualism as a form of intersex. For instance, in the following example – addressed to a cis man – Alex argues that trans/gendered feelings are innate, with reference to neuroscience research.

If you had an accident tomorrow and you lost your penis would you want to then go shopping for female clothes and shoes? No you would likely want that rebuilt. As you are not a female. As FTM Trans men prove having a penis does not make you a man - its a brain sex issue. (Alex)

Alex also links to an article by Kruijver et al. (2000), in which the authors draw upon an initial comparative analysis of neurons within trans and cis brains to argue that trans women's brains might more closely resemble those of cis women than cis men. In this way she seeks to provide an explanation for trans experiences with reference to medical research. This account offers a particular take on the 'wrong body' narrative of transsexual possibility, in which individuals desire transition because they are 'born in the wrong body'.⁶² Alex grounds her *justification* for being trans in both mind/body dualism and 'scientific' discourse: the gender dysphoric person's 'body' is 'wrong' because it is at odds with their brain. A related account is provided by Serano (2007), who argues that gender dysphoric individuals experience a conflict between their

⁶² For critiques of the 'wrong body' narrative, see Stone, 1991; Carter, 2013; Catalano, 2015).

sexed body and the 'subconscious sex' of their mind. As with Chris' appeal to diagnosis, these conceptualisations are important in offering a counterdiscourse to cultural cisgenderist norms, thereby rendering trans possible (and intelligible). This is seen mostly clearly in participant accounts that describe the process of physical transition and the changes that can take place, highlighting the comfort of transitioned individuals in their changed bodies. For instance, Ellie provides an overview of the male-to-female transition process, describing at length the satisfying physical, emotional and sexual changes that accompany hormone therapy and surgeries. She adds:

A transsexual isn't a guy pretending sometimes, she is someone who was ALWAYS female inside. A transsexual changes sex and drops a pretence of being a guy that she was forced to learn by pressure from parents and society, based on the birth-defect between her legs [...] So.....we aren't men-who-got-their-body-changed..... we ARE women, apart from perhaps being a bit big and angular. [...] We make a change because it's who-we-are. (Ellie)

Trans patients can therefore seek a diagnosis or explanation grounded in medical practice and/or medical science as part of a quest for personal and social understanding. Through these means, their identities and experiences might become possible and be reified as real and intelligible. These efforts represent an appeal to the specific professional expertise of gender identity specialists, as well as to wider cultural investments in the 'truth' of scientific language (Steinberg, 2015a). While trans might be understood as *conditional* in these terms – something that requires that conditions are met, or even something 'wrong' with the mind or body – it can nevertheless be defined and constructed as *real*. This is not simply a matter of trans patients being 'passive or culturally determined by coercive forces': instead, it represents a 'situational' engagement with available discourses (Davy: 2011: 107). For those such as Ellie who seek to change their bodies, the very act of physical transition on the NHS pathway serves to reify her identity by offering an alternative to cultural cisgenderism, even as this possibility continues to be shaped by the professional cisgenderism of gatekeepers and clinical pathways. In this way, trans patients' own accounts of trans as condition 'have both agentic and subjugating elements to them' (Davy, 2011: 107).

The possibility of movement

I have shown that discourses of trans as condition play a key role in shaping both clinical practice and patient approaches to trans identity, experience and embodiment. However, these conceptualisations typically intersect with understandings drawn from the discursive repertoire of trans as movement, particularly within trans community and activist spaces. I therefore turn now to examine how discourses of trans as movement complement and/or provide an alternative to discourses of trans as condition, while also challenging cisgenderism.

Alternatives to the transsexual narrative

Feinberg's (1992) account of *collective* trans movement incorporates a wide range of identities that, unlike 'transsexual', are not so typically associated with medical mediation or discourses of trans as condition. Historically, this includes 'drag queens and drag kings, cross-dressers, bull-daggers, stone butches, androgynes, diesel dykes', amongst others (Feinberg, 1992: 206); more recent movement-oriented possibilities include non-binary and genderqueer identities. All of these offer a fluid range of *individual* movement-oriented possibilities for identification and social belonging to those who do not want to transition as well as to those who cannot do so because of medical conditions, social circumstances and/or gatekeeping practices.

One non-transsexual identity that *can* be linked to discourses of trans as condition is 'transvestite'. The term originates from medical literature (Hirschfeld, 1910 [1991]) and remains present within diagnostic categories such as the ICD-10's 'Dual-Role Transvestism' (World Health Organisation, 1992: F64.1). However, in contrast to transsexualism, transvestism is no longer strongly associated with discourses of condition, in part because there are no medical gatekeeping processes associated with cross-dressing. Notably, none of the participants in this project who identified as transvestites or cross-dressers expressed a desire to seek confirmation or validation of their gender identity through medical diagnosis; this was similarly the case with individuals who identified with a non-binary or genderqueer identity.

Importantly, alternatives to transsexualism offer new modes by which physical transition can be conceptualised by those who do desire to undergo such processes. Movement-oriented identities offer a means by which trans people can expand traditional gender categories or otherwise conceptualise gendered possibility beyond the binary bounds of male/female. This is coupled with a sense of belonging and

validation grounded in shared experience and community. In this way, trans identities of movement offer a counterdiscourse to cultural *and* professional forms of cisgenderism. In this context, gendered knowledge and expertise resides within the individual and with trans communities, rather than with health professionals. This has consequences for all transitioning individuals, including those who continue to describe themselves as transsexual.

Embracing diversity? Building trans communities

Community spaces both online and offline offer trans people the opportunity to come together with others who share similar or comparable experiences. These spaces often constitute a 'community of care' (Hines, 2007), in which members offer mutual emotional support and practical advice that is not necessarily available within the predominantly cisgenderist spaces of the wider world. For instance, trans communities of care can provide some of the wider information on trans health that is missing from the practitioner sphere. They also provide members with an opportunity to explore and experiment with gender in relative safety, which can feed into the emergence of new language and modes of possibility, such as non-binary identities.

This is not to say that trans community spaces are without conflict. One common basis for quite severe disagreements within such spaces is identity. Many trans communities retain either an explicit or implicit identity-oriented focus, which works to include some and exclude others. Sometimes, this focus can be relatively narrow, as seen in social groups and online forums based around specific categorical identities such as male-to-female cross-dressers, or transsexual men. There is a long history of 'border' politics associated with such spaces (Rubin, 1992; Bornstein, 1994; Elliot, 2009). Within some spaces, members work to delineate the boundaries of their identity category through strategies of social inclusion and exclusion, or they may seek to validate their chosen identity category as 'real' through undermining related but alternative modes of identification. For instance, Judith/Jack Halberstam (1998: 287) describes how the borders of transmasculinity can be contested between butches and transsexual men: 'Some butches consider FTMs to be butches who "believe in anatomy," and some FTMs consider butches to be FTMs who are too afraid to transition'. I read Halberstam's (1998) account as illustrative of how an identity category rooted in a discourse of condition (female-to-male transsexualism) can be set against an identity category rooted in discourses of lesbian and/or trans movement

(butch). The outcome is a form of socio-cultural border patrol, policed by members of both categorical camps who act as an alternative form of 'gender expert'.

However, many trans spaces are more inclusive. The very concepts of 'trans' and 'transgender' in their widest sense are of relevance here, with strategic employment of either term in the title or description of an activist or community group often signalling a certain malleability of categorical borders (Pearce & Lohman, forthcoming). There are a growing number of trans spaces that aim (with varying levels of success) to be inclusive of all trans people, regardless of gendered (or intersectional) identity. In these contexts, '[i]t is not that there is an absence of divergence; it is that the divergences are framed in a non-conflictual way' (Richardson & Monro, 2010: 104). One of the forums from the community sphere – which I refer to as 'Forum 1' – and most of the Facebook groups from the activist sphere are instances of this. Other spaces focus on a particular area of the trans spectrum while taking care to be inclusive of a diversity of gendered categories *within* that area: examples include non-binary spaces that encompass a range of identities such as genderqueer, genderfluid, agender and non-gendered, and some 'FTM' spaces that are inclusive of transmasculine non-binary individuals, butches, drag kings and female-to-male cross-dressers as well as transsexual men. One instance of the latter is a forum from the community sphere, which I refer to as 'Forum 2'. This forum is aimed specifically at individuals on the female-to-male spectrum. The existence of these more diverse spaces reflects the discursive reach of Feinberg's (1992) conceptualisation of trans as movement, as well as Monro's (2005; 2007) concept of gender pluralism. In this way, inclusive trans spaces can work to unite people from a range of gender diverse backgrounds on the basis of perceived shared experiences and interests, in contrast to more exclusive spaces that divide on the basis of perceived difference.

Discourses of trans as movement and spaces that prioritise diversity create room for individuals who are exploring their gender but are not sure where they might fit in. For example, in the following quote trans journalist Juliet Jacques explains how the term 'transgender' offered her a conceptual space in which she could name her feelings, thereby enabling her to explore her gender without having to adapt to meet the criteria of a more rigid form of categorisation.

Gradually, I came to define as 'transgender'. I understood that transgender could include cross-dressers, transvestites, male-to-female (MtF) and female-to-male (FtM) transsexuals, and anyone else who considered themselves beyond the traditional gender binary. Having found a suitable

term for myself, which allowed space for me to explore my gender, I wanted to find places where I could express myself and meet like-minded people. (Article: Juliet Jacques, *'I was looking for a trans counter-culture'*, The Guardian, 16/06/10)

In the account from which the above quote originates, Jacques does not yet know exactly how she might fit into the trans spectrum. She is not entirely sure how she might describe her gender, whether or not she desires to transition, or what interventions she might seek if she *were* to transition. In defining herself as 'transgender' she finds a category that encompasses and describes her experience, while offering space for fluidity and uncertainty. For Jacques, 'transgender' enables affiliation and belonging without border control, within a category that is relatively wide and has fluid borders. This enables her to seek a 'trans counter-culture' without first meeting a particular set of criteria.

Spaces such as Forums 1 and 2 and accounts such as Jacques' demonstrate a gender pluralist understanding of trans/transgender. They unite identities such as transsexualism – more likely to be associated with discourses of essentialism and/or condition – with more fluid and postmodern non-binary possibility *and* the room for uncertainty. In this way, belonging and definition as 'transgender' need not be confirmed by external experts, be they adherents to the traditional transsexual narrative, practitioners who subscribe to professional cisgenderist norms, or movement-oriented border patrols.

The sense of possible trans unity across categories of gendered understanding and identification has given rise to an 'imagined community' (Anderson, 1991) of trans people: that is, a group of people bound by a sense of shared affiliation and experience amongst those who consider themselves to be a part of the group. Within this thesis, I refer to 'trans communities' in recognition of the complexity and diversity of trans affiliations and spaces. However, the imagined community of trans people is frequently referred to as '*the* trans community', within the activist and community spheres, conjuring up the impression of a single grand social unit to which all trans people might belong. An example of this can be found in the following quote from an article about #transdocfail by trans journalist Jane Fae:

[I]f you have been following the news over the last few days, you may have noticed something odd. The trans community, notoriously fissiparous, disunited and eternally at loggerheads with itself turned with one accord and sent forth a shaft of pure anger in the direction of the medical

establishment in general - and the General Medical Council in particular.
Never have I seen the community so united: never so angry. (Article: Jane Fae, #TransDocFail: the trans community rises, The F Word, 09/01/13)

Fae invokes *the* trans community in describing the high level of interest and participation in #transdocfail amongst trans groups online. Her account acknowledges divisions and the border politics of identity, but suggests that these differences can be overcome in the name of shared interests and concerns, such as over the perceived endemic of transphobic and cisgenderist medical malpractice. In this sense *the* trans community becomes *the* movement, united through both anger and political action.

Both trans communities and 'the trans community' offer means of social affiliation that reflect Feinberg's (1992) conceptualisation of trans as movement. As I have shown, these can be exclusive of condition-oriented identities, but they can also *incorporate* discourses of trans as condition in a gender pluralist manner. They further offer a posttranssexual alternative to the professional cisgenderism of gender clinic experts, providing a means by which a diverse range of trans people can 'read [themselves] aloud' (Stone, 1991: 232) as part of a community or movement without being bound by the strict medical dictates of trans as transition.

'Be yourself': validation through individual belonging

The proliferation of gender pluralist trans communities has meant that the boundaries of both trans and gendered belonging have become more fluid and less clearly delineated. While there was evidence of continued border patrols within the data set for this project, exclusionary actions and language were more often opposed and condemned within both the community and activist spheres. This typically works to create additional room for gendered complexity and bodily diversity.

In the example that follows, participant Joshua criticises a particularly stringent form of the discourse of trans as transition; one that reflects both the traditional transsexual narrative and Khoosal's concerns regarding the bounds of sexed and gendered possibility. A user of Forum 1 had posted to imply that trans identity should be linked to a desire for surgical intervention; by implication, any person who does *not* desire surgery is not 'really trans'. Such beliefs can arise from trans patients internalising 'societal beliefs about normality and disdain for those with such a condition' (Dewey, 2008). In response to this, Joshua argues that it is up to the individual to define the scope of their own identity and transition.

I don't hold with this "trannier than you" attitude. Really don't. Not wanting surgery is a common and perfectly understandable choice. I don't know why trans people have to imply that by not wanting the surgery you're somehow not truly trans. (Joshua)

The above quote is drawn from a wider argument put forth by Joshua in which he supports the gender pluralist idea that a spectrum of gendered options should be available to trans people. He suggests that trans people should feel able to find their own place within this spectrum, rather than be bound by 'trannier than you' hierarchies of appropriate(ly) trans behaviour. Thus, through opposing strict delineations of trans possibility, individuals such as Joshua can work to open up the boundaries of trans definition.

I have previously described how some trans community or Facebook group members advise new arrivals to follow the authoritatively 'expert', 'objective' advice of health professionals. However, others, including Joshua, instead told newcomers seeking answers to: 'be yourself'. The implication of this instruction is that the person in question should seek an identity and body that they feel comfortable in, instead of working to meet some external criteria of 'really trans'. In the following example, Jake responds to a transmasculine individual who is worried about living up to normative ideals of male behaviour.

Be yourself. Whatever you choose to do with your physical appearance, don't force yourself into a gender role if it doesn't feel right. (Jake)

On another occasion, Ellie – who identifies as transsexual – informs a new forum member that multiple identity categories and possibilities for physical transition exist. Her post implies that, however the individual she addresses chooses to describe themselves or plan their transition, the choice in question is reasonable and valid.

If you want a label, "Genderqueer" could work. If you want to present as a woman but keep a male body (Hope I got that the right way round!) you could be a transsexual (non-operative) [...] so - follow your heart, be who you want to be. (Ellie)

The advice offered within the community sphere by forum users such as Joshua, Jake and Ellie stands in stark contrast to the strictly delineated possibilities for identification and transition seen in the traditional transsexual narrative, as well as in the strict gatekeeping activities described by Barrett (2007) and undertaken by practitioners such as Khoosal. Drawing on alternatives to the traditional transsexual

narrative and notions of gender pluralist trans community, Jake and Ellie imply that the validity of any given gender identity or body lies in a personal sense of comfort – what ‘feels right’ (Jake) – rather than in professional cisgenderist models of appropriately gendered behaviour or embodiment. In this way, expertise is located within the individual, and granted authority through collective community recognition. This approach offers the opportunity of a trans authenticity linked to the fluid and open possibilities of a gender pluralist approach to trans as movement, rather than the more carefully delineated and managed possibilities of trans as condition.

When discourses clash: unpacking differing understandings of trans health

I have shown that multiple discourses drawn from the respective repertoires of trans as condition and trans as movement continue to influence practitioner and trans perspectives in the UK. Seemingly contradictory discourses can sometimes co-exist: for example, within gender pluralist trans communities. However, differing definitions and understandings of trans possibility can also lead to conflict, as border patrols within both the health professions and within trans spaces seek to delineate the bounds of trans possibility.

Discursive conflicts also arise within the context of care. Practitioner understandings of (trans)gendered possibility rooted in discourses of cisgenderism and/or trans as condition increasingly contrast with patient understandings of trans as movement, leading to difficulties in the provision of care. I use three examples to illustrate how this can take place. Firstly, I show that essentialist approaches rooted in cultural cisgenderism can work to erase the gendered reality of trans patients altogether. Secondly, I show how the discourse of trans as transition can inform inappropriate practices outside of gender identity services. Finally, I look at how gatekeeping practices within mental health and gender identity services can work to deny certain possibilities for individuals hoping to transition.

‘Misgendered three times’: essentialising gender, erasing trans realities

Numerous participants referred to instances in which health professionals working outside of gender clinics denied the very possibility of their being trans. In some cases, this was due to narrow ideas about how trans people could possibly look or behave: an extreme version of the discourse of trans as transition. However, on many occasions

the reported behaviour of non-specialist practitioners would seem to indicate a denial of trans reality altogether. This reflects the findings of Bailey & McNeil (2013), who found that some GP practices refused to acknowledge the possibility of trans patients being registered there, and Combs et al. (2008), who were told by gender clinic specialists that health professionals from outside their discipline would often balk at disrupting a 'healthy body' through hormonal or surgical intervention. Such perspectives arise from a cultural cisgenderism that tacitly essentialises 'gender as binary, biologically determined, fixed at birth, immutable, natural and externally imposed on the individual' (Kennedy, 2013: 4).

In the following example from my fieldwork diary, a trans patient seeks help from other members of an activist Facebook group in preparing a complaint.

An individual posts about poor treatment they have received at a local hospital after going in to see a doctor about a recurrent bladder problem, saying they are thinking about making a complaint. They were misgendered three times and asked what genitals they had in spite of the doctor having their gender history available to him. (Fieldwork diary: 18/4/13)

The patient in question feels distressed because their gender identity had not been respected. This perspective arises from the notion that trans people can and should determine their own gendered identity: as Ellie argues in asserting her womanhood, 'we aren't men-who-got-their-body-changed..... we ARE women'. As I have shown, this perspective can be grounded both in discourses of trans as condition and discourses of trans as movement.

The hospital consultant's failure to acknowledge the patient's gender could be described as transphobic, in that it is an example of individual, inappropriate behaviour towards a trans person that was experienced as disrespectful and prejudiced. However, it is entirely possible that this doctor did not intend to harm his patient. Instead, his behaviour could be linked to the wider, unspoken cultural processes of cultural cisgenderism, by which trans genders are rendered impossible and unreal. As the literature shows, this was after all, not an isolated incident (Whittle et al., 2007; McNeil et al., 2012; Women and Equalities Committee, 2016). Indeed, other members of the same Facebook group also responded with their own stories of misgendering in hospitals, such as in the following case.

She [...] relates a story about how she was assigned to a male ward with a male name on her ward file when she was last in hospital, in spite of transitioning 25 years ago and having a GRC. (Fieldwork diary: 24/4/13)

The pervasiveness of misgendering in hospitals points to the wider influence of cultural cisgenderism on medical practice. Kennedy (2013: 4) explains that cultural cisgenderism is 'predominantly tacitly held and communicated'. In the instances described above, there are no hospital policies that intentionally discriminate against trans people; there are instead tacit assumptions on the part of health practitioners and administrators that gender is 'binary, biologically determined, fixed at birth' (Kennedy, 2013: 4). This can be seen in the repeated misgendering of the trans patients, in placing a trans woman on a male ward, and for that matter in only having female and male wards available. Such occurrences betray a cisgenderist failure to acknowledge trans genders as real, in line with normative, essentialist discourses of gendered possibility. They hence work to erase transness within medical institutions (Bauer et al., 2009). For the trans patients in question, addressing these issues was frequently described as a matter of basic respect in healthcare; however, the very possibility of 'respect' in this instance must be linked to a recognition of trans possibilities. In order to meet the needs of the patients in question, it is therefore necessary to recognise trans genders as real, through subscribing to (diverse) discourses of trans possibility.

'Trans Broken Arm Syndrome': transition as definition

A weaker form of cultural cisgenderism can be seen in the behaviour of health professionals who recognise trans lives as real, but then associate all trans patient health needs with that patient's trans status in an extreme understanding of trans *as transition*. This phenomenon referred to by many participants as 'Trans Broken Arm Syndrome'.⁶³ It was most prominently discussed in the #transdocfail hashtag on Twitter, but relevant incidents were also described in a number of media articles, blog posts, Facebook groups and on both community forums visited for this project.

⁶³ It can also be referred to with reference to other ailments, e.g. as 'the trans cold' (Women and Equalities Committee, 2016: 38), or 'Trans Broken Leg Syndrome'.

Then there's the phenomenon known as Trans Broken Arm Syndrome. It's when healthcare providers assume that all medical issues are a result of a person being trans. Everything – from mental health problems to, yes, broken arms (Article: Naith Payton, *Feature: The dangers of trans broken arm syndrome*, Pink News, 09/07/15)

I have previously discussed how the discourse of trans as transition works to reduce the scope of information available on trans health. In Trans Broken Arm Syndrome, we see how this limited understanding of trans possibility can extend beyond information services and into everyday health practices. In understanding 'trans health' as transition, practitioners can fail to take trans patients' *other* health concerns seriously.

Trans Broken Arm Syndrome appears to be most common amongst mental health service providers, many of whom appear to regard trans people's mental health as relevant only in terms of or in relation to transition. This means that support for mental health issues unrelated to transition can be difficult for many patients to access.

Secondary care refuse to treat my mental health problems because I'm attending a GIC. The GIC won't treat them either. (TransDocFailAnon)

Alternatively, some participants did access mental health services, only to find that mental health practitioners would unnecessarily and irrelevantly raise the issue of their trans status. This reflects the findings of Jane Hunt (2014: 293-294), who noted that 43% of participants in her survey 'indicated their counsellor wanted to explore transgender issues in therapy with them even when this wasn't the reason they had sought help'.

However, the flawed logic of Trans Broken Arm Syndrome can be applied to almost any health issue.

Go to GP about non-trans related issues: "Have you seen the GIC about that?" Reduced down to my trans status everytime. (TransDocFailAnon)

One trans person, J, gave a long list of physical injuries, including a sprained ankle, a dislocated shoulder, broken ribs, and, of course, even a broken arm where their trans status and HRT were discussed unnecessarily, and at length. (Article: Naith Payton, *Feature: The dangers of trans broken arm syndrome*, Pink News, 09/07/15)

In these accounts, trans patients are recognised *as* trans, but they are not treated in the same manner as patients perceived as cis. Instead, the discourse of trans as transition leads a considerable number of health professionals to conceptualise trans patients entirely in terms of their access to a particular repertoire of medical interventions. This is a form of cisgenderism in that it problematises trans patients and can work to treat them as inherently different to patients implicitly regarded as ‘normal’ (i.e. cis). While trans possibilities are therefore not completely erased by Trans Broken Arm Syndrome, the phenomenon represents a tendency to define trans patients’ reality *entirely* in terms of their trans status, as well as through the trans-specific medical process of physical transition.

The situation is somewhat complicated by the fact that some health conditions *can* be affected by transition, including (ironically) the eponymous ‘broken arm’. For instance, changes to an individual’s hormone regime may have implications for their bone density and risk of osteoporosis (Weinand & Safer, 2015). However, the high prevalence of *unnecessary* incidents of Trans Broken Arm Syndrome – plus unnecessarily invasive questions that go beyond discussing relevant matters of (for instance) hormone regime – mean health professionals who *are* asking relevant, sensitive questions about a patient’s transition might not be trusted by patients.⁶⁴ In this way, the example of Trans Broken Arm Syndrome shows how conditional discourses of trans possibility can put patients at risk.

‘My name change was too ambiguous’: authoritative expertise vs personal identity

I have previously discussed how gatekeeping practices can limit the bounds of gendered expression. As with essentialising discourses and Trans Broken Arm Syndrome, the cisgenderist assumptions that frequently underpin gatekeeping practices can lead to clashes between health professionals and trans patients; clashes that are rooted in differing understandings of trans possibility. However, while the tacit assumptions of cultural cisgenderism are relevant to gatekeeping practices, I have also shown that the professional cisgenderism described by Ansara & Hegarty (2012) is particularly present within authoritative discourses of trans as condition. This is manifested through policy, practice, and in professional writings such as Barrett (2007). I now show how misunderstandings and practitioner-patient conflict can arise

⁶⁴ I am grateful to Dr Ro Bevan for advising me on this discussion.

when the professional cisgenderism of conditional gatekeeping practices clashes with patient self-definitions rooted in discourses of trans as movement.

There is a notable difference between participants in this project who respectively report positive or negative experiences with gatekeeping. Participants who report positive experiences tend to meet normative, binary expectations of gendered behaviour and presentation. This did not necessarily mean that they embodied gender stereotypes. For instance, Barrett (2007: 73) states that, '[i]t is not the function of a gender identity clinic to operate as some kind of style council concerning what does and does not constitute feminine or masculine dress'. However, gatekeeping processes often emphasise 'passing' and encourage patients to adopt a consistent gender presentation. This can be seen for instance in the use of RLE by gender clinics such as Nottingham that more closely manage their patients' transitions. It can also be seen in Barrett's account: in spite of his determination to avoid being part of a 'style council', he also emphasises the importance of guiding patients to pass. In his description of the assessment process, he recommends examining 'the physical composition that nature has provided the patient with [...], how well the patient manages to pass [...], mannerisms and demeanour' (Barrett, 2007: 15). He further passes judgement on the sartorial choices of his patients, describing how some 'state that every item of their clothing is appropriate to their new gender' when 'the final combination that has resulted seems not to be so' (Barrett, 2007: 73). As with Khoosal's concerns regarding patients with a mixture of sex characteristics, Barrett's approach implicitly works to reinforce (binary) norms of gendered presentation. Transitioning patients with desires, expectations and styles that happened to meet these norms – particularly those who have sought to reify and validate their identity through diagnosis – are less likely to have trouble with gatekeeping.

Participants who report negative experiences with gatekeeping are more likely to deviate from normative models of gendered possibility. These participants tend to subscribe to understandings of trans as movement: for example, through describing themselves as genderqueer, androgynous or neutrois, or through incorporating non-binary understandings into a transsexual identity. An instance of this could be found in Reubs J Walsh's contributions to #transdocfail.

In my initial consult, the Oxfordshire gatekeeper told me I was a 'dual role transvestite' (I'm non-binary), which isn't true. (Reubs J Walsh)

In Walsh's account, we see that that practitioner and patient understand the patient's identity quite differently. Walsh draws on a discourse of movement to understand her gender as 'non-binary': her sense of self does not conform to normative understandings of gender as entirely, straightforwardly female or male. She is 'being herself'. By contrast, the practitioner (in this case working at a local mental health service responsible for referring patients on to a gender clinic) draws upon the ICD-10 diagnostic category of 'dual role transvestism' in order to describe Walsh. Two key criteria of this diagnosis incorporate a cisgenderist assumption of binary gender, relying upon a notion of 'the opposite sex': 'The individual wears clothes of the opposite sex in order to experience temporary membership in the opposite sex [...] The individual has no desire for a permanent change to the opposite sex' (World Health Organisation, 1992: F64.1). In using this diagnosis, the practitioner rejects Walsh's non-binary account, instead seeking to make sense of her gender with reference to a binarist clinical discourse of trans as condition. This is an example of professional cisgenderism in that the formal diagnostic categories by which the practitioner attempts to understand Walsh are prioritised over her own understanding of her non-binary gender. Occurrences such as this often lead to patients being delayed in their journey along the treatment pathway, or otherwise denied treatment altogether. Alternatively, patients can lie about their gender to health professionals, fostering an atmosphere of mistrust that I unpack in the next chapter.

Walsh faced further challenges upon eventually attending an appointment at a gender clinic:

The GIC doc told me my name change was too ambiguous and told me that even though I have a cousin Ruby, I should get that name (Reubs J Walsh)

In this instance a gender identity specialist objects to the name 'Reubs', asserting that Walsh's chosen name is 'too ambiguous'. They instead tell Walsh to adopt the more feminine name 'Ruby'. This requirement reflects Barrett's (2007: 73) concerns regarding patients behaving in a manner that is not 'appropriate to their new gender'. It is also reminiscent of the aforementioned NHS England draft clinical commissioning policy, which prioritises 'clinical need' over 'social preference'. There are two presumptions at work here: firstly, that transitioning patients should define themselves in line with a binary gender category, and secondly that the category of womanhood cannot expand to incorporate a more ambiguous name. Both presumptions draw upon a professional cisgenderism rooted in discourses of trans as condition, implicitly asserting that the (largely cis) medical profession is in a position

to tell patients that they should present their gender(s) in a broadly binary manner. In their account of misrecognition by mental health professionals, Iggi Moon (2011: 194) characterises this prioritisation of cisgenderist, heterosexist medical definitions over queer patient understandings of self as 'epistemic violence'.

A professional cisgenderist approach can therefore be rooted in inflexible discourses that prioritise practitioners' understandings of trans as condition over patient understandings of trans as movement. In this approach it is possible to observe both an 'apparatus of production of gender' (Stone, 1991: 228), and a means by which certain trans identities and experiences are rendered impossible by health professionals. Liam Davidson states on #transdocfail that a greater focus on trans understandings of self is required from gender identity specialists. This would mean '[fewer] nonbinary trans people being coerced into inappropriate binary transition as only option' (Liam Davidson); moreover, a greater range of options for gendered expression would also be available to binary-identified transitioning patients.

Conclusion: the (im)possibilities of trans patienthood

'Trans' remains a fluid category, subjected to many competing definitions and understandings. There is not one language of trans possibility, but instead multiple languages and understandings that serve to both challenge and reinforce cisgenderist norms. Different uses of trans language continue to be shaped by the overarching discursive repertoires of trans as condition and trans as movement. In turn, the employment of these discourses within professional and trans patient settings feeds into trans/gendered possibilities of identity, experience and embodiment, and into the practice and perception of healthcare in the UK.

Discourses of trans as condition work to both enable and constrain the provision of trans healthcare services in the UK. Variants on the traditional transsexual narrative (Stone, 1991) are grounded in ideals of medical authority and expertise. This offers a means by which trans people can come to understand themselves and seek treatment, and by which practitioners working in gender identity services can justify their practices to other professionals within public health. However, this same notion of medical authority also empowers gatekeeping practitioners to determine what constitutes an appropriate form of gendered embodiment. This is a form of professional cisgenderism (Ansara & Hegarty, 2012; Kennedy, 2013), in that the expert, professional opinion of practitioners is prioritised over the lived identities, desires and

experiences of trans patients in terms of recognising gendered possibilities. That is not to say that all gender identity specialists are as strict as former Leicester clinician Khoosal: rather, the *operation* of medical practices and gendered discourses continues to empower specialists to impose their view of gendered possibility onto patients.

Discourses of trans as movement offer trans people an alternative to pathologising narratives. Non-binary gender identities, along with other alternatives to (and within) transsexualism, enable identification beyond the cisgenderist constraints of normative gender. While 'border conflicts' may occur, gender pluralist trans communities offer space for gender diverse peoples to find identity and belonging outside of medical definitions and pathways. This can be seen in particular in the commonly-offered advice to 'be yourself', which locates authentic possibility in individual experience rather than clinical definitions.

The respective discursive repertoires of trans as condition and trans as movement are not necessarily contradictory. Many individuals with movement-oriented identities seek or undertake physical transition under medical supervision, while gender pluralist communities offer space for multiple conceptualisations of trans possibility to co-exist. However, different understandings of trans possibility can also lead to conflict: within the health professions and within trans communities, as well as between trans patients and healthcare professionals. The consequences of this are particularly severe when healthcare provision is at stake.

Discursive clashes over trans possibility can work to undermine the quality of treatment available to trans people in a number of ways. I outlined three examples of this. Firstly, I showed that cultural cisgenderism (Kennedy, 2013) can inform practitioner understandings of trans as 'unreal', leading to inappropriate behaviour towards patients, such as misgendering. Secondly, I analysed how the pathologising discourse of trans as transition can lead to trans people's wider health needs being inappropriately associated with their transition, leading to a lack of information in the public sphere and the 'Trans Broken Arm' phenomenon. Finally, I argued that gatekeeping activities rooted in professional cisgenderism linked to understandings of trans as condition can work to deny transition-related treatments to individuals with complex gender identities rooted in understandings of trans as movement.

6

Trans Temporalities

Imagining a future in a time of anticipation

We live in a time of anticipation.

We anticipate misgendering, perplexed looks, ignorance, transphobia. Even when what we anticipate does not occur (yet), we act as if it has, and it becomes an inevitability.

I think it has something to do with waiting lists. My whole life seems to be about waiting lists nowadays (even if I am not on one yet – I am waiting to be on one). We are kept in a constant state of anticipation: waiting for a letter or phonecall from the GIC, a prescription, a surgery date...

We are used to waiting, orientated towards the future like iron filings lining themselves up towards a magnet. We are focussed on the future whether that's the future where we have already had access to healthcare treatment, or the future where the (seemingly inevitable) acts of transphobia have already taken place. Because we are always waiting for this future the present seems compressed somehow, like our lives are in limbo.

But looking to the future can also be positive. Creating change requires us to live in a state of anticipation. It seeks to build a politics of hopefulness rather than of dread, preparedness rather than an anxiousness [...] the way we think about the future has an impact on the present.

- Jess Bradley and Francis Myerscough (2015)

Living in the time of anticipation

Some months ago I began the process of seeking a referral for laser hair removal through the NHS. It was the first time I sought access to gender identity services since being discharged from Charing Cross gender clinic in early 2009.

I had previously considered my engagement with gender identity services to be long over. According to the traditional pathway narrative, my transition had taken place and ended. I had experienced counselling, negotiated various referrals and waiting lists, undertaken Real Life Experience and had been prescribed hormones. This journey culminated in surgery during the summer of 2008, after which I received a handful of final follow-up appointments.

Facial hair removal was absent from this NHS pathway; as was typical for the time, this intervention was not publicly funded in my area. I paid for a small number of private laser hair removal sessions with my savings and the last of my student loan. The introduction of the NHS England Interim Gender Protocol in 2013 changed the situation, however; for the first time, facial hair removal was funded nationally, meaning that it was (in theory) available throughout England and Wales.

Unfortunately, it did not seem likely that I would gain a direct referral from my GP. Written into the new pathway was the presumption that patients seeking facial hair removal were doing so under the care of a gender clinic. I – a former patient seeking access to a newly available treatment long after I had originally left the pathway – was an aberration. Would I be able to persuade my GP to refer me anyway, drawing upon old letters from Charing Cross in my medical records? Would I have to obtain a referral to a gender clinic and once again spend months on a waiting list, only to eventually request that a practitioner at said clinic fulfil a simple administrative task on my behalf? Tied up in these concerns were my personal experiences of ignorant, transphobic and cisgenderist behaviour from past GPs, as well as my knowledge of friends' negative experiences. I therefore worried not simply about negotiating the administrative complexities of seeking a referral, but also the possible social and emotional consequences of doing so.

I wrote about these concerns in my fieldwork diary ahead of an initial appointment with my GP. I *hoped* to obtain a direct referral for hair removal and be treated with respect, but *expected* to either obtain a gender clinic referral or otherwise be delayed, while possibly also encountering unhelpful or discriminatory behaviour for my troubles. Drawing upon Jess Bradley and Francis Myerscough's (2015) post *Transitional Demands* from the Action For Trans Health blog – an excerpt from which opens this chapter – I reflected on the notion of anticipation. 'I feel really *weird* about [my appointment]', I wrote, 'I'm not used to the anticipation any more – the anticipation of being refused treatment, of having to fight [...] I hate that feeling of

powerlessness I associate with being a trans patient on the NHS' (Fieldwork diary: 30/03/15). Bradley and Myerscough's account spoke cogently to me. I could feel myself 'orient[ing] towards the future', anticipating – if not transphobia – then confusion, ignorance, cisgenderism and the wait: a long, perhaps complicated administrative and emotional process to undergo prior to any eventual access to treatment.

This anticipation of a difficult experience arose not simply from my own past experiences of unhelpful and unpleasant health professionals, but also from community discourse. I found myself reflecting on the stories and perspectives shared amongst my trans friends, and in numerous spaces online. Furthermore, my feelings were informed by the ongoing analysis of research data for this project, in which I encountered innumerable stories of inappropriate behaviour from health professionals that ranged from innocent ignorance, to rudeness and prejudice, to dangerous malpractice.

In turn, I saw a similar process of anticipation play out over and over again amongst my research participants. Every participant who wrote about their experiences of planning for treatment – particularly those accessed through gender identity services – lived 'in a time of anticipation'. As with my personal experience, there were stories of worries and fears, informed by waits, delays, gatekeeping practices, and community discourses of mistreatment and malpractice. However, there were also stories of excitement and hope, informed by the freeing experiences of coming out and seeking authenticity, as well as community discourses of satisfaction and wholeness associated with completing elements of the transition process.

In this chapter, I explore Bradley & Myerscough's (2015) 'time of anticipation' as a form of *trans temporality*. The time of anticipation is grounded in the temporal displacements of transition and cisgenderism, and mediated through community discourse and *communal* identity. It emerges through a collective management of uncertainty: oriented towards the future, but shaped by many peoples' experiences of the past, and experienced as a liminal, never-ending present. In this sense, I understand the past as socially constituted and constructed in a similar manner to the present and future (Glass, 2016). The time of anticipation is not simply about the experienced operation of time itself, but also about *emotional engagements* and the politics of time: the relationships between existing in a temporality and the feelings or emotions that arise from this. In this sense, it is about the individual's relationship with oneself *and* others, as well as the influence of wider social factors. As I shall show, these temporal

relations are of great importance in shaping discourse around patient experience and the operation of the UK's gender identity services.

In unpacking the time of anticipation and illustrating its importance in the context of my findings, I draw on a number of other theoretical interventions regarding trans temporalities. I begin my discussion with an account of Judith/Jack Halberstam's (2005) conceptualisation of 'queer time', Julian Carter's (2013) analysis of 'transition time' and Laura Horak's (2014) observations on 'hormone time'. I also touch briefly upon José Esteban Muñoz's (2007) championing of 'queer futurity'. I then contextualise these trans temporalities in the context of my research findings, looking at how trans patients negotiate waiting, mistrust, gatekeeping, hope and suicide in the time of anticipation. This chapter primarily explores the time of anticipation in the context of gender identity services, although my discussion of mistrust looks at a phenomenon which is relevant to healthcare provision more widely. I draw predominantly upon data from the community sphere – where forum users discuss personal experiences in the context of their fears, hopes and plans for the future – as well as upon the Twitter hashtag #transdocfail, which provided a brief but important focal point for discussions of trans health.

Interrogating trans temporalities

Halberstam (2005: 6) theorises 'queer time' in opposition to normative frames, describing queer temporalities as 'those specific models [...] that emerge within postmodernism once one leaves the temporal frames of bourgeois reproduction and family, longevity, risk/safety, and inheritance'. These normative temporal frames – which may be described as 'straight time' (Muñoz, 2007) – prescribe a linear movement through life stages such as childhood, adolescence, employment, marriage, reproduction and death. Straight time defines both memory and expectation, past and present. By contrast, the concept of queer time recognises alternative continuities and non-normative temporalities. An example of queer time can be seen in the 'stretched-out adolescence' of childless queers involved in subcultural activities such as punk and hip-hop, who challenge 'the conventional binary formulation of a life narrative divided by a clear break between youth and adulthood' (Halberstam, 2005: 153).

A number of the individuals discussed within Halberstam's project on queer time and space – particularly those active within the realms of queer arts and subculture – demonstrate agency in actively rejecting the constraints of straight time. For instance,

gender variant artist and model Del LaGrace Volcano counters objectification through the intentional exposure of her transgender body – defined in the present by the surgical and figurative scars of the past – and also through bearing witness to the bodies of others in her art. Conversely, the queer temporality of other figures is shaped more by circumstance beyond the control of the individual. In particular, we see how Brandon Teena – made famous through media representations such as the 1999 film *Boys Don't Cry* – is transformed from individual agent to ‘fetish, icon, commodity’ (Halberstam 2005: 75) after being raped and murdered at the age of 21. Teena left his rural American hometown – where he was known as a woman – several months prior to his death in December 1993, and had been creating a new life (with a new history) for himself as a man in Humboldt, Nebraska. In the wake of his death he quickly became a contested martyr figure for trans and lesbian communities, as well the subject of investigative journalism, fictional prose, documentary and Hollywood film; all had their own investment in de/constructing a transgender history. Through these investments, Teena became a timeless symbol, rather than a temporally located individual. In such examples, therefore, we see how queer time can be associated with a complex liminality. This may come about through an intentional, agential rejection of normative temporal movements, as in the case of Volcano’s art or Teena’s decision to create a new, male history for himself. However, it can also occur through the imposition of external narratives. Teena may have sought a queer temporal rupture in building a new life for himself in Humboldt, but rupture was *imposed* upon his memory when the narrative of this life was re-written for multiple audiences following his death.

Halberstam’s account of queer temporalities – conceptualised as ultimately relevant to *all* who reject the prescriptive progression of straight time, regardless of sexual orientation or gender identity – focuses largely upon the interactions of past and present. At its most optimistic, Halberstam’s description of queer time offers the vision of an emotionally and politically liberating, continuously extending ever-present in which the past plays a complex but secondary role. This can perhaps best be seen in queer subcultural production, as epitomised in the art of Del LaGrace Volcano and activities of dyke bands such as Le Tigre and Tribe 8 (Halberstam, 2005). However, as Bradley & Myerscough (2015) note, a continuous, liminal present can be experienced as an unpleasant ‘limbo’ by many trans people; a theme I explore throughout this chapter. I therefore turn now to explore the accounts of Carter (2013) and Horak (2014), who describe specifically *trans* temporalities that are notably rooted in engagements with the *future*.

Carter's (2013) account of 'transitional time' draws upon a close reading of choreographer Sean Dorsey's dance work *Lou*, a biographical piece about the gay transsexual activist Lou Sullivan. According to Carter, (2013:141) 'Dorsey offers us a vision of transitional time, and transitioning bodies, as dynamic and relational negotiations of wrongness [... a]nticipation, retroflexion, and continuity co-exist in the same body, at the same moving moment of space and time'. Transitional time involves movements 'forward, backward, sideways, [and] tangential[ly]' and can be seen in the embodied co-existence of past, present and future, along with physical and social changes that might occur, will occur, have occurred. I read this as futurity without linearity. In an echo of Halberstam's account of Del LaGrace Volcano, we can regard the transitioning body as simultaneously rooted in a future through anticipation – or even multiple, differently gendered futures – and in the past through social readings that sex the body's physical frame. In this way, transitioning individuals might: 'anticipate a gender content they generate recursively out of their physical medium's formal potential in relation to the context of its emergence [...] transition wraps the body in the folds of social time' (Carter, 2013:141). Given the emphasis on possibility, fluidity and agency in Carter's account of transitional time, and the lack of focus on the linear, conditional norms of medical transition, we may regard it as a form of queer time, and associate it with discourses of trans as movement.

Transitional time accounts for many of the ways in which trans people can embody and experience temporal markers differently to individuals bound by the strictures of straight time. An example of this is found in how trans people tend to age differently to cis people. Halberstam's (2005: 153) concept of a 'stretched-out adolescence' is as relevant to trans narratives of coming out and transitioning as it is to queer subculture. Many trans men and otherwise transmasculine individuals look particularly youthful if they do not, or are not yet undergoing hormone therapy; their gendered appearance 'anticipate[s] a [masculinised] gender content' (Carter, 2013:141). This is inconsistent with normative chronological expectations, but consistent with the embodied co-existence of past, present and future that is a feature of transitional time. Conversely, many trans women and otherwise transfeminine individuals look particularly youthful *after* undergoing hormone therapy and/or 'facial feminisation' surgeries. Furthermore, the experience of transition can be seen as bringing about a second adolescence, in which transitioning individuals of all genders come to terms with moving through the world in their preferred gender role(s). In this second adolescence, the emotional and

interactional changes brought about by social transition can be compounded by the physical and biochemical changes wrought by hormone therapies (Serano, 2007).

A model for understanding the more *linear* possibilities of transition is offered by Horak (2014). Drawing on empirical research into trans vlogs (video blogs) on YouTube, she explains how a range of techniques are used to describe and/or show the changes that come with physical transition. For instance, transition vlogs frequently depict many months' or years' worth of change within a matter of minutes. Horak utilises these manipulations of time to describe the phenomenon of 'hormone time'. Hormone time is positioned as distinct from both queer time and straight time. It is 'linear and teleological, directed toward the end of living full time in the desired gender'; in this sense it is utopic, pointing to an anticipated harmony between the vlogger's gender identity, gender presentation and physical body (Horak, 2014: 580). This enables trans youth in particular to 'imagine' (or indeed, anticipate) a positive future. Hormone time thereby 'appropriates' elements of straight time for 'radical ends', pointing to the vital *possibility* of a non-normative future in which the transitioned/transitioning individual doesn't simply exist or survive, but instead experiences life as 'joyful' (Horak, 2014: 581).

While Horak's (2014) description of hormone time generally offers a more linear account than Carter's (2013) conceptualisation of transitional time, it also accounts for trans discourses and experiences that cannot be understood within the normative bounds of straight time. To return to the example of ageing: Horak (2014: 579) notes that according to the logic of hormone time, '[t]ime begins with the first shot of testosterone or HRT pills (hormone replacement therapy) and is measured against that date, even years afterward'. This provides a model for understanding the phenomenon by which trans peoples' chronological age might contrast with their *trans age*: that is, an age counted from the moment a personal comes out, begins to transition socially and/or begins to transition physically. The difference between chronological age and trans age is illustrated starkly within the community sphere of this project, where (for instance) trans people in their twenties or thirties who had been out for many years can often be seen offering advice and guidance to chronologically older individuals (perhaps in their fifties or sixties) who are tentatively moving towards coming out and/or transitioning.

The importance of queer and trans futurities – be they in an asynchronous form as with transitional time, or a more linear form as with hormone time – can be found in the possibility of a life that makes sense beyond the confines of straight time: a

possibility that can be *anticipated* by ‘younger’ trans people. In his discussion of marginalisation in Western societies, Muñoz (2007: 364) notes that: ‘[t]he future is only that of some kids. Racialized kids, queer kids, are not the sovereign princes of futurity’. He argues that, for these ‘kids’, queer futurities provide ‘not an end but an opening or horizon’ (360). This is vital because it offers the ‘anticipatory illumination’ (361) of a future that might not seem possible within the strictures of straight time. While Horak (2014) acknowledges that hormone time can entail elements of temporal disruption in the manner of transitional time (as seen for example in the temporal compression that is an effect of many video editing techniques), the key difference between hormone time and straight time lies not in temporal disjuncture, but in the differing progression narratives associated with each. The temporal logic of straight time is linked to normative reproduction, capitalist continuity, longevity and risk aversion, taking form in social structures such as the heteronormative (or indeed, homonormative) nuclear family (Halberstam, 2005). By contrast, Horak (2014: 581) links the futurity of hormone time to ‘expansive trans subjects and communities’: that is, subjects and communities who might defy normative, cisgenderist progression narratives.

Telling anticipatory stories

In his account of ‘sexual stories’, Ken Plummer (1995: 5) encourages the reader to regard such narratives not (simply) as examples of truth-telling, but as ‘issues to be investigated in their own right’. The anticipatory trans narratives I draw upon in this chapter are similarly not simply accounts of experience, but a medium in which both discourses of trans health and temporal phenomena play out. Prosser (1998) argues that storytelling helps to constitute transsexual subjectivities, echoing Stone’s (1991) call for trans people to write themselves into existence. In a similar way, the stories I describe here play an important role in constituting a trans temporality, shaping collective ideas and emotive personal experiences of the possible.

Most conversations around issues of trans health within the community sphere centre on anticipation. Forum users frequently begin such discussions with a post about their fears, hopes, concerns and/or desires ahead of a forthcoming appointment at a GP practice, local mental health service, gender clinic or hospital. Other forum users then typically respond either with their own anticipatory narrative (if they are also waiting for an appointment), or with comments drawing upon their own experiences or those of others in order to offer advice, guidance, and/or reassurance.

Similar narratives can also be found within Facebook activist groups. Hines (2007) describes this kind of support as constitutive of a trans 'community of care'. Most – but not all – of these conversations focus upon transition and gender identity services. They tap into a variety of discourses regarding the provision of trans health, offering an insight into patient perspectives on individual practitioners and clinics as well as the wider available treatment pathways.

The mode of conversation differs considerably in the case of #transdocfail. This reflects the more short-form, immediate and public function of communication on Twitter, especially in comparison to online forums. #transdocfail operated as a very visible platform for the dissemination of trans community discourses of health, with the majority of contributors describing their experiences and views rather than engaging in direct discussion. However, like the exchanges within community forums and Facebook groups, the stories told within #transdocfail reflect a number of wider anticipatory narratives.

In the discussion of research findings that follows, the time of anticipation is employed as a frame for conceptualising the trans patient narratives that emerge and are negotiated through community forums and Twitter. I read Bradley & Myerscough's (2015) 'time of anticipation' as a form of queer time (Halberstam, 2005) that intersects complexly with other modes of temporality. It links narratives of lived experience from trans patients to the possibility of a better future, in response to a 'compressed', liminal present. It enables a 'dynamic and relational negotiatio[n] of wrongness', (Carter, 2013:141), in which 'wrongness' resides not simply in the body of the individual, but also within limited, conditional discourses of trans possibility, stories of institutional cisgenderism and transphobia, and knowledge of the long waits for treatment. The discursive construction of 'wrongness' therefore takes place in and through *communally-mediated* narratives. These often centre apprehensive, often mistrustful attitudes towards healthcare providers. However, they can also enable patients to imagine post-transition futures, which offer an 'opening or horizon' (Muñoz, 2007: 360) and the possibility of joy (Horak, 2014).

The long wait

A defining feature of the time of anticipation is the wait. I showed in Chapter 3, *Trans Health in Practice*, that patients seeking access to gender identity services through the NHS negotiate a number of waits, the average duration of which has only increased in recent years due to the growth in patient numbers and a lack of proportional investment in gender clinics. Most patients now wait for many months or years for an initial consultation at a gender clinic.

In the time of anticipation, the wait lies at a nexus of uncertainty. Trans patients cannot know exactly how long the wait will be or what will happen at the end of the wait, and may wonder how to organise their lives (in both practical and emotional terms) during this time. In contrast to the more straightforward futurity of hormone time – most typically encountered by UK patients *following* assessment at a gender clinic – the uncertainty of the wait is perhaps best understood in terms of the futurity-without-linearity of transitional time (Carter, 2013), as well as in the ‘compressed’ liminality described by Bradley & Myerscough (2015).

A typical forum conversation about waiting begins as follows.

Finally 6 months after the psych evaluation I get a letter from the GIC saying they have sent a fax to my PCT to request funding. They will schedule an appointment when funding is approved. Is this how it normally happens? I know my referral got sent off in January as I double checked with my GP? Anyone got an idea of how much longer I have to wait for an appointment if all goes smoothly with the PCT? (Warren)

The length of Warren’s wait is not particularly unusual; neither is his uncertainty. He is reassured of this by other forum users, who note the length of their own waits, and explain that applications for funding can cause delays. There is no way of firmly answering Warren’s final question about how much longer he will have to wait for an appointment; this will only become apparent once he has been added to the clinic’s waiting list and received formal correspondence on the matter. Furthermore, the length of said waiting list depends on which gender clinic he is going to attend.

Delays caused by funding applications are now less common due to the abolition of PCTs, but the uncertainty of waiting time illustrated in Warren’s post remains. Trans

patients in England and Wales in particular⁶⁵ still find themselves waiting an uncertain period of time: for their GP referral to be processed by the gender clinic, for the approval of hormone therapy once they are attending the gender clinic, for surgery appointments once they have met the requirements of RLE and subsequently joined another waiting list. Patients with access to the relevant knowledge and a degree of personal flexibility can ask to be put on a cancellation list, meaning that they may be contacted with the offer of a sooner appointment at short notice. This only contributes to the temporal disjuncture of waiting time, reinforcing the sense of 'dynamic and relational negotiation' (Carter, 2013: 141).

Long waiting times can compound any existing mental health issues for trans people. Trans patients may feel a lack of agency due to the uncertainty and inevitability of these waits. McNeil et al. (2012) indicate that patients frustrated with long waiting times are extremely distressed, with many describing experiences of self-harm. Forum users therefore discuss a range of responses to the severe emotional demands of waiting. Some seek private treatment or self-medicate, while others contemplate ending their lives; these responses are discussed in later sections of this chapter. For most patients, however, the best available option is to remain within the time of anticipation, looking forward to a better post-transition future.

I try my best to simply laugh at it all and focus on a few years down the road when everything is sorted and I'm able get on with being a 'regular' guy.
(Aiden)

I'm really hoping to be seen by a psych this year, at least things are moving forward and in the right direction too. (Warren)

As I noted earlier, Bradley & Myerscough (2015) describe trans patients in the time of anticipation as 'orientated towards the future like iron filings lining themselves up towards a magnet'. In the above quotes from Aiden and Warren, it is apparent how this orientation towards the future can operate in a manner comparable to hormone time (Horak, 2014), with participants agentially and constructively anticipating a concrete future in order to cope with the unpredictably continuous pre-treatment present. In particular, Aiden positions an acceptable ('regular') mode of life in this future as an apparent certainty (*when* everything is sorted); it is the waiting time ('a few years') that remains unknown.

⁶⁵ Patients in Scotland can refer themselves directly to a gender clinic. Patients in Northern Ireland face a shorter (and hence more predictable) waiting list for their initial appointment.

Some participants regard the waiting time as an opportunity, with the wait for an initial appointment in particular offering temporal space to get one's life affairs in order prior to transition. This can involve: coming out to partners, friends, family and work colleagues; changing name by deed poll or statutory declaration; buying new clothes; starting a university or college course; changing job or school in order to enter a more supportive environment. Patients are also generally aware that many of these actions count towards RLE for the purposes of treatment at many gender clinics, meaning that they can sometimes be undertaken for the purposes of meeting assumed or known medical standards. The waiting time is also portrayed as an opportunity for self-reflection, a space to decide for certain whether or not transition is an appropriate step. On occasion, this perspective is recommended to newer forum users with worries about transition.

You can explore this further. You're not committed until you've been on hormones for a couple of months and if you go through the NHS pathway that point in time is six months away at the very, very soonest so don't frazzle - see a psych or GP and talk about it and take each step through the pathway if and when you're comfortable with it and you know it's what you want. Go at your own speed, don't be pushed (not that anyone in the medical establishment is going to push you). (Steph)

In recognition of how long waits can be, forum users frequently encourage people thinking about transition to approach their GP for an initial referral sooner rather than later. This is typically portrayed as a good first move even for those uncertain about whether or not transition is the right decision for them, with the logic being that the wait itself provides plenty of time for both contemplation and coming out to friends, family and work or school colleagues.

One thing I would say is that you should set the ball rolling immediately with the NHS. It is really very likely that it will take over a year for you to actually be attending the first of two Evaluation appointments at a GIC. Once you HAVE decided to transition, the long waits between different stages of progress are extremely frustrating, so get things in motion now. You don't have to tell anyone now - it could be a year before you are able to say "In three months time, I have got an appointment about my gender issues." If you change your mind in the meantime, you can cancel it. They won't mind. (Ellie)

For those who follow this advice, a shift into the time of anticipation might quite rapidly follow from their initial coming out. A patient's 'whole life' might '[seem] to be about waiting lists' (Bradley & Myerscough, 2015), with the fundamentals of transitional experience shaped by the uncertain futurity of waiting time. Moreover, practical advice about the management of waiting time can lead to trans individuals being encouraged to think about their gendered experience in terms of the formal medical pathway. In this way, transitioning individuals can find themselves 'living in prognosis' (Jain, 2007) in a similar manner to other patient groups, such as IVF patients (Franklin, 1997) and cancer patients (Steinberg, 2015b).

Much about the topics under discussion in the rest of this chapter is shaped by the impact of waiting time. Waiting provides a (frequently frustrating) time to anticipate, with agential narratives echoing hormone time in their vision of a better future constructed in opposition to a disempoweringly liminal present. I will show that patients within the time of anticipation also draw from the past – in and through personal experiences and communal narratives – during their wait, providing temporal and conceptual space for mistrust, fear, uncertainty, hope and excitement to grow.

Mistrust

A second key theme of the age of anticipation is a fundamental lack of trust in health professionals: patients anticipate 'misgendering, perplexed looks, ignorance [and] transphobia' (Bradley & Myerscough, 2015). These narratives of cisgenderism and transphobia – from both public and private providers in *all* areas of healthcare provision – derive from past experiences and shape the construction of possible futures. They thereby inform a pervasive attitude of mistrust towards the health professions amongst trans patients, stemming from an anticipation of being treated poorly.

Background: narratives of cisgenderism and transphobia

Stories about cisgenderism and/or transphobia in the provision (or denial) of healthcare services feature prominently throughout the community and activist spheres. Within forums, these stories are narrated in – and constructed through – discussion threads where individuals seek support following bad experiences, plus lengthy conversations (and sometimes heated debates) around the relative merits or demerits of different gender clinics. Such discussions have taken place for many years

within the hidden realms of forums, mailing lists and private social media groups. Activist groups on Facebook typically take a more interventionist approach, with individuals seeking advice on how best to actively address either a personal issue or a more systematic problem in their local area.

In January 2013 a large *public* discussion about trans health (primarily⁶⁶) in the UK took place on the Twitter hashtag #transdocfail. This was a spectacular manifestation of the stories that are told about cisgenderism and transphobia. According to hashtag instigator Sarah Brown, #transdocfail was created with the explicit intention of offering a counter discourse to prevailing medical and media narratives of trans health, which centre on matters such as the management of transition and public expenditure on services.

#transdocfail encompassed an enormous range of different issues. For example, a number of participants describe institutional problems such as ableism, binarism and unnecessary rigidity, grounded in the care pathways and diagnostic criteria of the gender clinics.

To prove commitment to transitioned life, you usually need an official full time occupation. Unfortunately I was a f/t⁶⁷ carer (Phoebe Queen)

Have an appointment with a local GIC next month. Not sure either of us see the point because non-binary treatment isn't funded (Kat Gupta)

Other participants noted examples of individual transphobia from health professionals. Within these stories, practitioners frequently draw upon factually inaccurate assertions in support of prejudiced claims.

My psychiatrist initially refused to refer me cos "most people regret transitioning" (Naith Payton)

Instances of Trans Broken Arm Syndrome – in which practitioners focus upon a patient's trans status in an irrelevant context, as discussed in Chapter 5, *Re/Defining Trans* – are frequently outlined.

Routine appts about non-trans stuff turned into chats about my gender even when I just wanted help for a hurt back or w/e.⁶⁸ (Tom Robinson)

⁶⁶ For this project, I looked only at tweets to #transdocfail posted from within the UK.

⁶⁷ 'full-time'

⁶⁸ 'whatever'

Many participants note the commonality of inappropriate language. As with Trans Broken Arm Syndrome, this sometimes arises from ignorance on the part of health professionals. It can be ignorance without malice if the practitioner in question is unfamiliar with trans issues, but ignorance can also arise from an *active* refusal to engage with requests from trans patients or their advocates.

Talking about me my wife kept correcting nurse from him to her, husband to wife. Nurse still continued to misgender each time (Judith Jones)

Other participants described more explicitly abusive transphobic language from health professionals.

“You’re too tall, too fat, too hairy & too masculine to even pass in public as a female” (Emma)

The sheer volume of such stories – which numbered in the hundreds on #transdocfail alone – demonstrates that these are not isolated incidents. Similar accounts have also emerged from research, with studies addressing (for instance) the high prevalence of ignorance, cisgenderism and transphobia amongst GPs (Whittle et al., 2007; Schonfield & Gardner, 2008; Bailey & McNeil, 2013), mental health professionals (McNeil et al., 2012; Hunt, 2014; Ellis et al., 2015) and gender identity specialists (McNeil et al., 2012; Ellis et al., 2015). In 2011, the Conservative/Liberal Democrat Coalition Government’s *Transgender Action Plan* noted that health was identified as the most significant area of concern by trans stakeholders (Home Office, 2011b). In 2015 evidence was heard from a number of trans individuals and organisations at the House of Commons Women and Equalities Committee *Transgender Equalities* inquiry; in light of this, the committee issued a damning statement on public health provisions.

The NHS is letting down trans people: it is failing in its legal duty under the Equality Act. Trans people encounter significant problems in using general NHS services, due to the attitude of some clinicians and other staff who lack knowledge and understanding—and in some cases are prejudiced. The NHS is failing to ensure zero tolerance of transphobic behaviour. GPs too often lack understanding and in some cases this leads to appropriate care not being provided[.] (Women and Equalities Committee, 2016: 3)

It is apparent therefore that cumulative narratives of cisgenderism and transphobia have come to shape public discourse on trans health. In turn, these narratives come to

shape trans patients' everyday expectations of health services, thereby impacting even the most mundane engagements with service providers.

Notably, many of the *positive* stories about health professionals within my data corpus (including on the very short-lived #transdocfail spin-off #transdocwin) involve health professionals of all backgrounds *providing very basic services*. These might include writing a letter, offering a referral, using a patient's correct name or preferred pronouns, or changing medical record details. The implication here is that a large proportion of trans patients do not *expect* to be treated well: rather, they anticipate being treated poorly, and adjust their expectations and views of what might constitute a notably 'positive' experience accordingly.

Fearing mistreatment

Trans patients frequently regard forthcoming or potential appointments with unknown practitioners (and sometimes, known practitioners) with a sense of caution and occasionally fear. They anticipate being treated inappropriately, or possibly even being refused treatment altogether. This mistrust can be tied to personal experience, with many participants talking about how a bad appointment with a particular practitioner increased their mistrust of others working in the same field. However, it can be linked to the sheer number of communally constructed/disseminated stories of cisgenderism and transphobia. In this way, the trans patient's emotive anticipatory projection of the future incorporates recurring elements of the past. On occasions, this is not the patient's *own* past, but instead *the real or imagined past of another*. For individuals undergoing or seeking to undergo physical transition, waiting offers more time to encounter and engage with stories of cisgenderism and transphobia (both online and offline), and to contemplate negative personal experiences.

Mistrust is most often discussed in relation to gender identity services. For instance, many participants raise concerns about sharing medical problems past and present – particularly those related to mental health – with their gender clinic, for fear of being denied treatment as a result. An example follows from an individual who contributed anonymously to the submissions-based Twitter account @TransDocFailAnon.

hiding anxiety and self harm from clinic doctors because I don't feel safe
telling them about it (TransDocFailAnon)

However, trans patients who are not specifically anticipating a transition-related appointment can also exhibit a serious lack of trust in health professionals. In the below instance, a contributor to TransDocFailAnon fears being openly trans within everyday medical appointments (which might, for example, entail transphobic incidents or instances of Trans Broken Arm Syndrome).

Experience extreme anxiety every time I see a doctor wondering if I'll have to disclose trans status (TransDocFailAnon)

The very presence of the TransDocFailAnon Twitter account is important to this analysis. The account – along with an associated email address and Tumblr page – was created by an anonymous person. It enabled individuals to contribute to #transdocfail even if they did not feel confident sharing stories under their own name or pseudonym. For some, this was a matter of protecting their identity if they had gone stealth, or if they were not yet out in all areas of their life. Others, however, did not trust their doctors to maintain treatment in the face of criticism.

I have been afraid to post on #transdocfail in case I'm identified and have access to treatment made even more difficult. (TransDocFailAnon)

Similar concerns were also raised by a number of participants from Twitter and from the forums when I contacted them to ask permission for the use of direct quotes in this thesis. The anticipation of harm represented in this mistrust means that participants felt it wise to withhold personal information relevant to their health – not just from their doctors, but from any context that might possibly be outside of their control. This can be said to represent an exercise of agency in a context where the projected future of cisgenderism and transphobia is likely to feel extremely disempowering for trans patients.

Strategic futurities

Less severe forms of mistrust can operate as a form of strategic engagement with possible futures, enabling trans patients to plan their medical appointments: who to see, and how to manage information. In these instances, which I refer to as strategic futurity, patients seek to respond agentially to the matters that concern them. Within the forums, this typically involves participants remaining realistic in managing their expectations ahead of appointments and/or finding a way to negate their concerns. For example, some participants ask others for advice on what to share (or not) with health

professionals. In the below instance, Aiden wonders whether or not to tell his GP or psychiatrist that he has been having sleeping problems.

I know the obvious answer is to go and ask my GP, or wait until [date redacted] and mention it at my psych appointment. To be honest, I'm anxious that it'll imply something negative about my transition. (Aiden)

Mistrust can lead participants to feel that it is necessary to strategically manage considerable elements of their own care. Most often, this is because of mundane ignorance or a lack of interest on the part of GPs, or due to the high frequency of administrative problems at gender clinics (McNeil et al., 2012; Pearse, 2012). Many experienced forum users recommend that others become familiar with treatment pathways and draw upon available evidence in making a case for being referred to a gender clinic: for instance, by utilising NHS guidance documents or the WPATH Standards of Care. Operating on the presumption that practitioners cannot necessarily be trusted, a number of trans patients carefully seek out providers who they *can* trust. For example, numerous people post to Forum 2 to ask for advice on where to find GPs with a good track record on treating trans patients. On Facebook, a user of one group asked for advice on finding a 'trans* friendly endocrinologist'.⁶⁹ These actions represent an attempt to manage and address the uncertainty that characterises the time of anticipation.

Sometimes, community or activist groups make systematic efforts to tackle the intersection of uncertainty and mistrust: for instance, at the time of writing, advocacy group Action For Trans Health have a page on their website entitled *List of Trans* Friendly GPs*. More often, advice is offered on an individual basis. On occasions where an individual has encountered problems, experienced patients might recommend looking around for alternative practitioners who might offer better treatment. In the below example, Steph responds to a request for advice from a patient whose GP first offered an inappropriate referral, before later asserting that the patient's trans feelings amounted to a 'phase' that would pass.

I think in this case it might be worth seeing a different doctor if you can which is something you are perfectly entitled to do. I would have a good

⁶⁹ In instances such as this, the asterisk that follows 'trans' is employed by the author to indicate that the term is being used in the widest/most inclusive sense. The form 'trans*' gained a certain popularity within trans spaces during the early 2010s, and was intended to counteract more limited uses of 'trans' and/or the conflation of 'trans' with 'transsexual'. However, its popularity has declined somewhat over the past year. In my writing, I prefer to claim the stand-alone 'trans' as an inclusive term.

read around this forum [...] make sure you're an "expert" patient and know exactly what *should* happen (Steph, emphasis in original)

Similarly, Emma recommends that a worried forum user check up on a forthcoming appointment at a gender clinic known for its administrative troubles.

Just keep an eye on things, around a month or so before the appointment give them a call and make sure everything is okay still... it's always best to be prepared in case things go wrong admin wise... (Emma)

Emma's advice is important in the context of waiting times. Following a wait of several months (or more), a further setback could cause the patient's anticipated positive future of a possible transition to recede even further into the imagined temporal distance. A strategic management of possible futures therefore offers a means by which trans patients can maintain an 'opening or horizon' (Muñoz, 2007) within a context where long waits and negative, communally-mediated narratives of the past dominate and curtail the possibilities of the present.

Myths of malpractice?

While common, mistrust is not universal within trans spaces. Many trans patients have overwhelmingly positive stories to tell about their own interactions with health professionals. A number of participants expressed wariness towards what they perceived as inaccurate or outdated information posted in forums. In the below instance, Ben cautions a fellow forum user who he perceives to be making negative blanket statements about an entire profession.

It's one thing to have had a bad experience with a specific psychiatrist, but to say [...] that psychiatrists are untrustworthy and should therefore never be believed is unhelpful, untruthful and potentially harmful. (Ben)

Gender identity specialists are often quite aware of the discourses around trans health that circulate within online communities. In light of this, Richards et al. (2014) caution that widespread mistrust can be damaging for the mental health and treatments opportunities of the most vulnerable patients.

Clients who are very young, or who have a learning disability, or mental health problems, frequently present to clinics extremely distressed about things that they have heard [...] which are simply not true. Such people often report that they were thinking of settling for sub-standard services, or risky

self-managed treatment, rather than approaching reputable clinics. Worryingly, especially given the rates of mental distress and suicide amongst trans people who are not provided with services, there are others who are completely put off by the myths circulating about trans-specific healthcare, leading to desired and necessary treatment being delayed for years. (Richards et al., 2014: 254)

The risk here is that stories of cisgenderism and transphobia from healthcare providers represent an ungrounded temporality. Patient experiences expressed in contexts such as #transdocfail are often undated, meaning that problems which may have commonly occurred ten years ago continue to be communally constructed as a part of possible futures. Trans community discourse frequently re-enacts and re-reifies multiple pasts as possible futures for newcomers, even though those pasts are no longer necessarily reproduced in the present. For example, Richards et al. (2014) note that – contrary to some stories that circulate – trans women are no longer required to wear dresses or skirts at appointments, and argue that gender identity specialists now often subscribe to the position that gender is socially constructed and performed.

However, Richards et al. (2014) overstate their argument. While potentially ungrounded communal temporalities do complicate the landscape of anticipation and uncertainty, even the most recent reported experiences from participants in this project indicate that (for instance) binary notions of gendered possibility continue to be imposed by many gender identity specialists. Moreover, institutional issues such as the lack of knowledge common amongst GPs and mental health practitioners, or varying interpretations of the WPATH *Standards of Care* at many gender clinics, continue to shape trans patient experiences and – therefore – other patients' anticipatory uncertainty and mistrust. Until these widespread issues are addressed, it seems unreasonable to suggest that stories of transphobia and cisgenderism circulate *primarily* as 'myths', even as this evidently is the case with some such stories.

Bradley & Myerscough (2015) suggest that the time of anticipation can inform 'a politics of hopefulness rather than of dread', of 'preparedness' rather than 'anxiousness'. While a considerable number of trans patients report avoiding healthcare services as a result of their fears – seen particularly in the contributions to TransDocFailAnon – many more employ their mistrust in order to anticipate and avoid potential problems. Trans patients can utilise mistrust productively by looking for and offering advice within community spaces, raising private issues publicly (such as through #transdocfail), and through becoming 'expert patients'. In this way, a strategic

'preparedness' with regards to the future can make 'hopefulness' possible. Thus, while the time of anticipation can close down future possibilities through the dissemination of fearful stories, it can also open up possible futures through the strategic negotiation of health services.

'Trans enough' to pass the test: anticipating difficulty in assessments

For trans people seeking to undertake physical transition through the NHS, assessment appointments are vitally important because they determine whether or not a patient might be able to access the necessary diagnosis. A typical anticipatory narrative on this topic is provided by Aiden.

One more day to go till my appointment. I'm kind of bricking it re: not cocking up the train journey and having to answer a lot of invasive questions. Exciting too though... (Aiden)

In his post, Aiden looks forward to his first appointment at a gender clinic. He is worried ('bricking it') about the train journey due to issues around personal anxiety and physical disability, but is also concerned about the anticipated events of the appointment itself. Aiden's concerns regarding 'invasive' questions are not limited to the possibility he might find them embarrassing to answer. Implicit within his narrative is the idea that assessment interviews are a *difficult* experience. This can be linked to a more widespread discourse of difficulty, which arises from a subset of the communally-mediated stories of cisgenderism and transphobia that reproduce past hardships as possible futures.

Anticipated difficulty

Some of the difficulties associated with attending initial gender clinic appointments are largely external to the medical process. For instance, there is a frequently expressed emotional difficulty in talking about being trans, where transness is associated with internal shame and unpleasant reactions from others. Similarly, many participants note a fearful anticipation of negative responses to transition from partners, friends and family members. Others are concerned that the major life changes associated with transition might not be right for them.

However, many anticipated difficulties relate to the assessment process itself. For instance, patients may worry about intrusive questions addressing intimate activities

such as sex and masturbation, which are common within assessments at UK gender clinics (Speer, 2013; Nieder et al., 2016). They might also be concerned about addressing other sensitive issues frequently raised by gender identity specialists, such as mental health diagnoses, education, work and family life (Barrett, 2007). It is apparent from Aiden's wider posts on the forum that his concerns are based in part upon an extrapolation from his experiences with a local mental health professional; however, he is also aware of typical assessment interview content due to past conversations with other forum users.

Encompassing all of the above issues is the difficulty of the *assessment process itself* as a gatekeeping procedure. Numerous participants describe being 'nervous', 'scared' or 'stressed' about past or forthcoming assessments: these feelings are unpacked by some who positioned such appointments as a test that might be 'passed' or 'failed'.

I recall how stressed I was ahead of the Assessment interviews and that is quite understandable because they are a gateway to further progress, as well as hormones and eventual surgery, if that's your aim. (Ellie)

The above quote is from a post where Ellie aims to reassure other forum users that the care pathway is navigable. However, in the quoted passage she draws attention to the imagined possibility of failure. This is where the difficulty lies, from which the stress, fear and nervousness arise: the possibility of failure, thereby foreclosing the desired possible future of transition. Notably, a number of forum users describe the gatekeeping process as a kind of *test*, comparing it to (for instance), a job interview or school exam. It is here, also, that a key difficulty of the 'invasive questions' feared by Aiden lies. His concern is not simply that the appointment will be awkward: it is that in attempting to field the practitioner's questions, he might fail this difficult 'test', possibly 'cocking it up' in a similar manner to the train journey. A number of participants describe this common concern as a fear that they will not be seen as 'trans enough' by health professionals.

Preparing for the test

Aiden does seem reasonably sure that he will pass the test: hence his 'excitement', which is unpacked later in this chapter. However, he hasn't left the matter to chance. This is shown in a later post, where he lists the documents he brought with him to his first appointment. These documents include Aiden's provisional driver's licence, bank card, bank statement, utility bills, NHS card and letters from the local council. They are

intended to provide evidence of his commitment to a new ('trans enough') life as a man through the adoption of a male name in all areas of his life. Such evidence is often explicitly requested by gender clinics: '[m]ore than in any other aspect of psychiatry [...] gender identity disorders require collateral history and confirmation' (Barrett, 2007: 14). Aiden also asks other forum users waiting for an appointment at the same gender clinic what documentation they intend to bring with them. This is a form of shared preparedness amongst community members who *collectively* engage with possible futures.

Advice on preparation is also frequently offered by experienced patients. An example of this is advice on how best to respond to assessment questions. The general feeling within the community sphere is that it is usually best to at first be honest and open with practitioners, with gender pluralist (Monro, 2005) advice to 'be yourself' applied beyond the realm of personal identity.

As ever "just be yourself"; answer the questions honestly and don't try to second-guess the answers. Is [your appointment] at Charing Cross or a local mental health practice? Good luck! (Steph)

Just keep your mind focused on what you want and be as truthful as you feel you can be. (Felix)

This kind of advice – to 'be yourself', be 'truthful' and be 'honest' – is often offered to individuals anticipating their first assessment appointment. This demonstrates an inclination towards hope and a positive view of the future within the time of anticipation in spite of mistrust, reflecting Horak's (2014) analysis of hormone time. Such advice is grounded in *positive* past experiences of trans patients, many of whom do return from appointments with accounts of helpful, kindly practitioners. In this way, communally-mediated anticipation can work to negate negative stories and instead construct a more hopeful vision of the future. Indeed, numerous participants question the worries of new patients: many note that gender clinic policies have changed since the 'bad old days' of the 1990s and early 2000s, while others argue that activities such as 'Charing Cross bashing' are based upon outdated information.

The advice given to new patients within community spaces is liable to change, however, if the recipients of this guidance express grounded concerns about their own ability to prove themselves 'trans enough'. Such concerns might arise from patients' non-binary gender presentations, alternative lifestyles, or actual difficulties encountered in a first appointment. In such instances, forum users are more likely to

recommend alternative strategies for passing the test, in another instance of strategic futurity. For example, Ellie responds to concerns from a trans woman who likes to dress androgynously with the following advice.

If you have unambiguously female clothes - whatever they are - that you are comfortable in then wear them for the appointment. If you turn up just in a plain T-shirt, plain jeans and white trainers with no make-up or jewellery, there isn't much clue to your gender is there? A girl absolutely has the right to wear what she wants, but at the appointment the objective is to make sure that they see the female inside that XY body so my personal view is that one should make it easy for them to do that from the second they set eyes on you. Why make it harder on some dumbass principle? As soon as you get home, wear what you like! (Ellie)

While more nuanced than advice simply to 'wear a dress', this advice would appear to run contrary to some of the guidance from gender clinics themselves. In exploring this matter, I return to the notion of gender clinic 'myths'.

Failing the test?

In 2010 a list of 'myths' about Charing Cross was shared in a number of trans forums, based upon a presentation by a consultant psychiatrist from the clinic. Items on this list of supposedly inaccurate patient expectations included: 'you have to wear a skirt to the GIC', 'you can't admit to doubt', 'they deliberately play Good Cop/Bad Cop', and 'you will have to give a standard trans narrative'. Similar information can also be found on current Charing Cross website.

There are as many different ways of being a transgendered person as there are transgendered people. (Web page: West London Mental Health NHS Trust, *General Trans FAQs*)

In this way, reassuring accounts from the gender clinics themselves can join the stories that circulate within community spaces, thereby potentially feeding into the construction of possible futures within the time of anticipation.

However, many trans patients find reasonable grounds to follow Ellie's recommendations. Certainly, the guidance offered to patients by Charing Cross – and the stories of many patients who attend or have attended this gender clinic – indicate that the specialists who work there no longer rely upon the bluntest of gender

stereotypes. However, a number of more recent accounts from participants indicated that practitioners at a number of gender clinics (*including* Charing Cross) still seek to ensure that patients ‘fit’ into relatively rigid models of trans as condition. For instance, Joshua describes how a gender identity specialist was perturbed by the manner in which he has sex. Joshua had reported having penetrative intercourse with a cis male partner, and asked the specialist in question about how he might best plan for a family.

I wasn't taken seriously when I asked about being fertile [...] the questions I was faced with at the gender clinic just for saying that I have sex with a male was like “omg you can't be trans!” (Joshua)

Such complaints are most frequently voiced by participants experiencing intersecting marginalisations. This includes gay, bisexual or queer individuals like Joshua, as well as non-binary or genderqueer people, disabled individuals, carers and/or people of colour. A second example can be found in the experience of a neutrois-identified individual who described the very negative reaction they received during their initial assessment at a gender clinic.⁷⁰ The practitioner they saw repeatedly described their androgynous appearance as too ‘gay’ and advised them to adopt a ‘more masculine’ name. The individual in question later posited that their ‘typically Indian name’ was seen as too ‘gender ambiguous’ by the (white, British) practitioner. In this way, being ‘trans enough’ to pass the assessment ‘test’ is not simply a matter of gender identification or the outcome of personal reflection. As discussed in the previous chapter, it can sometimes remain a matter of proving conformity to the practitioner or gender clinic’s conditional approach to trans possibility, an approach that may also be shaped by the intersection of gender with other social categories such as race, dis/ability and occupation.

At the Nottingham Centre for Gender Dysphoria, the gatekeeping test is taken two steps further. Patients at the clinic are usually asked to write a piece of prose exploring their gendered history for their second assessment appointment, and are instructed to bring a friend or family member to the third. While neither of these requests are necessarily unusual within the provision of mental health services (and indeed, a number of participants described the therapeutic value of writing about their experiences with gender), their presence within *assessment* appointments suggests that they are being used as diagnostic tools. Certainly, this is how they were perceived by many Nottingham patients, who described the anxiety of anticipating and preparing

⁷⁰ In order to protect the identity of the patient, I am not naming the practitioner or the clinic in this document.

for these appointments. According to the gender clinic, the purpose of the meeting with a friend or family member is to: 'socialise the transition that the patient is making [...] [e]nsuring the patient has the support that they will need and that there is a person or people within their circle that knows the treatment that they will go through over the coming months' (NHS England, 2015c: 20). However, numerous participants attending appointments at Nottingham described an additional reason for this appointment: the *corroboration* of their account.

Basically they asked him [a close friend] his thoughts on me. How well we know one another, how we met. What does he think about my decision. Whether or not he thought it was a snap decision or is it something that has always been there. What kind of support can he give me etc. (Sam)

The above account is a fairly typical community sphere description of the third assessment appointment at Nottingham. In it, we see how this appointment exists in part to assess the level of support a patient will receive within their social circle, but can also operate as a diagnostic tool, with Sam's friend asked about the conditions under which Sam might have made the decision to transition. In this way, gender identity specialists are *also* concerned with projecting the patient's perceived past into their present and possible future, looking for clues as to whether or not the patient has historically displayed (the right kind of) trans identity. The gatekeepers' reading of this past – as socially mediated by patients' friends or family members, in the case of Nottingham – can ultimately determine the patient's future, particularly in instances of inconsistent pasts. In particular, a number of participants describe having hormone therapy delayed after meetings where the person accompanying them was unsure or offered an account that differed from that of the patient.

I draw out these examples in order to show how trans community discourses of difficulty in the gatekeeping context are inevitably shaped by the temporal interventions of the gatekeepers themselves. In some cases, clinics such as Charing Cross seek to counter discourses of mistrust by providing an alternative and more reassuring vision of the future. However, the anticipation of potential difficulty is still mediated also by *continuing* narratives of difficulty from new patients, which can work to counter these reassurances in turn. It is also important to note also that stories arising from a patient's encounter with a particular practitioner or a particular clinic can influence *wider* anticipatory engagements with treatment. For instance, while Joshua's problem with a gender identity specialist might be due to the individual prejudice of the practitioner overseeing his appointment, his story feeds into the wider

communal narratives of anticipation that can shape a more general tendency towards mistrust. In this way, poor practice at one clinic can influence perceptions of other clinics. Finally, in the example of Nottingham's third appointment, it is apparent that gatekeepers can also draw upon multiple narratives of the past to model an individual patient's future. It is for these reasons that some patients attempt to meet the perceived expectations of gender identity specialists by following advice such as that provided by Ellie, refusing to take the risk of prolonging the waiting time. My findings here build upon observations from Schonfield & Gardner (2008) and McNeil et al. (2012), who observe that a large proportion of UK patients lie or withhold information from gender identity specialists.

Therefore, while UK gender clinics have changed many of their policies and practices over the past two decades, many individual practitioners and some clinical policies continue to frame "transgender" as "the effect to be explained" (Ansara & Hegarty, 2012: 141). As a result, treatment cannot simply be expected: instead, patients feel that they must make a case for their gender identity. It is from this that the discourse of difficulty arises, as a form of strategic futurity through which patients draw on communally-mediated narratives of the past in order to plan a swifter transition to their desired future. This is also why the discourse of difficulty arises *in spite of* the pervasiveness of positive experiences, as well as the common hope of accessing care (as seen in Aiden's excitement). The discourse of difficulty perpetuates fear and concern amongst patients early in the transition process, but also enables them to prepare. As a trans temporality – an emotional and material engagement with intersecting pasts, presents and futures – the time of anticipation sees trans patients engage with multiple possible futures and past/present narratives simultaneously. In this way, patient perspectives on the probability of accessing treatment intersect with grounded worries about passing the 'trans enough' test.

The possibility of joy: a discourse of hope

I now return to the post written by Aiden ahead of his first appointment with the gender clinic. As previously noted, he is not simply 'bricking it'; he is also looking forward to the appointment:

'Exciting too though...' (Aiden)

For trans patients seeking to transition physically, this excitement is another important element of the time of anticipation. With transition being such an important step for

these trans patients, the treatment pathway is tied to a discourse of hope. This defines the waiting period as much as mistrust and difficulty, as a part of the waiting time's wider field of uncertainty. In looking forward with hope, trans patients anticipate a future in which they are transitioning, as well as a 'joyful' future (Horak, 2014) in which they have transitioned; a future that becomes possible through positive narratives about the treatment pathway as much as more strategic approaches.

The anticipatory element of the discourse of hope is a community-mediated affair in a similar manner to mistrust and the discourse of difficulty. For example, Aiden's post ahead of his first appointment is just one part of a substantial forum thread themed around experiences at a particular gender clinic. Aiden joins others not just in gathering resources and sharing information that will help with their assessments, but also in sharing accounts of hopeful anticipation. Together they discuss plans for their respective journeys to the clinic and talk about which practitioners they will see. Within conversations such as this, participants use words such as 'thrilled' and 'happy' as well as 'excited' to describe how they are looking forward to their appointment.

The hope evidenced within such conversations can also be linked to the end of a particular 'limbo' period of waiting (Bradley & Myserscough, 2015), one that is particularly defined by uncertainty. In one thread, Aiden swaps appointment dates with another forum user, commenting, 'Yay us'. In this expression of joy, we see the anticipated end of waiting time, with its transitional uncertainties (Carter, 2013) to be replaced with the more linear temporal progress of hormone time. Horak (2014: 579) ties the beginning of hormone time to the 'first shot of testosterone or HRT pills': this can be compared to the implicit countdown *towards* that first shot or packet of pills in Aiden's conversation, as the anticipated day of diagnosis draws closer.

In Forum 1 a number of users embed countdown timers into 'signatures' that append all of their posts. These timers take the form of images that change every day (and in some cases, every hour or minute) in order to count down towards a set time, such as a gender clinic appointment or surgery date. This serves to emphasise that point in time as a temporal lynchpin, a focus for the user's time of anticipation. It positions the time of appointment as concrete, firm, a point of fixity within a temporal realm of uncertainty and disjuncture: something that the user can look forward to without the doubt or concern that attends other aspects of transition. Notably, no such countdown timers are ever used for the day on which patients begin hormone replacement therapy, as this date is usually unknown due to the uncertainty of administrative delays in arranging a prescription.

Many participants acquired hope over time, as a possible future became a viable conceptual 'reality' for them through community support. Upon arrival within community forums, many individuals lament the difficulty of their situation. They ask more established forum users if their trans/gendered feelings are valid, whether or not they can access treatment, and how this might happen. New arrivals are often particularly distressed, and write about the intense emotional pain that accompanies the uncertainty they feel. If they remain active within community spaces, these individuals become more familiar with the structure of the available treatment pathway(s), and orient themselves towards a future framed around this. Some more confident new arrivals have already reached this latter stage, and typically include an explanation regarding where they are on the pathway (e.g. awaiting an initial appointment, just starting hormones, awaiting surgery) when introducing themselves.

Similarly, participants typically gain confidence in themselves and in the concreteness of their projected 'better' future as transition progresses, and possibility turns into reality. Entering hormone time is a significant aspect of this, as the uncertain transitional futurity of waiting for diagnosis and a prescription is replaced with the grounded certainty of a physical transition that is definitely underway. For instance, during his initial assessment appointments, Sam demonstrates a similar sense of hope to Aiden, tempered with concerns about passing the 'test' of diagnosis.

[The practitioner at the gender clinic] asked how sure I was I wanted treatment - but didn't actually offer it I noted! He said it's mostly down to me as to how I wanted it to play it. Do I really have to 'beg' for this treatment? (Sam)

A few months later, he describes his delight after receiving his first testosterone shot.

Feeling a lot more confident in myself and a lot happier!! (Sam)

Sam's joy is grounded not simply in the initial physical changes and biochemical rush of hormone administration, but also in the certainty of hormone time. The shift in Sam's posts – away from a discourse of difficulty, towards a discourse of hope – provide a sense of possibility to other community members. Sam's story provides evidence that waiting does not last for ever, that practitioners can perhaps be trusted to provide treatment, and that difficulty can be overcome.

As Hines (2007) notes, a number of trans people continue to remain active in community spaces after their own journey along the transition pathway is over. This enables them to more actively counter concerns about the transition process with

positive stories. For instance, in response to the aforementioned 'Charing Cross myth' that practitioners play 'Good Cop/Bad Cop', Alan states:

As a patient at Charing Cross, I can confirm that many of these are of course myths. The two gentlemen I have had appointments with played a game of *Good Cop/Good Cop* in my opinion. (Alan, emphasis mine)

On another occasion, Ellie details how sad she is to bid farewell to the staff at the gender clinic she attended, stating how grateful she is for their support. She concludes:

It's been an amazing journey and I'm so happy that I made it. (Ellie)

These accounts work to counteract some of the narratives of mistrust and difficulty that are very much present within the same spaces, demonstrating a different means by which collective pasts and overlapping presents can be used to construct an individual's possible future. They offer a basis for the kind of excitement, thrill and happiness expressed by individuals such as Aiden in anticipating assessment appointments, as an 'opening or horizon' (Muñoz, 2007) through which patients can see themselves accessing treatment and being treated well by practitioners. Moreover, these accounts provide a model by which transitioning patients can foresee that they will not be caught forever within the temporally-mediated emotional uncertainty of transitional time and the long wait. It is through this means, as well as through strategic futurities, that the time of anticipation can be used to 'build a politics of hopefulness' (Bradley & Myerscough, 2015).

Circumventing the time of anticipation: private treatment and self-medication

For some transitioning participants, the discourse of hope is not sufficient to assuage their mistrust of gender clinics and/or the emotional demands of waiting. There are two alternatives to the public health pathway: private clinics, and self-medication. Those who access these alternative resources seek to escape at least some of the temporal disjuncture and uncertainty associated with publicly-funded services.

Forum participants contemplating transition are often recommended to 'go private' if they can afford it. While explicit praise for the NHS as an institution is common within these spaces, and the discourse of hope offers the possibility of a better future, the private route is typically portrayed as easier, faster and more flexible. This perspective is summarised powerfully within a document produced for the NHS by

young trans people working with the charity group Gendered Intelligence. In a table comparing the respective ‘pros and cons’ of NHS and private treatment, the following ‘pros’ were offered for each category:

NHS

- It’s free.

Private

- Will not have to wait long for the treatment.
- You have more choice over timescales and treatment options.
- You have a choice of surgeon if you choose to have surgery.
- You will be treated with respect.

(Document: NHS & Department of Health, *A guide for young trans people in the UK*, April 2007)

The document quoted above is now almost a decade old, and not entirely accurate (e.g. some gender clinics provide patients with multiple surgery options) but it is important in that it codifies a discourse common within many trans spaces to this day. The only ‘pro’ specific to transitioning on the NHS within this discourse is that it is free at point of use: in all other ways, private treatment is regarded as superior. Most notably, ‘[w]ill not have to wait long’ and ‘[y]ou will be treated with respect’ are portrayed as a *specific* property of private providers, in contrast to NHS gender clinics.

In the narrative below, Ben offers a typical rationale for taking the private route.

From my reading of the web plus various NHS websites and other people's experiences on the forums it looked like there would be a minimum wait of around a year (if you were fortunate with your GP) to be referred to local psych then gender psych then GIC then to be told that I had to have changed my name and done RLE and then come back 3 months later (minimum) before T⁷¹ would even be prescribed made me feel anxious and also (if I am honest) resentful that someone else could make all these decisions for me. It was these worries that made me opt for the private route. (Ben)

In Ben’s account, we can see anticipatory concerns regarding the *time* it takes to prepare for transition (incorporating RLE as well as the various referrals and waiting lists), alongside an everyday mistrust of health professionals (being ‘lucky with your GP’ to gain a referral) and a rejection of conditional models of trans possibility

⁷¹ ‘T’ is often used to refer to testosterone within ‘female to male’ spaces.

(‘resentful that someone else could make all these decisions for me’). In a separate post, Ben also invokes the discourse of difficulty, stating that he was ‘worried’ about being assessed for treatment through the NHS ‘in case I wasn’t “trans enough”’. Notably, Ben is *himself* a health professional, and states on a number of occasions that he is proud to work for the NHS. His mistrust is rooted in community discourses of *trans* health, and specific concerns regarding the operation of gender identity services.

The sense that private services are faster, more flexible and more focused on ‘respect’ than NHS gender clinics persists within the community and activist spheres. This is the case even as two of the four clinics – Gender Care in London, and Gender Dysphoria Clinic & Treatments Edinburgh – are run by individuals who do or have also worked as gender identity specialists within the public sector. This suggests that the ‘respect’ patients seek can be found in the private *pathway* process at least as much as in the attitude of individual practitioners, with these pathways offering an alternative to some of the institutional issues and anticipatory uncertainties associated with NHS clinics. While all private practitioners claim to operate within the bounds of the WPATH *Standards of Care* with their built-in waiting times, patients can at least expect to know when they will be seen, and can generally also expect to access hormone therapy a lot more quickly. The private pathways therefore offer a more predictable route characterised less by temporal disjuncture, and more by the linear futurity of hormone time.

While Gender Care in particular was discussed relatively often and always spoken of positively, the most popular private provider amongst participants in this research was Transhealth. The name ‘Dr Curtis’ is widely known and heavily associated with a more liberal form of care that centres informed consent rather than placing the burden of proof upon trans patients, a factor that is sometimes linked by participants to Curtis’ own background as a trans man. Transhealth patients such as Ben feel more confident that the possible future of transition will eventually manifest, and within a predictable time frame too. They are less worried about encountering cisgenderism or transphobia from Curtis, or having to prove themselves ‘trans enough’. When Curtis faced investigation from the GMC in 2011, a considerable number of participants expressed concern about the future for his model of treatment, which was seen as providing a vital alternative *philosophy* as much as a competing service. It is for this reason that media reports on the investigation provided a catalyst for #transdocfail in 2013.

Private services are not available to all, even as some participants from low income backgrounds describe going to great lengths to afford appointments at Gender Care or

Transhealth. It is for this reason that Davy (2010: 123) describes the experiences of transitioning patients as 'situated within a class system'. Some individuals therefore instead seek to self-medicate through the help of friends and/or online purchases from overseas pharmacies.

The legality and safety of self-medication is greatly contested within trans spaces; promoting the practice is considered bad form in Forum 1, and is explicitly against the rules within Forum 2. However, this did not prevent a number of participants in both forums discussing their decision to self-medicate, usually out of self-professed 'frustration' or 'desperation'. These participants see self-medication as an opportunity to take matters into their own hands, gaining some sense of control over the time of anticipation through invoking the more linear temporality of hormone time (Horak, 2014), while avoiding the need to prove themselves 'trans enough'.

Both private clinics and self-medication are frequently regarded as options to take *alongside* the NHS route, rather than as an alternative to it.

Many of us do start things off by self medding - I did because when I looked at the report from my 2nd Assessment I thought Charing Cross were about to start dithering. (Ellie)

Participants such as Ellie seek to circumvent the emotional and temporal uncertainty of treatment on the NHS by starting on hormones within the approval of a gender clinic. They are not committed to permanently undertaking private or 'DIY' treatment, and instead prefer to access public healthcare services; however, the financial costs of private treatment and/or the possible risk of self-medication are typically regarded as preferable to the uncertainty of waiting.

The private treatment route and self-medication therefore offer people aiming to transition an alternative means to manage the time of anticipation. Patients taking these approaches can still expect to wait: for the physical and mental changes that accompany hormone therapy, for additional services such as surgeries, and even for an NHS diagnosis that enables them to shift from one means of managing transition to another. However, the additional certainty granted through greater personal control over the timing of hormone therapy made people feel considerably more in control over their lives, enabling them to thrive within the more predictable context of hormone time (Horak, 2014).

Suicide, and the collapse of possible futures

Private treatment and self-medication offer one form of escape from uncertainty and the liminality of temporal 'limbo' (Bradley & Myerscough, 2015). Both approaches offer maintenance of hope, and the continued 'opening' of future possibility as described by Muñoz (2007). But what of individuals who not have the financial or social capital to access private care or self-medication, who see no opening, no way forward?

The shadow of suicide lies heavy across trans communities. A majority of trans people in the UK have considered killing themselves, with approximately one in three attempting suicide at least once (Whittle et al., 2007; McNeil et al., 2012). Participants from across the community and activist spheres indicated that they had considered and/or attempted suicide, or that their friends had killed themselves or attempted to do so. It is not within the scope of this research to unpack the many social and individual causes of trans suicide. Instead, through this analysis I link suicide to the collapse of trans futurities in the specific context of healthcare provision. While I continue to draw on data from the two forums visited during fieldwork, I will not be quoting directly from the community sphere out of respect for the sensitivity of conversations that took place.

A number of participants describe the 'choice' between transition and suicide. Such accounts link suicidal feelings to the hopelessness of life in the participants' assigned genders. They feel constrained and unable to express themselves, and imagine that these desperate and frustrating feelings will continue for the rest of their lives. This is a future without a future, bereft of fulfilment and happiness. By contrast, transition offers a way out: an 'opening or horizon' (Muñoz, 2007). Participants who describe the choice to transition in terms of a move *away* from suicide typically narrate an emotional journey in which the decision to transition offers them a newfound resolve and sense of purpose: a meaningful futurity. In this way, transition provides the possibility of a fulfilling, happy future that can be imagined as *attainable*. Narratives such as this inform a number of media articles written by trans people in the wake of #transdocfail.

[Trans] people consider transitioning well worth [doing] because in some cases the alternative is suicide. (Media article: Charlie Hallam, *As the #transdocfail hashtag showed, many trans people are afraid of their doctors*, The New Statesman, 09/01/13)

This idea of a 'choice' between transition and suicide is also indicated by McNeil et al. (2012: 59), who state that a majority of survey respondents were 'thinking about or attempting suicide more before they transitioned' than after. This indicates a link between transition and suicide reduction, reflecting the authors' wider findings on the benefits of transition for the mental health of trans patients. Conversely, delays and problems within transition can be linked to increased suicide ideation and suicide attempts. McNeil et al. (2012: 59) noted a 7% *rise* in suicide ideation and attempts during transition, even as suicide prevalence falls post-transition in comparison to pre-transition levels. Belcher (2014) noted that two of her survey respondents attempted suicide as a result of their treatment by health professionals.

Participants in this project describe suicidal feelings most often on encountering obstacles to transition. These usually include waits of an uncertain length, health professionals who delay or refuse treatment, and gender clinic appointments where requirements made of patients are opaque, confusing or otherwise difficult. All of these are factors that might prevent access to hormone therapy and/or other physical interventions such as surgery. There was also one case in which a very distressed patient expressed suicidal feelings after surgery upon experiencing unhelpful follow-up care. In each instance, the obstacle in the pathway works to disrupt the trans patient's passage from past to future and erode their sense of agency. In the below narrative from #transdocfail, a trans patient describes how they became suicidal after being refused a referral for gender identity services by their GP on multiple occasions over a three year period.

I went to my GP and asked to be referred. Waited a few months and asked again told they were looking into it. Repeat. Three years later was told it was not available. Became suicidal and was told others are much worse off than you. (TransDocFailAnon)⁷²

This story shows how waiting times can be extended over an indeterminate and unpredictable period, causing transition (which in this case has not yet begun) to become a future that is never quite realised, within a temporal space that stretches ever wider. In this way, the 'joyful' future of hormone time (Horak, 2014: 581) becomes unattainable as the patient is instead caught – seemingly forever, as there is no apparent end to the delay – within the time of anticipation.

⁷² For this quote I have joined two linked tweets for ease of reading. None of the content has been altered.

The future can appear similarly unattainable to participants who do not at first ‘pass the test’ set by gatekeepers at the gender clinic. For participants in this project, reasons for being (initially) denied hormones included: concurrent or comorbid mental health problems, a failure to meet the sometimes binarist or racist expectations of practitioners, a failure to hold down work or a volunteering position, and/or a failure to inform family members of their intention to transition (in one instance, a patient in his late 40s was chastised by a gender identity specialist for not having immediately come out to his mother). This can lead to suicide ideation amongst the most vulnerable. McNeil et al. (2012) report similar findings. One of their participants states, ‘if they had refused me hormones and surgery, I would probably have committed suicide’ (34), while another reports that ‘NHS refusals [led] to failed suicide’ (55). In these examples, an anticipated future has effectively been denied, and there is typically no indication of when the continued waiting time might end. I have previously quoted Bradley & Myerscough’s (2015) poetic description of trans subjectivities within the time of anticipation as ‘orientated towards the future like iron filings lining themselves up towards a magnet’; in an extension of this metaphor, suicide can be understood as a reaction to the removal of that magnet, leaving no focal point for the projection of an optimistic trans futurity.

Participant experiences of suicide ideation further demonstrate the importance of anticipation to trans patients and their communities. For participants who consider suicide, the possibility of a transitioned future can offer an alternative.

Former GP told me to pull myself together and stop wasting his time[.]
Wasted ten years of my life in and out of depression. Became suicidal. Went
to Dr Curtis. (Christabel Edwards)⁷³

The time of anticipation might be frustrating and difficult, but within this temporal frame a possible future is always invoked. Participants such as Christabel who find a way to re-enter the time of anticipation (such as through private care) are capable of moving out of the shadow of suicide. This is, however, a fragile futurity: one that can be shattered through the repeated denial of treatment, or through waits that stretch into a seemingly infinite temporal distance.

⁷³ For this quote I have joined two linked tweets for ease of reading. None of the content has been altered, aside from the indicated insertion of a full stop.

In which I continue to wait (a contingent conclusion)

At the time of writing, I am waiting for an appointment at the nearest gender clinic, where I seek a referral for laser hair removal. I do not know how long I will be waiting; only that I have been added to the gender clinic's waiting list. I have been waiting for some months, following a referral from my new GP, who turned out to be exceptionally helpful. Given my unusual relationship with the new care pathway, I still do not know how easily I will obtain funding for hair removal from NHS England or a referral for this from the gender clinic. This future is bound up in uncertainty.

Some of the concerns I held in advance of seeking a referral for hair removal – concerns shaped by the overlapping pasts and presents of others as well as myself – are reflected in my current circumstances. I am waiting, and this wait is taking place because of the inflexibility that resulted in my referral to the gender clinic, rather than directly to a laser clinic. My experience as a trans patient is inherently bound up in the temporal and emotional disjuncture of waiting time, oriented towards a future that I am sure will come, but I am not sure *when*. Even as a devout believer in the importance of public health, I would be tempted by the prospect of paying for hair removal privately, if I could but afford it. Like the participants in this project, I anticipate, but do not know when the time of anticipation will end. This is not (yet) a linear path equivalent to hormone time (Horak, 2014), a futurity fixed through appointment and prescription: instead my experience of seeking hair removal can be understood within the frame of transitional time (Carter, 2013), moving backwards, sideways and tangentially even as I progress. Halberstam (2005) and Carter (2013) regard the movement-oriented fluidity of queer time and transitional time respectively as potentially liberating. However, this liberation comes only with agency: but agency is limited within the time of anticipation. For this reason, the more predictable temporality of hormone time (Horak, 2014) feels – to me – greatly preferable in this instance.

Other concerns I held in advance of my referral for hair removal are *not* reflected in my current circumstances. While my GP was broadly ignorant of trans health issues and the current treatment pathway, she was kind, considerate, and supportive. My mistrust ahead of meeting her arose not from any bad experiences at the practice where I am now registered, but from an anticipatory mistrust rooted in both my own negative experiences with my former GP, and in wider community discourse. I *know* that transphobia and cisgenderism are common; some level of mistrust feels like a

rational, strategic response that enables me to manage my future and reduce uncertainty.

Nevertheless, I look forward to the time I will no longer have to shave my face every day. The technological possibility of hair removal and the delivery of this service through the means of public health imbue me with a sense of possibility. This is not the all-encompassing hopeful futurity of many who anticipate transition, but it is a future that redefines my emotional experience of the present, offering 'not an end but an opening or horizon' (Muñoz, 2007: 364), thereby rendering my embodied transness more bearable and the wait less frustrating.

The purpose of this vignette is not to collapse the many stories present within this chapter into one easy narrative. After all, there are some key elements missing from my own story in this instance, such as the discourse of difficulty and the shadow of suicide. Moreover, there is not one trans health system or form of trans patient experience in the UK, but instead a repertoire of potential experiences shaped by geographical location, health professionals, medical institutions, community narratives and individual subjectivity. I have therefore sought to use my own account to instead demonstrate the everyday operation of trans temporalities in the context of the time of anticipation.

The time of anticipation is a queer time, heralded through disjuncture, liminality and futurity. This temporal frame sits at the nexus between agency and dis/empowerment, offering trans patients a range of discursive means to understand and manage their interactions with medical systems and health professionals. 'Time' in this sense is not an object but a context, mediated communally through the queer interaction of multiple pasts, presents and possible futures. Halberstam (2005) and Carter (2013) celebrate the disruptions of queer temporalities, but most participants in this project seek instead to find some kind of stability and predictability through which an escape from the time of anticipation might be imagined. In my own example, as in the examples of project participants throughout this chapter, possible futures come to define the present and past alike, with projected futures offering a means by which we can better cope with the demands of the present.

7

Changing Trans Health Negotiating credible knowledge

Okay, well it tells me here that you have a complaint about your arm. Why don't you tell me about yourself?

"Sorry, what?"

"Well my first memory must be from around when I was six..."

Figure 1: A Trip To The Clinic (a)

A Trip To The Clinic

You have seriously hurt your arm.

You seek help at the fracture clinic. Unfortunately, the doctor isn't simply interested in your arm. He wants to know a lot more, asking for seemingly irrelevant details from your childhood, and probing your emotional response to the accident. It seems that the burden of proof is on you, not simply to demonstrate that you have indeed broken your arm, but that you are also in a great deal of pain and therefore require immediate treatment. The doctor's questions are all asked in what seems to be a broadly disparaging manner. At one point, he insists that you tell him all about your sex life.

I feel I should tell you now that, in my notes, I've been writing "pain" in inverted commas. I'm just not yet convinced that you have actually experienced any pain.

"What?"

Figure 2: A Trip To The Clinic (b)

You see, there are certain symptoms we associate with pain. You come to pick them up with experience. Things like screaming, "in pain" as it were. Grasping at body parts. Writhing. Certain vocalisations, such as "it hurts!" and "the pain!" You just don't seem to be showing these signs. You understand my scepticism.

"Um, no, I don't. I'm telling you that I'm in pain. I'd appreciate if you'd respect that."

"Um, right, I see. Maybe it's not all that obvious. I'm sorry. I assure you though, it hurts."

Figure 3: *A Trip To The Clinic* (c)

The above narrative can be found in the short 'choose your own adventure' text-based browser game *A Trip To The Clinic*. It was released for free on the Internet by indie game creator Wojit in January 2013, in the immediate wake of #transdocfail.⁷⁴ The game, which was shared widely on trans and feminist blogs and in a range of social media spaces, is a very transparent satire of gender clinic appointments. In order to 'win' through gaining access to treatment, the player must present correct narrative to the doctor, and respond in a deferential manner to the doctor's requests. This can be done by clicking on the 'correct' response to questions where an option is available. For instance, in Figure 3 (above), the 'correct' response is the second of the two options highlighted in blue. A failure to provide enough 'correct' responses may result in the player character waiting longer for treatment (Figure 4), or being denied treatment altogether (Figure 5).

I see... Okay...

I believe I've heard enough. Now, I'm afraid I don't really understand the difference between some of these terms that you people use, like "hairline fracture," and "greenstick fracture," but I should be able to communicate my judgment in terms we'll both understand.

Though I have some reservations, it's clear that your arm is causing you real problems. However, the way we work here is to have each patient evaluated by two doctors, so you'll have to see Dr. Bradley or Dr. Wildman. The receptionist should be able to get you an appointment within five months. Good luck.

"Oh, I... Thanks Doctor."

Figure 4: *A Trip To The Clinic* (d)

⁷⁴ You can play *A Trip To The Clinic* here:
<http://aliendovecote.com/uploads/twine/others/chaosjam/Clinic.html>

I see... Okay...

I believe I've heard enough. Now, I'm afraid I don't really understand the difference between some of these terms that you people use, like "hairline fracture," and "greenstick fracture," but I should be able to communicate my judgment in terms we'll both understand.

Frankly, I don't see any strong reason to refer you on for fracture treatment. I understand that you believe that this is the right course for you, but I'm just not convinced that you've really thought things through, or looked at all your options. If you'd like, I'd be happy to refer to you to a psychologist.

"... Right, thanks."

Figure 5: *A Trip To The Clinic* (e)

A Trip To The Clinic reflects and feeds into prominent discourses of trans health present within trans community and activist spaces. Firstly, it addresses the fundamental differences of *definition* and *understanding* that can sometimes exist between practitioner and patient, as discussed in Chapter 5, *(Re)defining Trans*. In particular, the game can be said to depict a discursive conflict arising from varying understandings of trans possibility and reality in the context of patient experience and medical practice, resulting in a burden of proof being placed on the patient by medical gatekeepers to prove that they are 'trans enough'. Secondly, it both reflects and constitutes an element of the of communally-mediated temporality of *anticipation* – as discussed in the previous chapter – through reproducing and informing mistrust of health professionals, and a discourse of difficulty that arises from the aforementioned gatekeeping practices.

This chapter examines a third, related aspect of *A Trip To The Clinic*: it can be seen as a means to communicate and hence reproduce trans knowledges and critiques of the aforementioned issues, thereby challenging the conditions under which these issues arise. Such challenges are not simply a matter of seeking to change policy and practice amongst healthcare providers, although this is typically the ultimate aim. I have shown that existing policies and practices are most often embedded deeply in cisgenderist assumptions and/or discourses of trans as condition. Bringing about change therefore requires an attempted shift in the epistemic status of *alternative* trans knowledges – knowledges grounded instead in understandings of trans as movement and/or a gender pluralist (Monro, 2005; 2007) approach – through seeking to render such

knowledges *credible*. Here, I follow Stephen Epstein (1996: 3) in using ‘credibility’ to describe ‘the capacity of claim-makers to enroll supporters behind their arguments, legitimate those arguments as authoritative knowledge, and present themselves as the sort of people who can voice the truth’. I shall show that *A Trip To The Clinic* operates as one small part of a great network of interventions by which patient advocates can render their alternative knowledges and truths credible through mutual recognition and iterative repetition.

By ‘trans knowledges’, I refer to discourses of trans possibility constructed in and through trans people’s communities, activisms and academic work. Interventions such as *A Trip To The Clinic* represent both an individual act of education and a wider play in the ‘epistemic politics’ (Hess, 2004) of expertise. Through a myriad of such interventions within social media as well as through traditional media platforms, professional networks and radical activism, trans patient advocates can work to *recognise* one another’s stories and ideas – thereby reinforcing their claims to knowledge and truth – and *repeat* them through continued dissemination. This has the effect of increasing the discursive weight and reach of patient knowledges.

In this account I continue to position the ‘reality’ of trans health as a social construct, a ‘field of intelligibility’ (Steinberg, 2015a: 153) that is linked to the mediation of discourse and the operation of power. As such, discursive clashes on the *macro* level between patient and professional knowledges and understandings – that is, clashes at the level of collective politics rather than the individual clinical encounters discussed in Chapters 5 and 6 – must be resolved through gradual *negotiation* of the respective discourses’ epistemic status. I describe this as a constant, ongoing process ‘without rest’ (Pereira, forthcoming).

I begin this chapter with a brief look at how the epistemic politics of trans knowledge might be understood in the context of insights from other patient activists. I show how the trans patient body might be collectively understood as an ‘epistemic community’ (Haas, 1992; Akrich, 2010), in which mutual education and the rise of ‘activist-experts’ (Epstein, 1996) heralds a change ‘in the epistemic status of the patient’ (Hess, 2004: 697). I then turn to evidence from the activist sphere to show how trans people have sought to make patient knowledges credible through mutual recognition and iterative repetition. Examples in this discussion include knowledges communicated through personal or individual interventions – such as contributions to #transdocfail – plus forms of journalistic, health-oriented professional and activist intervention. Finally, I look in depth at how the promotion of patient knowledges can

require negotiation between these positions and entrenched professional discourses and practices. I do so with reference to two case studies: the depathologisation movement, and the non-binary movement.

This chapter therefore focuses on how the communally-mediated discourses that inform individual clinical encounters can also influence trans patients' *collective* encounters with medical practice on an institutional level. In this context, 'patienthood' may be regarded as a 'field of contention', as well as a basis for 'experiment[s] in power-sharing' (Landzelius, 2006: 536).

Establishing credibility: the epistemic politics of trans health

Since the emergence of the trans social movement in the 1990s, trans patient groups in the UK have sought to change the landscape of healthcare provision, particularly in the context of gender identity services. Persistent concerns have included the long waiting times and strict management of patients associated with the gender clinics, as well as the high prevalence of cisgenderism and transphobia within wider health services (Burns, 2006; Davy, 2011; Women and Equalities Committee, 2016). In many senses this has been quite an isolated struggle, with few formal links existing between trans patient activists and other patient movements. Nevertheless, a number of the tactics by which trans patients have pushed for change resemble those pioneered within other patient movements.

Stephen Epstein's (1996) account of the AIDS movement in the United States shows how a complex and multifaceted range of interventions from various patient groups came to influence the operation of medical science. AIDS activists involved in these interventions sought to challenge policies, practices and/or the provision of services in a range of contexts, including medical school curricula, clinical trials and the development of potential cures. The aims and tactics of different activist groups varied considerably, but their actions generally reflected a distrust of traditional medical experts and shared an urgency that reflected the scale of the epidemic. Many of these activists therefore sought to establish *themselves* as credible authorities on matters of medical research and care, leading to a large-scale 'conversion of [people] from 'disease "victims"' to 'activist-experts' (Epstein, 1996: 8).

One of the many issues addressed by early AIDS activism was that of perceived paternalism on the part of medical institutions. A number of individuals and groups argued that traditional medical approaches worked to undermine patient agency.

Activists [...] would exert a demand for greater patient autonomy by challenging medical authority from two directions at once. On one hand, they would insist that patients interested in trying experimental drugs should have the right to assume risks rather than endure the benevolent protection of authorities. On the other hand, they would criticize certain approved and accepted research methods, like trials in which some patients received placebos, characterizing them as unethical for subjecting patients to unfair risks that the patients *did not* want to assume. (Epstein, 1996: 190, emphasis in original)

Numerous trans activists similarly argue that gender clinic policies and practices need to reconsider the role of consent in regards to their interactions with patients. In the below example, Michael Toze – a trans advocate and PhD student in Health and Social Care at the University of Lincoln – offers a nuanced assessment of how the gatekeeping system can work to deny patients the opportunity to take responsibility for their own care or offer properly informed consent.

Assessment procedures in clinics are not transparent and not consistent, and patients are aware of this through informal discussion. For example, Nottingham GIC recently sent new patients a form asking them what video games they play. It is not clear why this is relevant to their assessment or care, and if it is relevant, why other clinics are not asking. Some patients suspect this data was collected for a research study, although if so, no informed consent was sought [...].⁷⁵ Some clinics ask patients highly personal questions about sex; some ask if patients have gay relatives; some have refused treatment for people who are full-time carers and hence unable to work. Other clinics do none of these things. Because clinics control access to treatment, patients do not feel empowered to challenge being asked irrelevant and highly personal questions, or having judgements made about their lives. (Letter: Michael Toze, *Written Evidence submitted by Michael Toze to the Inquiry into Transgender Equality*, data.parliament.uk, 17/07/15)

⁷⁵ The findings of this study featured in a poster presentation at the 2016 WPATH Symposium. The abstract for the poster states that: '[o]ne hundred trans people attending the Nottingham Center for Gender Dysphoria were invited to complete the Video Gaming Questionnaire as well as a battery of questionnaires measuring levels of psychopathology, including depression and anxiety' (Arcelus et al., 2016). During the latter stages of supplementary data collection I encountered a number of trans patients at Nottingham echoing Toze's claim that the gender clinic did not adequately seek informed consent. These patients felt that they were required to complete the questionnaire as part of the clinic's registration process.

Toze describes his submission as written ‘in a personal capacity’ in spite of his stated role ‘undertaking PhD research on LGBT health’. However, even as he contributes to the inquiry explicitly as a trans man – and hence as a service user, or ‘patient’ – he draws on an extended and sophisticated knowledge of the UK’s medico-legal landscape in crafting his response to the *Transgender Equality Inquiry*. Moreover, Toze’s submission is structured like a formal report, with an ‘executive summary’ at its head and his recommendations broken into clearly titled sections and numbered points. Toze was later quoted and cited repeatedly in the eventual report produced as part of the inquiry (Women and Equalities Committee, 2016: 37, 44, 48, 61, 62). In this way, he successfully asserts himself as an ‘activist-expert’ (Epstein, 1996: 8), drawing upon established professional norms of communication to establish his credibility.

In the rise of the kind of ‘counter-expertise’ exemplified by Toze, David Hess (2004: 697) identifies ‘a historic change in the epistemic status of the patient’. Hess argues that this has resulted in wider changes to medical professions and associated research communities. In the context of trans health, this assertion is reflected in the claim that a paradigm shift has taken (or is taking) place amongst gender identity specialists (Bockting, 2009a; Nieder et al., 2016). Hanssmann (2016: 124-125) argues that ideological changes *within* gender identity services are being driven by ‘insider-providers’ – practitioners who are themselves trans – as well as patients, ‘lawyers, and activists [who] increasingly shape policies and protocols’. Hess (2004: 703) describes interventions by insider-providers as the ‘direct form’ by which medical science might be shaped. Toze’s contribution as a patient and activist is an ‘indirect form’ of intervention, sitting amongst ‘contributions to the media or to engagement with the policy process and funding decisions’ by members of a social movement or advocacy group ‘who have developed the appropriate literacy to engage the policy and funding communities’ (Hess, 2004: 703).

This chapter focuses primarily on the *collective* role of trans people from different backgrounds and within different arenas who engage in both ‘direct’ and ‘indirect’ forms of ‘activist-expert’ intervention. Drawing on Madelein Akrich’s (2010) account of health-oriented activist mobilisations on the Internet, I regard the diffuse network of trans patients engaging in this kind of activism as a lay ‘epistemic community’: that is, a collection of individuals and groups amongst whom complementary forms of knowledge and expertise circulate. The term ‘epistemic community’ was originally coined by Peter Haas (1992) in order to describe specifically *professional* networks who draw upon a shared knowledge base to shape public policy. In this sense, the

specialists who work within NHS gender clinics might be said to comprise an epistemic community. Akrich (2010) argues that the extensive epistemic work done by health activists within online communities – through sharing personal stories, collecting and disseminating personal *and* scientific evidence, and presenting cases for change to authoritative bodies – means that they are effectively a lay body performing a similar epistemic function to a professional body. However, it is the professional communities that typically wield authority on the basis of their knowledge. This means that lay epistemic communities:

have no hegemonic position in the elaboration of public policies. On the contrary, they appear as opposing forces facing professional epistemic communities and reopen the range of possibilities, which professionals tended to limit and keep under their control. (Akrich, 2010: 11.1)

The body of this chapter therefore explores how epistemic communities comprised of trans patients and their advocates might challenge professional authority. I show that a range of tactics are employed to this end within a variety of contexts. Activist-experts (Epstein, 1996) and insider-providers (Hanssmann, 2016) can both play a key role; however, I argue that the specifically *trans* knowledges from which they draw are emerge ultimately from the (initially) non-authoritative, everyday ‘expert’ knowledges that circulate within trans spaces on the Internet.

Recognition and repetition: promoting patient knowledges

Trans patient advocates frequently differ from one another philosophically, politically and in terms of their tactics for bringing about change. However, in spite of the differences that are articulated (particularly) within the community sphere, a number of goals are quite consistently outlined across the activist sphere. These include seeking to reduce cisgenderism and transphobia within medical settings, reduce waiting times, and reform the adversarial gatekeeping relationship satirised in *A Trip To The Clinic*. Achieving these goals requires trans knowledges to be recognised as credible beyond trans spaces. This can be difficult given the institutionalised expertise and authority of health professionals in the realm of trans health (Davy, 2011), and the historic silencing of trans academics within the professional sphere (Stryker, 2005).

With reference to the work of Althusser and Butler, Mary Bunch (2013) describes how trans patients can be interpellated as ‘unbecoming’ subjects by normative medical

and social discourses. Unbecoming is in this sense a failure to meet, *or* an exceeding of, 'the standards of normalcy' as defined within 'the law' (that is, the disciplinary operation of social norms) (Bunch, 2013: 41). All trans subjects are rendered unbecoming by social norms in the UK; however, some are interpellated as *particularly* unbecoming within gender clinics and beyond, including non-binary individuals, trans people marginalised for their profession (e.g. carers or sex workers) and/or people marginalised on axes of (dis)ability, class/income, race or sexuality. While unbecoming is immensely risky, it can also lead to the possibility of change:

If subjects do not believe in the law, even despite its recourse to violence, the law may be shaken to its very foundation. Indeed, the fundamental instability of the law's foundation – its fiction – is unmasked and a space for change is opened. (Bunch, 2013: 53)

Like Butler (1990; 1993), Bunch (2013: 39) ultimately locates the potential transformation of oppressive social conditions in 'the subject's deconstructive relation to the law'. She argues that the oppositional performativity of unbecoming can operate to interpellate both the unbecoming subject and social change as possible. In this way, 'the "un" of unbecoming does not signify purely negative abjection, but also a creative and transformative politics of becoming' (Bunch, 2013: 40).

In the discussion that follows, I consider how trans patients' 'deconstructive relation to the law' is constituted and the credibility of this position established through mutual recognition and iterative repetition. By this I mean: when trans patients explicitly state their deviance from 'the law' of normative social and clinical relations, the credibility of their position/perspective is bolstered if their alternative knowledge of trans health is 'seen' and reproduced *by other trans people* in a range of contexts. I explore four such contexts here: personal or individual interventions, interventions by journalists, interventions by professionals working in the arena of health, and interventions by activist groups. Negotiations of knowledge and meaning across these contexts ultimately intersect and influence one another, as patient advocates recognise the work of knowledge construction and meaning-making that takes place elsewhere. In addition to drawing on individual examples to illustrate the recognition and repetition of knowledges within these contexts, I use #transdocfail as a running example throughout the discussion.

Personal or individual interventions

There is a long history of trans people drawing on self-knowledge from gendered experience in order to negotiate access to medical interventions that might facilitate transition (Lester, forthcoming). Examples can be found in the work of Stone (1991), Meyerowitz (2002), Rubin (2003), Hines (2007) and Davy (2011). These interactions between practitioner and patient typically take place within the private realm of the consultation, or through other private means such as letter-writing. The data for this project revealed an increasing assertiveness on the part of patients within these private, clinical settings. This can be linked not only to the emergence of new understandings of trans possibility, but also to wider discursive shifts related to matters such as the role of ‘the patient’ in public health.

In recent years, the discourse of public health in the UK has shifted away from a prioritisation of medical authority and expertise, and towards more liberal notions of patient ‘choice’, patient ‘rights’ and ‘putting patients first’. While these ideas were prominently promoted by the New Labour government of the late 1990s and 2000s, they are perhaps best exemplified in more recent interventions such as the 2010-2015 Coalition Government’s publication *Equity and Excellence: Liberating the NHS*. This document promised that patients would be involved ‘fully in their own care’ on an individual level, stating that ‘the principle of “shared decision-making” would ‘become the norm’ (Department of Health, 2010: 13). This vision was rapidly undermined by extensive cuts to public spending and the extensive reorganisation of services (The Lancet, 2011), with the impact of these disproportionately falling on the most vulnerable (UCL Institute of Health Equity, 2012). Mental health services in particular have faced major funding issues (Layard et al., 2012). However, the *ideal* of patients’ involvement in their own care has retained considerable discursive capital. The increasing assertiveness of patients can also be linked to contemporaneous legal developments, including the implementation of the Sex Discrimination (Amendment of Legislation) Regulations 2008 and the Equality Act 2010. Participants frequently discussed appeals to such legislation and to patient ‘choice’ and ‘rights’ in contesting health professionals’ decisions and power differentials between service providers and patients, particularly as time went on.

Glasgow currently have a patient who has highly intellectualised the gender issues, he is biological male and in between somewhere [sic]. No evidence [base] to treat it, but knows he [has] rights and how he can be treated. (Document: G3 - Gender Governance Group, *G3 Meeting Held on Wednesday 13th October 2010*)^{76,77}

[A] very long [Facebook] post explores [...] removing gendered titles from documentation for non-binary individuals [...]. [The post's author] hope[s] to potentially make an argument for the removal of gendered titles with reference to the Equality Act (and are asking others for advice with this). They ask if the Equality Act, Data Protection Act (1998) and Human Rights Act (1998) are useful/relevant to any such attempt. (Fieldwork diary: 15/04/13)

In a further development, the emergence of 'Web 2.0' social media platforms has enabled formerly personal, 'private' narratives to proliferate within *public* digital spaces (Pearce, 2010; Jenzen & Karl, 2014). In the past, trans community conversations around health (and related activism) in the UK took place largely within spaces with restricted memberships, such as web forums and mailing lists (Whittle, 2008; Gauthier & Chaudoir, 2004; Shapiro, 2004; Hines, 2007; Ekins & King, 2010). Political demands emerging from these conversations might then be disseminated by advocacy groups such as Liberty, the Gender Identity Research and Education Society (GIRES) or Press For Change (Davy, 2011; Burns, 2013). However, recent years have seen a shift towards the conversations *themselves* taking place more publicly within visible Internet spaces such as blogs (Pearce, 2012; Yeadon-Lee, 2016) as well as social media platforms such as Facebook, Twitter, Tumblr and Youtube (Horak, 2014; Jensen & Karl, 2014; Raun, 2015; 2016). This means that personal knowledges and trans realities with regards to health can be more easily asserted in a wider series of public settings. Such "underground" media-making' can be said to carry 'values and connotations of

⁷⁶ This document comprises the minutes of a meeting between representatives from a number of gender clinics. During the meeting, gender identity specialists raised issues they had encountered in order to seek help and advice from fellow professionals. The case of the apparently non-binary patient who 'knows [they have] rights' was raised in the context of a discussion about how gender clinics might respond to the requirements of the Equality Act 2010. It was eventually concluded that the 'Equality bill only mentions the male to female or female to male', an interpretation that has been contested by trans legal scholars (Whittle, 2016).

⁷⁷ The portrayal of non-binary, genderqueer or 'third gender' patients as demanding individuals who have 'highly intellectualised' their gender identity forms a trope across areas of the practitioner sphere. For instance, Barrett (2007: 43) states that: '[p]atients of this sort nearly all had rather cold, schizoid, personalities. They have tended to lack humour. Two have been fluent in psychological-sounding jargon[.]'

rebellious authenticity' (Hills, 2009: 115). The key instance of this within my data corpus is #transdocfail, in which hundreds of trans patients sought to raise awareness of inappropriate treatment within the public setting of Twitter.

#transdocfail was not an organised or particularly focused campaign. Instead, the hashtag tapped into a range of (sometimes contradictory) discourses already present within more private trans spaces. For instance, many contributors criticise how understandings of trans as condition can be imposed through gender clinic gatekeeping. Such interventions include accounts of gender norms being imposed through gatekeeping practices, but also included assertions about how care might be improved.

Gave GIC evidence for RLE for a year stating I was presenting as male despite also having a gender neutral title (on 3 items). Told I had to change to Mr or be discharged. (TransDocFailAnon)

if there was less #transdocfail, there'd be less nonbinary trans ppl⁷⁸ being coerced into inappropriate binary transition as only option (Liam)

Others, however, focus on access to gender identity services purely in terms of the impact of waiting time.

I've been in the system for 6 months. Moving to uni has reset the process and I'm not even on a waiting list for a GIC yet. (TransDocFailAnon)

The hashtag also addressed wider trans health issues as well as transition-specific care, with users sharing accounts of mistrust and of inappropriate treatment as discussed within previous chapters.

However, a unifying feature across the hashtag's approximately two thousand tweets is the promotion of personal trans knowledges and experiences as *credible*. This can be seen not simply in the assertive manner of the complaints, but also through retweets and sharing of the hashtag. In this way, patient advocates both trans and cis worked collectively to *recognise* and *repeat* individual stories, thereby imbuing them with a 'rebellious authenticity' (Hills, 2009: 115).

If you're interested in what the trans* community is up against, get an education and read #transdocfail (Claire)

⁷⁸ 'people'

Check out #transdocfail to discover how trans people are still treated by doctors in this day and age #enraged (Caroline Duffy)

The #TransDocFail is an object lesson in how stigma, discrimination and poor clinical behaviours can and do go hand in hand (Christine Burns)

The above examples are just three of a great many tweets directing the users' followers to read patient accounts on #transdocfail. Approximately a hundred people (cis and trans alike) shared the hashtag in this manner, sometimes to thousands of followers. Terms such as 'education' and 'lesson' highlight how trans knowledges are positioned as credible through the portrayal of patients as *educators*. The browser game *A Trip To The Clinic* can be understood as a part of this phenomenon. It was produced in the wake of initial interest in #transdocfail and then shared a number of times on the hashtag, operating as a sort of educational exercise for cis players as an insight into trans perspectives on treatment within gender identity services.

In this way, individual #transdocfail contributors sought to change the way in which trans health is discussed through *actively* juxtaposing the knowledges held by 'unbecoming subjects' (Bunch, 2013) with those held by traditional (medical) authorities. Twitter provided a platform for individual accounts to be collectively and mutually (re)constructed as credible, with these knowledges affirmed through iterative repetition in a public space. However, this sense of credibility does not automatically extend to the professional realm. For that, further interventions are required.⁷⁹

Interventions from journalists

The notion that expert trans knowledge can be drawn from personal experience is similarly asserted by trans *journalists*. I use the term 'journalist' here in reference to all individuals who work for media organisations⁸⁰ on a freelance or salaried basis. Media organisations afford journalists a platform from which to provide credible accounts of – or opinions on – current affairs. While the influence of the mainstream media has

⁷⁹ Whilst the analysis that follows focuses on alternatives to individual interventions, it is worth noting that #transdocfail provided an important precedent for public displays of outrage and demands for change on Twitter. This foreshadowed later, similar contributions to the #nhsgenderid hashtag, which was treated as a formal part of an NHS England consultation (NHS England, 2015a).

⁸⁰ Recent years have seen a break-down of the binary division between 'mainstream' and 'alternative' digital medias with the rise of citizen journalism and news/opinion blogs, and as mainstream media platforms increasingly make use of 'amateur' footage and insights in their reporting. An in-depth discussion of these complexities is beyond the scope of this thesis; therefore, my brief account of trans journalism focuses on individuals who build a living in full or part around working for media organisations.

arguably diminished in the Internet age, articles produced by established media organisations retain a high level of plausibility within the popular imagination (Fae, 2015), particularly in contrast to social media. Similarly, journalists retain a position of ‘professional power’ (Hills, 2009: 115). In writing from trans knowledge in the media, trans journalists are therefore able to imbue the personal expertise drawn upon in social media accounts with an additional *professional* authority.

Until recently, mainstream media articles about issues of interest to trans people were written rarely in the UK, and almost solely by cis journalists.⁸¹ This began to change during the late 2000s as newspapers and mainstream news websites increasingly commissioned pieces from freelance writers who were themselves trans. I attribute the growing role of trans journalists to the increasing presence of trans people in public life during the 2000s, which followed the initial emergence of the trans movement in the 1990s and the successes of early UK trans civil rights campaigns (Burns, 2013).

The emergence of trans journalists as a body of people⁸² is therefore a relatively new phenomenon. Trans journalists present within fieldwork for this project typically entered public life through activism, often within mainstream party politics or through involvement in campaigning groups such as Trans Media Watch. However, there were also a handful of career journalists who came out and/or transitioned ‘on the job’; an occurrence that is increasingly likely given the ongoing exponential growth in the visible trans population (Reed et al., 2009; Titman, 2014).

Trans journalists who write about issues of trans health can work to recognise and legitimate trans knowledges as credible in two distinct but interrelated ways. Firstly, trans journalists’ connections to the activist and community spheres mean that they are in a good position to amplify the voices of others, thereby extending the reach of trans knowledges on matters of health. This was certainly the case with #transdocfail, for instance: articles written about the hashtag by trans journalists⁸³ appeared in *The*

⁸¹ A similar situation in the US is described by Capuzza (2014).

⁸² As opposed to the occasional isolated individual, such as travel writer Jan Morris. Morris initially made her name in the 1950s with her exclusive on the first successful ascent of Mount Everest. She transitioned during the 1960s-70s, continuing her career during and after this time.

⁸³ #transdocfail coincided with a high-profile debate about freedom of speech in mainstream media. This debate originated in objections made on Twitter to the use of transphobic language by columnist Suzanne Moore following the publication of her article *Seeing Red* in the *New Statesman*. The heated series of discussions that followed on Twitter inspired a second article by Julie Burchill, writing for *The Observer*. Entitled *Transsexuals Should Cut It Out*, Burchill’s piece was written in an overtly inflammatory manner and attracted a considerable number of

Guardian, The Independent and the *New Statesman*, as well as on prominent LGBT news websites such as *Pink News* and *Gay Star News*. Secondly, the professional power of their role means that journalists' perspectives are imbued with an authoritative weight. In writing as *trans* journalists, these individuals therefore contribute to public discourse on trans health directly in a similar but more authoritative – and thereby credible – manner to trans people who discuss the same issues on social media.

Interventions from health-oriented professionals

A different form of professional authority is held by trans people who have established themselves as 'activist-experts' (Epstein, 1996), taking part in the contemporary production of research, policy and/or guidance both within the UK's public health setting and on an international stage. While I have noted in previous chapters that a (very) small number of such individuals play a 'direct' part in the epistemic politics of trans health (Hess, 2004) as inside-providers (Hanssmann, 2016), I focus here upon the wider body of trans people who play an *indirect* role through their involvement in other health-oriented professions.

An example of this can be found in trans people who gain employment as equalities experts, working either directly for the NHS or as private consultants. For instance, Christine Burns developed a career as an equalities specialist after making her name with trans activist group Press For Change. She worked with the Department of Health to commission a number of publications offering advice and guidance for practitioners and patients on the subject of trans health, and was later asked to produce an extensive guide for NHS managers and service commissioners (Burns, 2008). Burns also contributed to formal conversations around renewed clinical protocols and commissioning policies for NHS England following the implementation of the Health and Social Care Act 2012, and wrote extensively about these issues on her blog *Just Plain Sense*. In this way, her connection to the formal structures of the NHS offered an opportunity to pursue evolutionary discursive and policy-oriented change.

complaints, resulting in it being withdrawn from the newspaper's website with an apology from the editor. The affair attracted a great deal of attention from numerous other newspapers, websites and blogs from across the political spectrum. The level of coverage offered to the debate around Moore and Burchill's articles contrasted greatly with that of #transdocfail. Many cis editors and journalists commissioned and wrote articles about Moore, Burchill and the issue of free speech and offense; conversely, #transdocfail was reported on by a small number of trans journalists working largely for publications with a left-wing reputation. #transdocfail therefore held less interest for cis editors and journalists than the Moore/Burchill affair. I therefore conclude that articles on #transdocfail were published specifically due of the efforts of trans journalists who sought to raise awareness of the hashtag.

Burns played a part in the #transdocfail phenomenon through her equalities role. In addition to posting on the hashtag itself, she wrote a number of blog posts about #transdocfail, seeking to use her position to raise awareness of the hashtag and promote the narratives of trans patients. As with journalistic articles, these interventions represented both a recognition and a repetition of trans knowledges within a wider sphere. In this way, Burns was able to imbue knowledges that emerged from 'ordinary', individual trans people's accounts with a credibility afforded to her professional position.

Another example of the construction of health-oriented professional expertise as credible can be found in trans people who seek to join and change professional bodies from the 'inside'. For instance, Stephen Whittle (2016) – an academic specialising in law and also a former vice-president of Press For Change – describes how a small group of trans activists met in London in 2005 to plan a 'take over' of WPATH. In 2007, Whittle became the first trans president of the association. Together with other trans professionals in the organisation, Whittle played a role in revising the WPATH *Standards of Care*. This ensured the inclusion of concepts associated with trans as movement – such as the possibility of non-binary gender – within the Version 7 of the document. In bringing about this change, professionals such as Whittle drew upon trans discourses that had developed over many years within online spaces (such as those discussed in Whittle, 1998).

In this way, health-oriented professionals such as Burns and Whittle work to redirect narratives and resources alike, drawing upon ideas that have emerged from lay epistemic communities in order to push for change within the discursive and material landscapes of trans health. While such individuals frequently struggle to be heard within their respective fields, their role within the professional realm means that their individual failure to 'believe in the law' (Bunch, 2013: 53) – that is, by refusing to fully ascribe to pre-existing norms and expectations around trans health – can have profound consequences. Whittle's interventions in particular provided groundwork for the depathologisation and non-binary movements, which I discuss later in this chapter. Whereas the personal and journalistic reproduction of knowledge can be used to produce a somewhat credible *demand* for change, health-oriented professional expertise can occasionally couple this with the authority to more directly *implement* change.

Collective activist interventions

The promotion of trans knowledges through mutual recognition and iterative repetition can also be undertaken by activist groups. Such groups offer a means by which individual interventions might be more coherently harnessed for the purposes of negotiating discursive and material change. Forms of journalistic and health-oriented professional expertise frequently evolve from activist interventions: for example, Trans Media Watch members Helen Belcher and Paris Lees have acquired mainstream media platforms as a result of their activist work, while Christine Burns and Stephen Whittle built upon campaigns undertaken with groups such as Press For Change and the FTM Network. However, activist expertise can also be constructed entirely independently of journalistic and health-oriented professional models, as an alternative mode of potentially revolutionary knowledge production. I examine three examples of how activist group interventions can work to construct trans knowledges as credible: undertaking action research, producing guidance, and (more extensively) imagining alternative approaches to trans health. Each approach draws on informal community resources in order to establish credibility, although some also draw on authoritative platforms and connections with respectable institutions such as universities.

Action research enables activist groups to build an evidence base for trans knowledges. For example, Manchester organisation TransForum ran a quantitative survey of trans patient experiences with GP practices (Bishop, 2013). In common with many such studies, the sample size was very small and acquired through snowballing, and findings were not analysed for statistical significance. Nevertheless, the resulting report offered an indicative basis for knowledge claims to be made about the experiences and needs of trans patients, particularly given the dearth of formal research in this area. Studies undertaken by trans activist groups can also be conducted by (or in collaboration with) activist-experts such as trained social researchers. Often, these studies are formally commissioned by public bodies. Examples include Press For Change's *Engendered Penalties* report (Whittle et al., 2007) – commissioned by the Equalities Review – and the Scottish Transgender Alliance's *Trans Mental Health Study* (McNeil et al., 2012; Ellis et al., 2015). Both are cited extensively in this thesis, as well as in NHS and government reports and in the academic literature, reflecting their continuing status as a *credible* basis for knowledge claims about trans health in the UK. The involvement of trans academics such as Stephen Whittle and Louis Bailey is evidence of an important intersection with health-oriented professional expertise.

With reference to the action research undertaken, these various reports tend to call for action against endemic cisgenderism and transphobia and/or the incorporation of movement-oriented ideas and understandings into medical policies and practice.

The tradition of action research informed the creation of a qualitative survey to gather information on allegations of abuse and malpractice in the wake of #transdocfail. In a further example of intersecting forms of trans expertise, this was heavily promoted through both media organisation and social media channels. The resulting *TransDocFail: The Findings* report (Belcher, 2014) offered a basis for formal complaints to be raised with the GMC. Findings of the report were disseminated at trans community events, within academic spaces, and in the media.

Guidance documents produced by trans activist groups can also work to reify trans knowledges as credible through recognition and reproduction, adding to the aforementioned work in this area by professionals such as Burns. A considerable number of documents created and distributed by activist groups have been in circulation over the last few years. These include guidance for practitioners and/or patients produced by groups such as the education charity GIRES, community support organisation The Gender Trust, trans youth support group Gendered Intelligence and the Trans Women's Support Group for patients at Glasgow's Sandyford Gender Identity Clinic. Such documents are often produced in collaboration with – and published by – NHS bodies, thereby implicitly reifying the credibility of knowledges produced by the groups in question. As with reports written on the basis of action research, guidance documents often call for better treatment of trans patients and/or the integration of movement-oriented perspectives into policy and practice, although this can vary.⁸⁴

Imagining alternative approaches to trans health is a considerably larger enterprise than producing research or guidance. Those previous examples involve seeking some reform of the existing medical system(s), either through working for improved conditions within the discursive paradigms of trans as condition, or by seeking to build understandings of trans as movement (such as non-binary gender and/or gender fluidity) into medical policy and practice. By contrast, alternative approaches to trans health seek to entirely re-imagine how medical provisions for trans people might be conceptualised. Groups who advocate these approaches are often particularly 'unbecoming' (Bunch, 2013) in that they stand in stark, sometimes proud opposition to normative discourses and authoritative systems.

⁸⁴ See Davy (2011) for a discussion of how the language used by trans activist groups can sometimes work to reinforce pathological discourses.

One alternative approach to trans health is advocated by the ‘Harry Benjamin Syndrome’ (HBS) movement. This very loose movement subscribes to a deeply conditional understanding of trans possibility: specifically, its advocates call for a recognition of the titular ‘syndrome’ as a medical condition. In a manner similar to some of the historical interventions described by Meyerowitz (2002), this approach would position transsexualism as a congenital intersex condition that can be cured through transition. The HBS movement largely regards gender and sex as binary, referencing Benjamin’s (1966) typology of the ‘true transsexual’ in distinguishing HBS individuals from other gender diverse people. During the 2000s, at least two HBS *Standards of Care* documents were produced and disseminated online in an attempt to inform and influence medical practice.⁸⁵ In this way, HBS activists seek to reify their identity with reference to medical discourse while simultaneously advocating a *particular* means by which trans experience can be understood and cured. By drawing upon medical literature and utilising the pseudoscientific term ‘Harry Benjamin Syndrome’, HBS activists seek to establish themselves as experts in a medical realm, with authority over the means by which trans feelings and experiences might be regarded as possible and real.

The HBS movement forms a small but vocal community within the wider Western trans population, with activism generally organised online. While I did not directly encounter any dedicated HBS spaces during data collection for this project, many participants were familiar with the movement and its ideas were discussed on a number of occasions within the community sphere. However, interest in (and subscription to) HBS knowledges faded during the 2010s; moreover, the movement has never had any significant representation amongst active trans activist groups in the UK. HBS has been increasingly seen as prescriptive and exclusive by many trans people (the movement largely centres trans women and is known to engage extensively in ‘border patrols’), while others reject the conflation of ‘trans’ with ‘intersex’. This demonstrates the importance of a *continual* recognition and repetition of ideas in order to establish credibility even within community spaces. It also shows how only some

⁸⁵ The existence of more than one such document reflected divisions within the HBS movement, such as between groups that were respectively inclusive or exclusive of ‘pre-operative’ individuals. The original websites that hosted the HBS *Standards of Care* have now been removed from the Internet, reflecting a broader decline in the movement’s activities and influence throughout the 2010s. However, the Internet Archive’s *Wayback Machine* hosts a copy of one such document here: <http://web.archive.org/web/20070111194727/http://www.harrybenjaminsyndrome-info.org/soc.html>. I would like to thank Freja Sohn Frøkjær-Jensen for providing me with advice and information on this topic.

trans knowledges achieve hegemony – or transnormativity – within trans spaces. As Ekins & King (2010: 26) note, some trans stories are ‘unwelcome’ within wider community spaces. Hence, while members of the HBS movement recognise *one another* and sometimes work collectively to promote their ideas, when these knowledges do not speak to other trans people more widely (or, indeed, when they work to exclude many trans people) they fail to gain wider recognition and hence are marginalised within trans spaces.

A quite different example of an alternative approach to trans health – rooted in understandings of trans as movement – can be found in activist group Action For Trans Health. This group campaign for a ‘democratic trans healthcare system’, a concept that draws upon Marxist ideals of public ownership (in an echo of Feinberg, 1992; 1999; 2006) as well as anarchist ideals of autonomy. While Action For Trans Health acknowledge the expertise of practitioners, they argue that trans knowledges should be regarded as credible and that greater authority should be invested in trans patients. This position is coupled with a critique of private healthcare providers, demonstrating that a ‘democratic’ approach to trans health would in this context require ownership *by* trans people in a material as well as a discursive sense.

Trans people are experts on our own lives and we know more about our health care needs than NHS management (and frequently, the doctors who are treating us). We need trans people at all levels of decision making regarding our healthcare and an end to cis (non-trans) gate-keeping of our lives. We need a health care system which is based on what we need, not on some psychiatrist’s outdated idea of what gender should look like. We need an end to the privatisation of health care services, and a massive investment in transition-related care and mental health services which are actually empowering rather than institutionalising. (Blog post: Action For Trans Health, *Demand #16: Action for Trans Health - Democratise trans healthcare now! Stop cis gatekeeping of essential treatment*. Demanding the Future, 24/03/15)

In this way, Action For Trans Health interpellate trans knowledges as authoritative through the rhetorical device of *demanding* revolutionary change. The intended credibility of their case is constructed through a recognition of trans people’s lived experience and forms of self-education: ‘we know more about our health care needs than NHS management’. While this approach emphasises ‘transition-related care’, it also addresses health care more widely, particularly services such as mental health

provision. Action For Trans Health assert the value of an intersectional approach (Crenshaw, 1991; Richardson & Monro, 2010) in a mission statement on their own website, acknowledging the differing ways in trans people from different backgrounds experience marginalisation. In doing so, they locate a *diversity* of trans expertise in a range of socially situated subject positions, each shaped by intersecting experiences of marginalisation and privilege. Moreover, they aim to extend mutual recognition beyond the limits of an explicitly trans activism through wider coalition-building.

We believe that trans people come from all walks of life: we are working class, we are black, we are disabled, we are LGB, we are women. As such, for trans liberation to be achieved we need to also be actively fight[ing] against all forms of bigotry and build coalitions with other groups with progressive aims. (Web page: *Join*. Action For Trans Health)

Notably, Action For Trans Health couple their demands with public engagement, as well as extensive knowledge of relevant academic literature and public policy. In particular, they have drawn on literature pertaining to the ‘informed consent’ model of trans healthcare (Deutsch, 2012; Reisner et al., 2015) – for instance in a submission to the *Transgender Equality Inquiry* (Women and Equalities Committee, 2016) – in order to promote an alternative to the gatekeeping model for transitioning patients. They are also involved in providing formal advice to both patients and health providers through workshops and other events. In this way, the overtly radical political stance taken by the group is coupled with an ‘activist-expert’ approach (Epstein, 1996) through which they might seek to establish the credibility of their ideas.

The notion of a democratic trans healthcare system therefore offers a holistic alternative to the existing provision of trans healthcare: one that locates authority in the political demands of trans as (*social*) movement, and credibility in individual patient experience. While Action For Trans Health differ enormously from the HBS movement in terms of ideology, they are similar in seeking to establish their own authoritative expertise *as an activist collective* on the matter of trans health.

Expertise through authority; authority through expertise

I have shown that individual and collective actions in a range of contexts are employed by trans patient advocates in order to reproduce trans knowledges through mutual recognition and iterative repetition. These processes frequently intersect and interact. Individual trans knowledges of *self* – identity, embodiment and experience –

can be drawn upon to conjure a sense of authority, which can in turn be reinforced and constructed as credible through mutual recognition. When trans knowledges are recognised and repeated by advocates in positions of power (such as platforms within journalism or health-oriented professions) they can be also be reified as credible through established channels of authority. In this way there are multiple means by which the *reality* of trans health – its ‘field of intelligibility’ (Steinberg, 2015a: 153) can be challenged and reconstructed: ‘the fundamental instability of the law’s foundation – its fiction – is unmasked and a space for change is opened’ (Bunch, 2013: 53). As I have argued, the broad, loose collective of individual and group contributions to this process of challenge and reconstruction can be said to constitute a *lay epistemic community* (Akrich, 2010), in that members of this ‘community’ collectively provide new means by which knowledge of trans health might be constituted.

I have largely portrayed these complex processes as empowering for trans patients and trans knowledges. However, it is also possible for such processes to erase patient advocates even as their knowledges are reified. An example can be seen in the guidance document *Advice Process for changing name and gender in Primary Care*, produced in 2011 by the National Information Governance Board for Health and Social Care (NIGB, 2011). The document cites a guide previously produced by Press For Change: *Name Changing on Personal Documents: A Guide for Organisations*. In this way, it works to interpellate activist group knowledge as credible, and Press For Change as an authoritative source on the matter. The NIGB document was also based closely on an NHS Coventry policy, also entitled *Advice Process for changing name and gender in Primary Care*. This was produced in 2010 in consultation with local trans patients – including myself – following complaints about misgendering in GP practices. However, the role of patient advocates in shaping the NHS Coventry policy is not acknowledged on paper, meaning that it is the named author (a cis NHS Coventry employee) who receives credit from the NIGB document, and *not* the trans patients and activists who made the demands that shaped it. In this way the trans people involved in producing the document are effectively erased (Namaste, 2000), with the constructed reality in this case locating credibility primarily in the institution of NHS Coventry. Similarly, the assimilation of many years of discursive work by a myriad of individuals into a report or document produced by an activist-expert can work to erase the collective action of knowledge production, even as *ideas* are recognised and reproduced.

Through all of these examples, it is apparent that the establishment of credibility requires *work* (Pereira, forthcoming). This is the work of mutual recognition – of

unbecoming, writing, researching, theorising and sharing – work that is constant, collective and not necessarily recognised. As a result, the negotiation of change is most productive as a collective effort, a theme that I explore further next.

Negotiating change: the depathologisation and non-binary movements

I now look at how trans knowledges that have been constructed and constituted as credible within the lay epistemic community of patient advocates can work to directly challenge the professional epistemic community of gender identity specialists, thereby potentially transforming the discourses and material conditions of trans health in the UK. I draw on two intersecting case studies in this analysis. The first of these is the depathologisation movement, which has sought to (re)define ‘trans’ through a move away from conditional understandings rooted in mental health models such as psychiatry. The second is the movement for non-binary recognition, which seeks to expand understandings of gendered possibility for the purposes of social and legal recognition in all areas of society, including healthcare provision. In order to contextualise this discussion, I first outline some changes that *have* recognisably taken place in recent years.

Discursive shifts: embracing movement?

The professional epistemic community of trans health in the UK increasingly recognises gender pluralism and partially incorporates insights from understandings of trans as movement. In particular, trans subjectivities are increasingly regarded as (potentially) fluid and not necessarily diagnosable. This is evidenced in a number of recent publications from UK health professionals working with trans people in gender clinics and/or mental health settings. For example, Richards et al. (2015) and Barrett (2016) argue that being trans is not a psychiatric disorder, while Richards et al. (2016; forthcoming) discuss how non-binary identities and experiences might be understood and managed within gender identity services. This approach has the potential to pave the way towards a context in which a wider range of trans knowledges and identities are affirmed in healthcare settings, thereby challenging the conditions under which many patients currently find themselves experiencing severe distress.

Discursive shifts within the practitioner sphere are also evident in the changing language of NHS documents. This is illustrated in the following excerpts from recent draft policies put out for consultation by NHS England. The second document is a

revision of the first, and both quotes are selected from the same part of the respective documents. Once implemented, the final version of this document is intended to guide the commissioning of NHS gender identity services in England. In this way, it will in theory provide a level of oversight regarding acceptable clinical practice.

Gender Dysphoria (GD) is a rare condition in which there is a psychological experience of oneself as male or female, which is incongruent with the external sexual characteristics of the body. An individual with profound and persistent GD may need clinical intervention to facilitate a change of status, to live in accordance with his or her core gender identity rather than with the phenotype. This degree of GD is termed transsexualism[.] (Draft document for consultation: *Clinical Commissioning Policy: The Provision Of Gender Dysphoria Services*, NHS England, 01/01/13)

Gender dysphoria refers to discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics). Trans and gender variant people are not necessarily gender dysphoric. There are gradations of gender experience between the binary 'man' or 'woman', some of which cause discomfort and may need medical intervention; others may need little or none. A few people who reject the gender concept altogether, and see themselves as non-gendered, may require gender-neutralising treatments from appropriate clinical services. (Draft document for consultation: *Clinical Commissioning Policy: [Gender Identity Services]*, NHS England, 24/03/15)

Both the first draft commissioning document (from 2013) and the second (from 2015) outline the manner in which the DSM-5 diagnosis 'gender dysphoria' and the ICD-10 diagnosis 'transsexualism' are to be conceptualised for the purposes of the commissioning policy. However, two important discursive differences can be noted.

Firstly, there is a shift away from understanding gender in innate, positivistic and prescriptive terms between the 2013 and 2015 documents. Where the 2013 document utilises language such as 'core gender identity' and employs a more traditional understanding of 'transsexualism', the 2015 document draws upon the 'unbecoming' (Bunch, 2013) language of contemporary UK trans activists.⁸⁶ This language

⁸⁶ There are, of course, major differences in how different activists and groups articulate the language of gender. However, my assertion here is made on the basis of broad and surprisingly homogenous trends I observed across the activist sphere, representing a convergence of new languages. A greater variety of vernaculars (including those that draw especially on more

acknowledges the possibility of gender as social construct through the use of inverted commas around 'woman' and 'man', and through the term 'assigned at birth'. The inverted commas serve to destabilise understandings of womanhood and manhood as natural and given. The term 'assigned at birth', meanwhile, is common within trans spaces, echoing Stryker's (1994: 244) critique of the 'collective assumptions of the naturalized order' as manifested in coercively declaring a child to be a boy or a girl at birth. The term can hence be linked to an understanding of sex and gender as historically contingent and socially constructed.

Secondly, there is a move away from binary language. This represents a shift towards the possibility of *non*-binary treatment; that is, treatment possibilities which encompass the expansion of 'female' and 'male' categories as well as moves beyond these categories altogether (Monro, 2007). Where the 2013 document refers to a 'psychological experience of oneself as male or female', the 2015 document describes gender and sex in non-binary terms ('a person's gender identity' and 'person's sex assigned at birth') while also stating explicitly that there are 'gradations of gender experience between the binary "man" or "woman"'. This provides space for some trans people to identify into a 'binary' (male or female) *or* identify with non-binary possibility/possibilities in a gender pluralist manner.

There is accordingly a weakening of the gender identity specialist's authoritative power to assess and diagnose *gender* in the discursive shift between the two documents. The 2013 document primarily employs assertive language to denote clinical possibilities; for instance, the phrase '[a]n individual with profound and persistent GD' is indicative of a clinical category that can be firmly defined and recognised by health professionals. By contrast, while the 2015 document utilises similar language in describing 'appropriate clinical services', it states that these services should be available to people who '*see themselves* as non-gendered' (emphasis mine). This is a complex positioning of authority and knowledge, in which patient accounts are provided greater credibility and expertise is potentially shared (and potentially contested). As I shall show, the discursive shifts that enabled these substantial changes required extensive epistemic and political negotiation.

conditional understandings of trans possibility) are common within other trans spaces, such as within the community sphere.

The depathologisation movement

The trans depathologisation movement exists to '[challenge] the dominant medical understanding of transgender' (Vähäpassi, 2013: 34); that is, the understanding of trans as *psychiatric condition*. This understanding is associated in particular with diagnoses found in the DSM and in the 'mental and behavioural disorders' chapter of the ICD. In this way, the depathologisation movement can be understood as primarily concerned with *depsychopathologisation*: it is concerned with understanding and treating trans health differently, rather than removing access to medical interventions for transitioning individuals.

The movement is a loose, multi-faceted coalition of campaigning interventions involving both trans activists and health professionals. It operates on an international level – and can be shaped by multinational networks, such as Global Action For Trans* Equality – but takes on different characteristics in different countries according to the local socio-political context. Trans activists have organised co-ordinated campaigns for depathologisation since at least the early 1990s, but activity related to this issue intensified ahead of the publication of DSM-5 in 2013 (Burke, 2011; Vähäpassi, 2013). I shall show that depathologisation activism both internationally and in the UK has contributed significantly to changing discourses of trans possibility both internationally and within the NHS.

Davy (2015: 1166) identifies two central 'arms' of the depathologisation movement. The first arm 'casts trans identities within a biogenetic framework, or as an intersex condition'; we can locate the HBS movement within this arm. In this way, activists aim to reconceptualise 'trans' as an issue of *physical* condition rather than *mental* health. The second arm of the depathologisation movement 'proposes a self-determination and human rights model', effectively rooted in discourses of trans as (social) movement. This second arm encompasses campaigns for 'complete depathologisation' as well as those that seek diagnostic *reform* (Davy, 2015: 1173). It is the latter incarnation of the movement's second arm that has gained a particularly strong level of support within the UK.

On an international level, the second arm of the depathologisation movement has achieved a number of important successes. These most notably include the aforementioned revision of WPATH's *Standards of Care* to incorporate a more flexible approach to treatment in Version 7, and the securing of depsychopathologised public health pathways for transition in Argentina, Denmark, France and Malta (Davy, 2015).

In the UK context, debates around depathologisation are primarily shaped by the political realities of NHS funding. A considerable number of trans patient advocates, sympathetic academics and gender identity specialists have argued that diagnosis offers an important basis for the funding of gender identity services through the NHS (Davy, 2015; Richards et al., 2015). This has not prevented fierce disagreements around the issue of diagnosis, however, particularly in conjunction with the international 'Stop Trans Pathologization!' campaign in 2012. Opinions on the matter were most divided within the community sphere, where support for the current medical system – often drawing upon the importance of an 'expert' perspective for the purposes of reifying identity – was expressed alongside (and in opposition to) arguments favouring various forms of depathologisation. Within the activist sphere I observed a broad consensus in favour of depathologisation, reflecting Burke's (2011) finding that a majority of trans activists reject the pathologisation of trans identity. The evidence of discursive change seen within documents such as the NHS England draft clinical commissioning policies suggests that the depathologisation movement is gaining ground in the UK. I attribute this to two key factors: changes within WPATH, and long-term activism addressing clinical pathways within the NHS.

The shift in discourse between Version 6 and Version 7 of the WPATH *Standards of Care* is significant. Version 6 centred the role of the health professional in 'guid[ing] treatment and research' on the basis of mental health assessments informed by the DSM and/or ICD (Meyer et al., 2001; Coleman, 2009). Version 7 instead:

established a language which mandates a shift in trans healthcare from a gatekeeper to a collaborative model [...] stress[ing] that it is important for healthcare professionals to recognize that transpeople's health interventions should be principally based on patients' decisions (Davy, 2015: 1176).

This collaborative, patient-centred approach marks a move away from understandings of trans as (fixed) condition *and* a move towards a more gender pluralist affirmation of trans patient knowledges. Moreover, the publication of Version 7 was pre-empted by a formal statement calling for the 'the de-psychopathologisation of gender variance' more widely.

The WPATH Board of Directors strongly urges the de-psychopathologisation of gender variance worldwide. The expression of gender characteristics, including identities, that are not stereotypically associated with one's assigned sex at birth is a common and culturally-diverse human

phenomenon which should not be judged as inherently pathological or negative. (Bockting et al., 2010)

While the literature of transgender studies is notably absent from the bibliography of the Version 7 *Standards of Care* and the recommendation of depsychopathologisation, the impact of lay epistemic communities is nevertheless felt. As previously noted, Whittle (2016) argues that the discursive changes discussed above happened *because* of trans activism. In particular, he states that these changes occurred because of the emerging body of evidence in the literature of transgender studies – which itself recognises and repeats everyday trans knowledges even as it interrogates them – and because of interventions from health-oriented professionals. Through obtaining formal recognition in their respective fields, activist-experts such as Whittle (and 2013-2016 WPATH president Jamison Green) gained the credibility necessary to enter WPATH *and* the necessary authority to negotiate change within this professional organisation. The recognition of both *personal* and *collective* activist trans knowledges as credible can also be seen in interventions from other members of WPATH, including cis members. For example, Matte et al. (2009) and Winter (2009) formally recommended that the organisation reconsider its use of pathologising binary language ahead of the revision to the *Standards of Care*, explicitly drawing on a great range of patient knowledges and experiences in doing so.

The Version 7 *Standards of Care* were, in turn, of benefit to trans activists seeking to reform gender identity services in the UK. In providing an authoritative international standard for care, the new WPATH guidelines offer a basis from which to negotiate change. For instance, where the *Standards of Care* now coincide with movement-oriented and/or gender pluralist trans knowledges and perspectives on health, they work to enhance the credibility of activist calls for diagnostic reform. The role of activists is important here because the existence of a new version of the *Standards of Care* does not *necessarily* lead to changes within gender identity services. For instance, for several years the gender identity clinics in Leeds and Nottingham explicitly stated that their respective pathways adhered to the ‘Harry Benjamin Standards of Care’ (i.e. Version 6 of the *Standards of Care*, published prior to the renaming of WPATH) rather than the more recent Version 7 document. This approach was attributed to a need for the continued implementation of RLE prior to hormone therapy, so that practitioners could ensure that they were happy with their patients’ conformity to a consistent gender identity and presentation.

[O]ur Care Pathway follows the stages laid down within The Harry Benjamin International Standards of Care (this differs from the WPATH guidance), as we believe that hormone treatment is best undertaken after real life experience has begun to ensure that, possibly irreversible hormone treatment is not undertaken without there being a completely coordinated comprehensive care approach which has the ability to meet the changing needs of our service users flexibly and safely. (Letter: *attachment to the Freedom of Information request 'Registered doctors involved in FofI response'*, Leeds and York Partnership NHS Foundation Trust, 02/03/12)⁸⁷

Both individual and collective action (such as letter-writing) was undertaken by activists in order to challenge the gender clinics' continued adherence to Version 6 of the *Standards of Care*. These actions, which appealed to the *authority* of the Version 7 *Standards*, were ultimately somewhat successful: at the time of writing, references to the 'Harry Benjamin International Standards of Care' have been removed from the Leeds and Nottingham GIC websites and there is some evidence from participants to suggest a slight relaxation of these clinics' particularly stringent assessment procedures.

Appeals to the *Standards of Care* form just one part of a wider use of newly credible trans knowledges in public health reform. Through successfully building wider recognition of trans knowledges, activists have been in a strong position to benefit somewhat from recent changes in the NHS, both discursive (such as in the shift towards 'choice' and 'patient rights') and material (such as in the structural re-organisation of the NHS in England and Wales). This position is also bolstered by a related move towards 'patient and public involvement at all levels in the governance of science and health services' (Weiner, 2009: 255). The *Gender Reassignment Protocol for Scotland* (NHS Scotland, 2012) was therefore shaped in part by the new *Standards of Care* and the input of stakeholder groups such as the Scottish Transgender Alliance. This document takes steps towards depsychopathologisation, such as through the relaxation of assessment criteria; for instance, only *one* assessment is now required in order for Scottish patients to obtain access to hair removal, speech therapy, hormone treatment and 'masculinising' chest reconstruction surgeries.

Similarly, trans knowledges play an important role in ongoing stakeholder consultations regarding gender identity services under the management of NHS

⁸⁷ This letter was acquired by trans activists and published online following a Freedom of Information Request by blogger Emma Brownbill.

England. The 2013 re-structure of the NHS in England and Wales offered new opportunities for trans people to have more of a say in the policies, practices and treatment pathways of NHS gender clinics. Clinical Reference Groups (CRGs) were created to oversee the *national* development and commissioning of specialist services within NHS England, in contrast to the local commissioning previously undertaken by bodies such as PCTs. Moreover, the Coalition Government's *Transgender Action Plan* – itself a product of extensive lobbying from increasingly influential trans activists – included a commitment to '[c]ommission and publish a clear and concise guide for health practitioners [...] and the transgender community on care pathways and available treatments' by April 2013 (Home Office, 2011b: 11). The Gender Identity Services CRG therefore sought to replace the patchwork of existing approaches with a single commissioning policy and a national protocol for treatment. Previous attempts to create a national framework for gender identity services had taken place during the 2000s, but these had all stalled due to disagreements between gender clinic representatives and trans patient advocates (Burns, 2013). On this occasion it appeared that change was to be enforced by the newly-formed NHS England in line with external political priorities.

A draft protocol for NHS England was made public in July 2012, just weeks after the publication of the *Protocol for Scotland*. This document had been prepared by representatives of the English gender clinics at the request of the Department of Health. In contrast to the Scottish protocol, the English document emphasised a relatively psychopathological understanding of trans possibilities.

The most recent WPATH guidelines emphasise the *pivotal role* of the qualified Mental Health Practitioner: a mental health professional (eg. psychiatrist or psychologist) who specialises in transsexualism/gender dysphoria and has general clinical competence in diagnosis and treatment of mental or emotional disorders [...]. Anyone referred to a Gender Service will be assessed to ensure that there is a confirmed diagnosis relating to Gender Dysphoria. (Draft document for consultation: *Gender Dysphoria Services – An English Protocol*, Department of Health, 26/07/12, emphasis mine)

The supposed adherence to the WPATH guidelines in the creation of this draft protocol was questionable, particularly given WPATH's stated opposition to psychopathologisation. Indeed, like the aforementioned Leeds and Nottingham gender clinic pathways, the protocol appeared to contradict a number of passages in the

Version 7 *Standards of Care* that emphasise patient agency and a more movement-oriented understanding of trans possibility.

The overall goal of the [Standards of Care] is to provide clinical guidance for health professionals to assist transsexual, transgender, and gender-nonconforming people [...]. This assistance *may* include [...] mental health services[.] (Coleman et al., 2012: 166, emphasis mine)

Health professionals can *assist* gender dysphoric individuals with *affirming their* gender identity, exploring different *options* for expression of that identity, and making decisions about medical treatment options for alleviating gender dysphoria. (Coleman et al., 2012: 171, emphasis mine)

The contrast between the language of the draft English protocol and that of the *Standards of Care* was not lost on trans activists familiar with the latter document. This was particularly relevant as the Department of Health sought the view of trans stakeholders in an online survey. Numerous trans bloggers⁸⁸ sought to encourage participation in the survey, while raising awareness of the psychopathologising language within the draft protocol and contrasts with the Version 7 *Standards of Care*.

The critical feedback offered by trans groups and individuals in response to the Department of Health survey put the new Gender Identity Services CRG in a difficult position. Reconciling the psychopathologising perspective of the gender clinic representatives with the anti-psychopathologising stance of many trans respondents would require months (if not years) of work. The April 2013 deadline passed without any public action being taken. However, on 16 May 2013 a formal letter to stakeholders (including trans survey respondents *as well as* gender clinic representatives) from NHS England Deputy National Medical Director Steve Field and newly-appointed CRG Chair John Dean announced that:

the specification and policy for Gender Services did not obtain approval by the Clinical Priorities Advisory Group, largely due to inconclusive feedback through the consultation exercise on specifications and policies.

The CRG therefore took the decision to impose an amended version of the *Protocol for Scotland* upon the English gender clinics. In July 2013 this was replaced with the

⁸⁸ My own presence within the field is of relevance here. I wrote several posts in 2012 and 2013 about the Scottish and English protocols on my personal blog, *Trans Activist Takes On World*, gaining hundreds of views. My analysis in these posts was based in part upon work undertaken for this project. This thesis is therefore both a product of and a contributor to the very phenomena it seeks to analyse.

NHS England Interim Gender Protocol (NHS England, 2013), which was again based largely upon the Scottish protocol. At the time of writing, this interim English protocol is still in place. More formalised consultations hosted by NHS England have followed, with input from trans stakeholders leading to outcomes such as the previously quoted 2015 draft clinical commissioning policies.

The depathologisation movement has therefore seen a number of successes in the UK, including shifts away from pathologisation in gender clinic care pathways and national protocols for Scotland, England and (by extension, due to absence of NHS gender clinics in the country) Wales. These shifts have been made possible through extensive negotiations both in the UK and on an international level. They rely upon a restructuring of macro-level power relations through the establishment of trans knowledges as credible. However, the *delivery* of gender identity services in the UK continues to rely on an extensive process of assessment, which broadly maintain the micro-level power differentials between practitioner and patient.

The non-binary movement

A non-binary/genderqueer movement has existed in numerous forms since at least the early 1990s. This movement seeks to expand understandings of gendered possibility beyond the binary of male/female through recognising (and constructing) the reality of additional genders, individuals as multiply gendered, and/or individuals as non-gendered. UK activists such as Christie Elan-Cane have long fought for the legal recognition of non-gendered individuals (Ekins & King, 2006). Concurrently, US writers such as Stone (1991), Feinberg (1992) and Bornstein (1994) laid a theoretical groundwork for an understanding of gendered possibility beyond the binary. Together with community discussions taking place largely on the Internet (Whittle, 1998; Pearce, 2010) these works came to inform social identities such as 'genderqueer' (Nestle et al., 2002; Bornstein & Bergman, 2010) and, more latterly, 'non-binary' (Richards et al., 2016; Yeadon-Lee, 2016).

Individuals who describe their gender in non-binary terms are effectively responsible for the emergence of the contemporary 'trans' movement. However, the continued discursive power of the traditional transsexual narrative means that 'trans' has long been conflated with binary notions of 'transsexual' possibility, including within activism (Richardson & Monro, 2010). Consequently, the recognition of non-binary patients as a 'stakeholder' group has lagged behind formal acknowledgement of

binary-identified trans patients within political contexts. In order to address this, many trans activist groups have declared themselves to be ‘non-binary inclusive’ in recent years. Furthermore, dedicated Internet spaces such as Beyond the Binary, the Nonbinary Inclusion Project and Practical Androgyny have been created as writing and campaigning platforms by and for non-binary and genderqueer identified people in the UK.

I have previously outlined many ways in which binary understandings and experiences of trans possibility have led to difficulties in healthcare settings for individuals who do not identify as female or male. As Bunch (2013: 50) notes: ‘[a]s exciting as the proliferation of genders often seems in queer communities, [this can result in] risk and abjection’. Many of the strategies for seeking diagnostic reform in terms of depathologisation have therefore also been utilised in the negotiation of non-binary recognition; indeed, the campaigns have frequently overlapped. For many years non-binary and genderqueer activists have asserted themselves as credible and *real* through strategies of mutual recognition and iterative repetition; through actions that range from individual posts on blogs and Twitter through to the production of research and reports by activist-experts and insider-providers. This has provided a basis by which trans activists might challenge and change binarist norms amongst healthcare providers. Their role can be seen, for example, in the aforementioned challenges to binary language in previous versions of the WPATH *Standards of Care*, and also in the appeals to the *Version 7 Standards of Care* in following years as protocols and commissioning documents for Scotland and England/Wales were consulted upon.

As NHS England’s formal consultations with trans patients have continued, non-binary activists have been increasingly involved on both an individual basis, and as representatives of trans and/or non-binary organisations. With non-binary knowledges and subjectivities increasingly recognised as credible and *real*, the language of NHS England reports and documentation has changed. For instance, NHS England (2015b) use the phrase ‘transgender and non-binary’ in an effort to counter the conflation of ‘trans’ with (binary) ‘transsexual’.⁸⁹ This move is coupled with commitments to action on non-binary recognition within public health services, and important changes to language such as seen within the draft clinical commissioning policies.

⁸⁹ This follows a similar move first undertaken by activist organisation UK Trans Info.

In the past few years some of the first openly non-binary transitions have taken place under the supervision of NHS gender clinics. The narratives of non-binary and genderqueer participants in this project indicate that such individuals have, in fact, been obtaining access to medical interventions such as hormone therapy and surgeries for many years. However, until recently this was mostly only possible through private providers, or through intentionally lying to or misleading practitioners in NHS gender clinics. The historic lack of knowledge regarding non-binary possibilities amongst gender identity specialists can be attributed in part to a discursive gap between the literature of transgender studies and that of the medical profession, in which transgender studies scholars generally engage critically with the medical literatures, but medical professionals tend to refrain from referencing the insights of transgender studies. This can be attributed to the lesser epistemic status of academic work produced by trans people and/or associated with 'gender studies' (Stryker, 2005; Pereira, 2012). As a result, while non-binary and genderqueer scholars have been producing theory since the early 1990s, this population was portrayed as 'uncommon' and 'mysterious' (Barrett, 2007: 43) in the practitioner sphere well into the 2010s. Nonetheless, Barrett offers an account of what an 'experimental' provision of services to non-binary/genderqueer individuals might look like.

It might perhaps be best to comply with the wishes of a group of four or five such patients (on the strict understanding that they accept that a good outcome can be in no way guaranteed), and then to declare a moratorium on all others until the first four or five have been followed up for at least 5 years. (Barrett, 2007: 43)

In 2014, in the wake of many years of non-binary activism, this 'experiment' began. In the following quote, agender patient Cass describes an appointment with Barrett following their receipt of a letter which stated that they were being recommended for chest reconstruction surgery under certain conditions.

He told me, but in more polite words, that I would be a guinea pig - I am required to keep going to appointments at the clinic for two years, and if it were up to him it would be five years. (I said I was happy to attend appointments for at least two years.) He said that the experiment was to find out if it's possible for a nonbinary person to have medical treatment and go on to live happily and successfully outside of the gender binary. (Blog post: *My top surgery adventure as a nonbinary person continues*, spacious perspicacious, 03/04/14)

Similar experiments have been more recently reported by participants at a number of other gender clinics in England, demonstrating that a public health pathway for non-binary transitions is beginning to emerge. This has been further bolstered by the professional input of trans and/or non-binary insider-providers (Richards et al., 2016; forthcoming).

However, the gains of the non-binary movement remain limited at present. Non-binary and genderqueer individuals continue to report extensive binarist cisgenderism and transphobia within both gender clinics and wider health settings (McNeil et al., 2012; NHS England, 2015a; NHS England, 2015b). Cass themselves wrote later of cisgenderist behaviour such as misgendering from practitioners at Charing Cross, even as surgery was eventually provided. Moreover, at the time of writing at least one gender clinic continues to refuse non-binary and genderqueer patients *any* treatment. The language used to justify this demonstrates the continued epistemic status of international guidance as a basis for authoritative claims about appropriate service provision.

Northamptonshire Gender Clinic uses the ICD classification system (World Health Organisation) and you will see the term 'Transsexual F64.0 - male to female' (or female to male) in the section referred to in the head of your letter as 'diagnosis'. We recognise that terminology changes and classifications often lag considerably behind and that many service users object to the term 'transsexualism' or 'gender identity disorder'. We are however obligated to use these terms until there is an official change in the classification system [...] At present this service is not commissioned to provide treatment⁹⁰ for persons not identifying as male or female, or wishing to present for treatment in intersex states. (Web page: *Terminology*, Northamptonshire Healthcare NHS Foundation Trust Gender Clinic)

It would seem therefore that the non-binary movement is only just beginning its campaign for medical reform. The historic lack of non-binary recognition within many 'trans' activist groups limited discussion of non-binary or genderqueer issues in trans health until recent years. This is compounded by the failure of health professionals and healthcare providers to recognise non-binary and genderqueer identities as *real* until very recently indeed (with NHS England for instance only properly incorporating non-binary language into its work in 2015). Consequently non-binary and genderqueer

⁹⁰ As I have shown, the current NHS England commissioning guidance is interpreted differently by other English gender clinics such as Charing Cross.

trans people in particular continue to be regularly denied access to treatment, both within gender clinics and within wider health settings (Valentine, 2016). However, it is also apparent that vigorous negotiation of these issues by non-binary activists has begun to inform a gradual reform of medical guidance and procedures; a process only bolstered by the successes of the depathologisation movement.

Conclusion: The epistemic politics of epistemic analysis

In this chapter I have shown that the repetitive recognition of knowledges *within* lay epistemic communities (Akrich, 2010) is important for negotiating change. Concepts such as ‘Harry Benjamin Syndrome’ that do not gain wider purchase as an explanatory basis for existence and/or politics remain relevant only to a relatively small group of adherents. By contrast, ideas such as ‘non-binary identity’ that are seen to speak to the experiences of a growing number of people, and can therefore eventually gain credibility within a wide range of contexts. This does not just ‘happen’; it comes about through a myriad of collective interventions over a period of time, as ideas are disseminated and discussed and repeated over and over and over again; by individual community members, activist groups, and professionals of all kinds, including activist-experts (Epstein, 1996) and insider-providers (Hanssmann, 2016). These processes can ultimately work to grant knowledges such as ‘non-binary possibilities’ *credibility*, thereby providing a ground upon which they can be drawn on to actively negotiate change within the discursive and material realm of healthcare provision. Shifts in understanding and practice are therefore the outcome of concerted, non-linear collective negotiation on the part of a multitude of actors, with each newcomer to trans activism building upon, rejecting, and/or reconceptualising the achievements of those who came before them.

Consequently, important discursive and material changes *are* taking place within the realm of trans health, albeit at a relatively gradual and uneven rate. The emergence of credible trans experts, coupled with the increasing recognition of everyday trans knowledges by authoritative professional bodies, has influenced changes such as moves towards depsychopathologisation within WPATH and the NHS, and the increasing recognition of non-binary patient experiences. These changes grant increasing prominence to discourses of trans as movement in a gender pluralist (Monro, 2005; 2007) context, in that they acknowledge a myriad of trans possibilities that can operate beyond traditional boundaries or means of categorisation.

However, these macro-level events still fail to immediately impact upon the power differential located in the individual relationship between trans patient and gatekeeper, where trans knowledges often continue to compete with the perspectives of gender identity specialists. On this *micro* level of gatekeeping encounters, especially ‘unbecoming’ (Bunch, 2013) trans patients such as non-binary and genderqueer individuals face particular challenges in attempting to access everyday treatment, as highlighted and satirised in *A Trip To The Clinic*. Of course, the very presence of the game demonstrates that patients are asserting themselves in turn. I regard this as an epistemic *clash of credibility*, in which the authority of medical knowledge is questioned and set against an increasingly credible range of trans patient discourses.

This thesis too, of course, is an epistemic intervention. Like Michael Toze, I write as an ‘activist-expert’. I assert myself as ‘credible’ through the conduct of social analysis and an extensive demonstration of knowledge in the form of academic citation and references to the field; simultaneously, I reproduce a range of trans activist and community knowledges *within* this academic field through recognising and repeating their ideas and insights. As such, this thesis forms another part of a long chain of collective interventions. I do not pretend to be apart from the field because *no* actor, no contributor to this conversation is ‘unbiased’ or removed.

In recognition of the issues raised throughout this thesis, I believe that the changes to medical discourse and practice in this chapter are *necessary*. Issues such as the power differential between practitioner and patient, long waiting times and limited understandings of gendered possibility are the cause of stress, anxiety and depression for a great many individuals, and can lead to treatment being denied to those who don’t ‘fit’ into a very narrow model of gendered reality. This is most likely to impact upon patients who experience a greater number of intersecting marginalisations: for instance those who are disabled, people of colour, poor, and/or sex workers. Mistrust of health professionals is common amongst trans patients, meaning that many regularly mislead or lie to their doctors in medical settings. This is not a productive way to manage the healthcare of a deeply vulnerable population.

While the considerable collective achievements of activists in interpellating trans knowledges as authoritative, expert and *real* are not in doubt, I believe that current reforms do not go far enough in addressing the substantial problems with the provision of trans healthcare services. Unnecessarily strict interpretations of the *Standards of Care* continue to provide a justification for gender identity services that exclude many. The changes achieved by the depathologisation and non-binary

movements have succeeded in reducing the extensive demands of the assessment procedure (particularly in Scotland), but not replacing them with a more collaborative model. This has informed moves such as Charing Cross' limited and authoritarian 'experiment' in the provision of surgery for non-binary patients. Similarly, forthcoming protocols for the management of non-binary patients within current gender clinics (Richards et al., 2016; forthcoming) may result in a form of 'inclusion' that does not address the wider problem of the micro power differential; as Davy (2015: 1167) notes, 'diagnoses of multiple gender disorders under one overarching [gender identity] diagnosis [maintain] the clinical monopoly on additional forms of permanent or non-permanent gender transitioning practices'. In the conclusion to this thesis that follows, I unpack the consequences of this discursive monopoly.

8

Conclusion Towards affirmative care?

Jess Phillips MP:

I think I'd like to go back again to this idea of living in one gender identity: I wonder if you can tell me – clinically – what 'living like a woman' – or alternatively, man – actually means?

Will Huxter (NHS England):

I'm not a clinician I can't tell you what that's –

Jess Phillips:

Do you think that there is a clinical way to live as a woman? Or a man?

Will Huxter:

The point I am making is that we are guided by specialists who work in this area, the clinical consensus among gender identity specialists about how services should operate. We are absolutely open to looking at how that might change, but I'm not in a position to make a change to the way in which those services are commissioned without having gone through a clinical process.

Maria Miller MP:

Mr Huxter, sorry, I think we're going to have to press you on that. Is – this is just factual, we have read that people have to 'live like a woman' or 'live like a man', we as a committee have struggled to know what that looks like in a day and age where men and women live in very similar ways. What do you – factually – what does that mean?

- Transcript: House of Commons Women and Equalities Committee
Transgender Equality Inquiry: fourth oral evidence session (2015)

'Living like a woman': gatekeeping, power, and models of care

In late October of 2015 I took a break from writing to watch a livestreamed oral evidence session from the UK Parliament's *Transgender Equality Inquiry*. The House of

Commons Women and Equalities Committee had scrutinised written and oral evidence from variety of stakeholders – including activists, academics, health service managers and gender identity specialists – on a range of issues pertaining to trans equality. In this fourth session, members of the committee addressed the issues that had been raised by stakeholders to a number of government ministers, as well as an NHS England representative.

One exchange particularly caught my attention. With reference to assessment procedures such as RLE, committee members Jess Phillips and Maria Miller raised a pointed question about some of the underlying assumptions present in many clinical encounters for trans patients attending gender identity services. As gender roles become less rigid in everyday life, what does it *mean* to ‘live like a woman’ or ‘live like a man’? Surely, ‘there cannot be a clinical list of things that a person can be told to do by a doctor in order to tick those boxes’? (Jess Phillips).

A few months later I travelled to Amsterdam to present a number of findings from this thesis at the 2016 WPATH Symposium: an event attended largely by the professional epistemic community (Haas, 1992) of trans health. A ‘pre-conference’ was hosted by two of the Dutch gender clinics the day before the symposium proper began. At this event, I realised that I had taken on the role of ‘activist-expert’ (Epstein, 1996), seeking to provide an ‘indirect form’ of intervention in the epistemic politics of medical knowledge (Hess, 2004: 703) on the basis of my research findings and analysis.

An interactive session looking at modes of informed consent in clinical contexts took place on the afternoon of the pre-conference. For this, the session facilitator introduced five simple models for decision-making between practitioners and patients, as shown in Figure 6 (Molewijk & Wensing-Kruger, 2016).

Model 1:	The caregiver should decide, taking into account what is known about the treatment.
Model 2:	The caregiver should decide, taking into account the preferences of the [patient/client].
Model 3:	The caregiver and [patient/client] should decide together, based on equality.
Model 4:	The [patient/client] should decide, taking into account the preferences of the caregiver.
Model 5:	The [patient/client] should decide, taking into account what is known about the treatment.

Figure 6: Five models of care

These models effectively formed a scale, with the practitioner deciding how treatment should proceed on the basis of available evidence in 'Model 1', and the patient deciding how treatment should proceed on the basis of available evidence in 'Model 5'. Session attendees were asked to discuss their favoured model in small groups.

Several individuals were then invited to feed back on their group discussions. While a number of the individuals feeding back did note that the available options were perhaps somewhat reductive, all offered a view on the models most popular within their group. Notably, most practitioners described how they might offer different approaches to care depending on the patient; perhaps a Model 4 (or even 5!) for an 'easy' case, whereas a Model 1 or 2 might be used for more 'difficult' patients, such as autistic individuals or those who did not subscribe to a clear and consistent female or male identity.

It was at this point that I raised my hand to query my fellow participants' understanding of the exercise. Is it really possible, I asked, for a practitioner to truly subscribe to Models 3, 4 and 5 if they are *also* working within the context of Models 1 or 2 with other patients? Surely in these instances the practitioner is making the *decision* to allow their patient to take the lead somewhat, while maintaining the *power* to deny them this, thereby ultimately adhering to Model 1 regardless?

I later reflected that the same gatekeeping *power* was questioned by Jess Phillips and Maria Miller at the *Transgender Equality Inquiry*. While the intention of gatekeeping is to ensure that patients with significant co-morbid conditions (mental or physical) do not undergo unnecessary and potentially dangerous irreversible treatment (Barrett, 2007; Richards et al., 2014), in practice it would seem that the *impact* of current gatekeeping reaches beyond this. In concluding this thesis, I argue that the power invested in – and actively *wielded* by – gender clinic gatekeepers has significant consequences for the possibility of 'trans' subjectivities, as well as for the wider terrain of trans health. To make this argument, I now revisit the original stated aim and research questions for this project.

This project aimed to uncover how both 'trans' and 'trans health' are *understood* in multiple contexts, in order to grasp the social processes at play in encounters where trans patients feel marginalised, misunderstood and/or discriminated against. I formulated two main research questions in response to this aim. First, I asked how the meanings and possibilities of 'trans' are produced, reified and legitimated through

health discourses and practices. Secondly, I asked how discourses of trans healthcare provision are *negotiated* within and between trans community groups, trans activists and health professionals. In order to explore how I have responded to these questions, I look thematically at topics that weave through the various chapters of this thesis.

Producing, reifying and legitimating trans possibilities

In this thesis, I have analysed how understandings of trans and gendered possibility are shaped by clinical concepts, protocols and practices. For example, the ICD-10 definition of 'transsexualism' presupposes a male/female binary through the use of terms such as 'opposite sex' (World Health Organisation, 1992: F64.0). Similar language was used until very recently within most national and/or local guidelines for gender identity services in the UK, and such language continues to be employed by some providers, such as the Northamptonshire Gender Clinic. A less overt means of defining trans possibility can be seen in the continued use of RLE in the assessment and management of trans patients. Underpinning RLE is the presumption that trans people *can* and *should* maintain a consistent gender identity and mode of gendered presentation, usually through 'living as a woman' or 'living as a man'.

This kind of language draws upon and contributes to medical discourses of *trans as condition*. These understandings frame 'trans' as fixed: that is, clearly delineated and definable. In this sense, being 'trans' is *conditional*: it is only possible for a person to be 'trans' if they 'fit' clinical expectations. Condition-oriented medical understandings of trans possibility also frame 'trans' as *fixable*, that is, curable through a carefully managed transition (or through some form of therapy, depending on the perspective and approach of the practitioner).

In Chapter 2, *Condition or Movement?*, I explored how discourses of trans as condition have historically been produced through the interventions of trans people as well as through the writings and practices of health professionals (Meyerowitz, 2002; Rubin, 2003). However, these discourses can also be enforced, reified and legitimated through authoritative clinical guidance (such as NHS protocols and the WPATH *Standards of Care*) and practice; I analysed these processes in Chapter 5, *(Re)defining Trans*, and Chapter 7, *Changing Trans Health*.

Conditional notions of trans possibility have important consequences for patient subjectivity and social identities. As I showed in Chapter 5, many patients continue to draw on the discursive authority of medicalised, condition-oriented understandings of

trans in order to reify their own identities and experiences, both within themselves and in wider social contexts such as schools, workplaces and the family. Where these understandings work to *limit* gendered possibility – for instance, through constructing gender as binary – the possibilities for constructing and reifying personal subjectivity and social identity are limited also.

Conditional models of ‘trans’ have consequences for trans people’s health that reach well beyond specialist gender identity services. An example of this can be seen in the discourse of trans *as transition*. The idea that all trans people are necessarily transitioning/transitioned, and that this defines their health needs, can lead to inappropriate treatment from ill-informed health professionals, informing phenomena such as Trans Broken Arm Syndrome. This is of particular concern in an environment where relatively little information is easily available on trans health, as seen for instance in the limited content of the NHS Choices *Transgender Health* web page discussed in Chapter 5.

Alternative ‘movement’-oriented discourses of trans possibility *are* increasingly available, entailing less strictly categorical queer tendencies towards continual creation, fluidity and gendered worldbuilding. Notably, however, discourses of trans as movement – including understandings of trans possibility that create space for *non*-transitioning individuals – are often defined *against* medical understandings of trans as condition, as I demonstrated in Chapters 2 and 7.

Discourses of trans as movement provide space for less consistent and potentially non-binary understandings of trans/gendered possibility, as well as a collective trans social movement built around diversity and solidarity rather than clear definition and the delineation of appropriate (‘trans enough’) identity. In Chapters 2 and 7, I examined how these movement-oriented understandings of ‘trans’ *are* increasingly incorporated into international and NHS guidance, policy and practice (e.g. Coleman et al., 2011; NHS Scotland, 2012; NHS England, 2015a). I attribute this largely to the intervention of ‘activist-experts’ (Epstein, 1996) who work to establish themselves as credible while drawing upon the collective insights of community discussions, as well as ‘insider-providers’ (Hanssmann, 2016), who work with sympathetic allies to build activist-expert insights into everyday practice.

Importantly, the discursive repertoires of *both* trans as condition and trans as movement provide a ‘field of intelligibility’ (Steinberg, 2015a, 153) by which gender diversity can be rendered socially *real* (and thus, possible). This can work to counter

cultural and professional cisgenderist norms (Ansara & Hegarty, 2012; Kennedy, 2013), which otherwise render trans subjectivities unreal, impossible or non-credible. As I showed in Chapter 6, rendering trans bodies, identities and experiences intelligible provides a basis for gender identity services to be publicly funded through the NHS (Combs et al., 2008), as well as a means by which trans people might be recognised and understood in everyday, non-specialist medical encounters.

Contribution to knowledge

My account of the discursive repertoires of ‘condition’ and ‘movement’ offers a valuable sociological contribution to the field of transgender studies as well as to feminist and poststructuralist accounts of subjectivity and health. This conceptualisation moves beyond paradigmatic accounts of a discursive shift in understandings of trans health (e.g. Bockting, 2009a; Nieder et al., 2016), enabling instead an analysis of how multiple framings of trans possibility co-exist and intersect. In this thesis, I have shown how past contestations within medical literatures, trans communities and feminist theory continue to influence contemporary ideas and practices within the activist, community and practitioner spheres. In tracing how these ideas and practices emerge and influence one another, I have drawn productive comparisons between intellectual positions that are frequently regarded as necessarily opposed, such as traditional medical accounts of transsexualism, Prince’s (1978 [2005]) ‘transgenderist’ model, and ‘trans-exclusive’ radical feminist critiques of trans theory and medical practice. I have also explored the material consequences of discursive clashes, analysing how differences of understanding can lead to the delay or denial of medical treatment. In this way, I have built on the work of researchers such as Hines (2007), Davy (2011), McNeil et al. (2012) and Ellis et al. (2015) in order to better understand the construction of trans patient possibility, as well as the processes by which trans patients (and their doctors) encounter difficulties in a wider range of UK healthcare settings. Moreover, I have provided an expanded empirical basis for the models of professional and cultural cisgenderism outlined by Ansara & Hegarty (2012) and Kennedy (2013).

This thesis therefore offers a response to the question raised by Jess Phillips MP when she asked what, ‘clinically’, ‘living like a woman’ or ‘living like a man’ *actually means*. Within the context of social and physical transition, living ‘like’ a woman or a man is not simply a matter of behaving according to a particular model of womanhood or manhood; rather, it is about how an individual navigates the available medical (*and*

'trans community') models of trans gendered possibility in defining themselves and constructing their future.

I have demonstrated that there is no 'one' position on what it *means* to be trans, or on how trans can be *possible*; this was observed amongst trans and cis people, groups and institutions across the 'activist', 'community' and 'practitioner' spheres of fieldwork in this ethnographic project. However, lines of influence and resistance can be traced within and between all three spheres. I unpack these in the discussion of 'negotiation' that follows.

Negotiating discourses of trans health

Differences of understanding, definition and legitimation inform discursive clashes and material challenges within and between the activist, community and practitioner spheres. In this thesis, my analysis of these clashes and challenges focused primarily upon how they might be *negotiated* by trans patients. I looked at these negotiations on two levels: an individual level, and a collective level. I understand 'negotiation' here as the means by which trans healthcare systems might be navigated, as well as the means by which a collective agreement can be reached through extensive discussion.

Individual negotiations

In Chapter 5, I explored how individual trans patients might negotiate the opportunities and limitations of the respective discursive repertoires of condition and movement, as well as the oppressive consequences of cultural and professional cisgenderism. As previously discussed, trans patients frequently draw upon understandings of condition and/or movement in order to define themselves and their relation to the social world. This offers a means by which they might construct their identities and experiences as *possible* in medical encounters, thereby potentially improving their access to services. Similarly, both condition- and movement-oriented understandings of trans can be used to construct and justify trans existence in the wider social world. This is particularly important given that the high prevalence of ignorance (both innocent and malicious) amongst health professionals can mean that trans patients have to take a great deal of responsibility for their own care. In this way, even strictly conditional models of trans possibility can be agentially drawn upon (albeit only by those who are 'trans enough' to 'fit' these models) in order to challenge cisgenderist assumptions and norms.

The challenges trans patients can face in negotiating medical systems in particular were unpacked in detail in Chapter 3, *Trans Health in Practice*, and Chapter 6, *Trans Temporalities*. In Chapter 3 I demonstrated how cisgenderism and transphobia can produce barriers to care in all areas of healthcare provision. I also outlined the standard public health pathway that must be negotiated by patients seeking to transition through the NHS: a pathway typically defined primarily by strict assessment procedures such as RLE, as well as very long waits for treatment. Patients with access to the appropriate financial and/or social resources have more options for negotiating physical transition, be it through private providers or self-medication. In Chapter 6 I examined how the strict assessment procedures and long waits of the NHS route can inform a collectively-mediated temporality of *anticipation*, a queer time (Halberstam, 2005) that offers an opportunity for mistrust and fear as well as hope and excitement to grow. The temporal and emotional disjunctures of the time of anticipation can potentially be managed through strategic futurity, in which patients prepare carefully for clinical encounters and/or use the waiting time as an opportunity to reflect on their forthcoming transition and tell others about their plans. However, the uncertainty of the time of anticipation is emotionally difficult to negotiate; this uncertainty and difficulty can ultimately inform poor mental health and suicide ideation as well as the aforementioned mistrust and fear of health professionals.

Collective negotiations

The time of anticipation can also be understood as a collective negotiation of physical transition. Individual projections of future possibility by trans patients within the time of anticipation necessarily draw on multiple experiences of past and present, in terms of challenges that people have faced and improvements that they have seen in their lives. In this way, the queer time of anticipation is mediated communally in and through the interaction of various pasts, presents and possible futures that circulate within narratives of trans health in activist and community spaces.

The collective negotiation of trans health may be further understood as a means through which material and discursive change can be sought. In Chapter 2, I touched on how discourses of trans possibility constructed within the activist and community spheres might be drawn upon to influence policy and practice alike within the practitioner sphere. This theme was more fully examined in Chapter 7. In this chapter, I explored how trans patient advocates collectively construct their knowledges as *credible* through concerted and continual mutual recognition and iterative repetition

across a range of social and professional contexts. Having been constructed as credible, these knowledges can then potentially be drawn upon by activist-experts and insider-providers – as well as sympathetic cis professionals – in order to reconstruct the discursive and material conditions of healthcare provision, as seen in the examples of the depathologisation and non-binary movements.

Negotiating the field of trans health as a social researcher

This thesis also explored how the multiple discursive fields of trans health might be productively analysed and theorised by social researchers. I write as an ‘insider’ trans activist-expert who seeks to better understand (and, hopefully change) the discursive and material conditions of healthcare provision for trans patients. I have sought to make my own position *as* a trans patient and activist visible throughout this thesis, through vignettes reflecting on my own experiences, and acknowledgements of my presence within the ethnographic field. These interventions serve to contextualise the ‘epistemic politics’ (Hess, 2004) of my own academic work, while offering ‘analytic autoethnographic’ insight (Anderson, 2006) into the field of trans health. However, as I examined in Chapter 4: *Evoking the Field*, this was not an easy process; it entailed a range of quite significant methodological and emotional challenges.

A number of interesting issues also arise with respect to undertaking research online. In Chapter 4 I conceptualised this project as ‘Internet research’: specifically, as an ‘online ethnography’. However, in the chapters that followed I also showed how much the negotiation of discourse online is interwoven with material practice *offline*. Most of the social processes and practitioner sphere documents analysed in Chapters 5-7 are not located wholly online; rather, they represent the extension of institutional as well as ‘trans’ cultures *onto* the Internet. In this sense, the ongoing (re)construction, (re)definition and (re)negotiation of ‘trans’ possibilities is shaped not simply through a ‘street-Net-street effect’ involving trans activists and communities (Whittle, 1998; 393), but also the intersection of communally-mediated online discourse with medical practices and ideas formulated largely offline. This can be seen for example in my analysis of the operation of ‘mistrust’ in Chapter 5, and my discussion of trans activists’ critical response to the initial English protocol for gender identity services in Chapter 7. It can also be seen in my autoethnographic use of vignettes drawn from personal offline experience in order to illustrate and analyse discursive phenomena on the Internet. Hence, while I frame this project as an online ethnography, it specifically addresses a range of issues and encounters that reach well beyond the bounds of the

Internet. In this way, the Internet can be conceptualised as a (range of) site(s) through which knowledge claims are organised and contested, joining up arena of discourse through narrative links and hyperlinks alike.

Contribution to knowledge

By examining the negotiation of trans health, I have expanded upon the work of Hines (2007), Davy (2011) and Hanssmann (2016) to explore how the field of transgender studies can speak to sociological, queer and feminist work on health, and vice-versa. In addition to contributing to emerging accounts of trans temporalities (Halberstam, 2005; Carter, 2013; Horak, 2014; Bradley & Myerscough, 2015), my account of trans patient narratives explores how transitioning individuals in particular can find themselves 'living in prognosis' (Jain, 2007; Steinberg, 2015b). I have further explored how emotional and practical demands of these experiences have informed a range of activist interventions. Through my account of the epistemic politics (Hess, 2004) of trans health, I have analysed how trans health activists can be said to constitute a 'lay epistemic community' (Akrich, 2010), which has sought to establish the *credibility* of trans patient knowledges and experiences in a similar manner to other patient advocacy groups such as those concerned with AIDS (Epstein, 1996), pregnancy (Akrich, 2010), and cancer (Jain, 2007; Steinberg, 2015b). In particular, I have looked at how the interventions of trans patient advocates have worked towards a more gender pluralist (Monro, 2005) approach to healthcare provision.

Finally, I have made a number of methodological contributions to understandings of how the field of trans health might be negotiated by researchers. I described an approach to online ethnography that accounts for the interplay of discourse, narrative and material conditions within and between the Internet and the offline world, while accounting for a range of particular concerns that arise when conducting research on trans issues. I also examined the advantages and difficulties of negotiating the research process *as* a member of a marginalised group, contributing a number of suggestions for how researchers and the institutions in which they work might better account for the mental and physical demands of social research.

Beyond assessment

I opened this thesis with a quote from Meads et al. (2009) that noted the dearth of information on the *general* health of the trans population. Yet, having highlighted the importance of this intervention, I opened *this* chapter with a quote from the *Transgender Equality Inquiry* and a story from the 2016 WPATH Symposium that respectively appear to address only issues raised by gender identity services. This is not because I have intentionally sought to subsume wider issues of trans health within a project that specifically centres gender identity services. Instead, it is because conversations within and between all three spheres of the field tend to discuss ‘trans health’ in terms of how this is mediated by these services. I attribute this to *the enormous role that the medical discourses perpetuated in and through gender clinics play in shaping trans discourse*, both in terms of defining the scope of trans possibility and shaping the wider field of trans health. Discourses of condition and movement alike are generally defined either through or against the ideologies and practices of gender identity services. In turn, the conditions produced in and through these discourses shape how trans patients find themselves negotiating both general and specialist healthcare contexts.

This observation has profound consequences for understandings of both trans subjectivity and trans health. The strict management of trans/gendered possibility by gender clinics can work to stifle patient expression and inform harmful medical practices. This can be seen, for instance, in the adoption of condition-oriented perspectives on trans health within wider health contexts, meaning that individuals with more movement-oriented identities find themselves misunderstood even by health professionals who are trying to provide inclusive care. Moreover, transitioning patients can face not just a postcode lottery for care – which is most profound at present for Welsh individuals – but also a *framework* lottery, in which access to gender-affirming care is not guaranteed.

Within NHS gender clinics, even those gender identity specialists who have sought to build movement-oriented understandings – such as an acknowledgement of non-binary gender (Richards et al., 2016) – into their practice *continue to maintain the power to pronounce on their patients’ gender*. As highlighted in my question at the 2016 WPATH pre-conference, the current gender clinic model employed in the UK (and often, elsewhere) imbues gender identity specialists with a great deal of power. This is not simply the power to advise on whether or not a patient is healthy enough to transition; it is the power to assess whether or not a patient is *appropriate* for

treatment, and capable of providing a *credible* perspective on the matter of their own health. Multiple factors may shape the appropriateness and credibility of any given patient within the micro-setting of the diagnostic encounter: in addition to being ‘trans enough’, these might include (for instance) the intersection of gender with the patient’s occupation, race, dis/ability, family situation and/or preferred style of dress, as mediated by any given practitioners’ individual biases and any given gender clinic’s specific approach to conceptualising trans/gendered possibility and providing care. It is the fact that treatment *can* be delayed or denied on these grounds which informs much of the stress, anxiety, fear and mistrust that transitioning patients feel with regard to gender identity services.

In order to address these issues, it is not simply enough to incorporate insights from discourses of trans as movement into a more gender pluralist form of medical practice. Instead, trans patients must be better empowered to make decisions about their own health, to ‘actualize their embodied needs rationally, euphorically perhaps, and in whatever ways they desire, without the need for psychiatric gatekeeping in the form of [gender dysphoria] diagnoses’ (Davy, 2015: 1174). Approaches to gender identity services that affirm patient identities and desires through centring their ‘informed consent’ – rather than the knowledge and authority of practitioners – have been trialled successfully in countries such as Argentina, Canada and the United States (Deutsch, 2012; Reisner et al., 2015; Hanssmann, 2016). Decentring diagnosis and gatekeeping in this way can empower service providers ‘to establish a more trusting, supportive, and facilitative relationship with patients’ (Deutsch, 2012: 145). I read this more ‘trusting’ relationship as grounded in a regard for patient *credibility* on the micro-level of the clinical encounter, with the institutional provision of such care providing an alternative to the kind of framework lottery that is seen within the UK’s public health setting.

Looking to the future

This thesis does not provide a clear diagnosis for the challenges and difficulties inherent in the contested field of trans health, nor does it offer a firm prescription for the future. Numerous questions remain to be asked. For instance, can models that emphasise the informed consent of transitioning patients – as an alternative to extensive assessment – provide a practical basis for affirmative, gender pluralist public healthcare in the UK? Undoubtedly any attempt to implement any such model would encounter a range of challenges, including ‘suppression tactics’ (Hess, 2004: 705)

similar to those encountered by Russell Reid and Richard Curtis, along with potential NHS funding issues as highlighted by Richards et al. (2015). Moreover, I have argued that gender identity specialists' conceptualisations of trans possibility play a part in shaping understandings within the wider context of healthcare provision; would a shift in authority in this context, coupled with the deprioritisation of assessment, inform a wider recognition of a plurality of trans possibilities?

However, even as new questions arise from the conclusion to this work, I have provided a range of useful perspectives and analytic tools for those who follow me. In particular, this thesis has offered a broad overview of the many investments and negotiations that characterise the field of trans health in the UK, exploring the processes by which discourses and material conditions are shaped and the means by which they are conceptualised. It is my hope that these insights will prove pertinent for future sociological investigations and experiments in practice. A range of challenges lie ahead: the continued exponential growth in the visible trans patient population, the continued under-resourcing of gender identity services, and the continued rapid emergence of new trans knowledges and languages from increasingly active activist and community spaces. In order to meet these challenges, the lay and professional epistemic communities of trans health will need to get better at speaking to and understanding one another.

postscript: mists and landscapes

ancient hills in driving rain
bring context to our coach delay
massive cities of the north
motorway as we head forth
crumbling walls barely describe
human designs on this hillside
moody dressed with misty cape
somehow less real than this landscape

still I see that smile upon your face
the way you laughed with me
gone forever never replaced
but you're still here with me

soft ripples now in dark red warm
of an evening glow
a reign that will outlast our own
chaotic life in which we've grown
I've seen fear and I've seen rage
furious words leap from my page
friendships formed and sunset skies
promise burns in fiery eyes

still I see that smile upon your face
the way you laughed with me
gone forever never replaced
but you'll be here with me

Appendix

A sketch of the field

This appendix provides an overview of the ethnographic field and data corpus from which the analysis and findings of this thesis are drawn. In it, I list the sites in which fieldwork was conducted, and briefly describe some of their features.

I conducted fieldwork in a variety of online spaces, across a range of platforms: from static websites and documentation, to traditional Web forums, to social media platforms Facebook and Twitter. This wide scope was intended to reflect the range of trans spaces available online, as well as permeable boundaries of the medium itself (Baumer et al., 2011; Postill & Pink, 2012). The field was just one part of a far wider ecology of ‘trans’ themed sites, pages and mailing lists on the Internet. Many of these spaces did not exist simply to host a discussion of trans health: however, for the purposes of this project, I sought to examine how trans health *specifically* was discussed within them.

This is necessarily a sketch of the field rather than a complete picture for two reasons. Firstly, a number of details are not easily available. Secondly, I have chosen to omit other details in order to preserve participant anonymity. Thirdly, while I endeavoured to keep a full record of my research activity, this was not always possible (for instance, if I was accessing websites from a remote location without secure access to my project data and methodology folder).

For an analytic discussion of my methodological approach, see Chapter 4: *Evoking the Field*.

Activist sphere

For the purposes of this project, I understood the activist sphere to consist of social media spaces and opinion pieces written for blogs and news media platforms. I observed seven Facebook groups, a Twitter hashtag, and approximately 100 individual articles written for blogs and media organisations. A wide range of political tactics were discussed and/or implemented by trans individuals organising within or through these spaces, including protests/pickets, letter-writing campaigns, petitions,

information/awareness drives, academic analysis, event disruption, and the lobbying of politicians.

Blogs and activist websites

I visited the following blogs and activist websites during the fieldwork process, all of which are (or were) publicly available to any Internet user. Blog articles were written in long-form prose (typically 200-2000 words in length) by a single author, for the sake of sharing information, stimulating discussion and/or or expounding a point of view.

<i>A Gentleman And A Scholar</i>	(https://cnlester.wordpress.com/)
<i>Action For Trans Health</i>	(http://actionfortranshealth.org.uk/)
<i>All About Trans</i>	(http://www.allabouttrans.org.uk/)
<i>Beyond The Binary</i>	(http://beyondthebinary.co.uk/)
<i>Challenging Journeys</i>	(https://challengingjourneys.wordpress.com/)
<i>Cheryl's Mewsings</i>	(http://www.cheryl-morgan.com/)
<i>Complicity</i>	(http://www.complicity.co.uk/blog/)
<i>Demanding the Future</i>	(http://demandthefuture.tumblr.com/)
<i>The F Word</i>	(https://www.thefword.org.uk/)
<i>Free Speech Blog</i>	(http://blog.indexoncensorship.org/)
<i>Gendered Intelligence</i>	(http://genderedintelligence.co.uk/)
<i>GIRES</i>	(http://www.gires.org.uk/)
<i>Hel Gurney</i>	(https://helgurney.wordpress.com/)
<i>Jane Fae</i>	(https://faeinterrupted.wordpress.com/)
<i>Julia Walker</i>	(http://juliakwalker.blogspot.co.uk/)
<i>Just Plain Sense</i>	(http://blog.plain-sense.co.uk/)
<i>Kaberett</i>	(http://kaberett.dreamwidth.org/)
<i>Lesbilicious</i>	(site expired)
<i>Mixosaurus</i>	(http://mixosaurus.co.uk/)
<i>No More Lost</i>	(http://www.nomorelost.org/)
<i>Nonbinary Inclusion Project</i>	(http://nonbinary.co.uk/)
<i>Outreach Cumbria</i>	(site expired)
<i>Penny Red</i>	(http://laurie-penny.com/)
<i>penwing.site</i>	(https://www.penwing.me.uk/)
<i>Practical Androgyny</i>	(http://practicalandrogyny.com/)
<i>Press For Change</i>	(www.pfc.org.uk/)

<i>Protest Transphobia</i>	(site expired)
<i>The Quietus</i>	(http://thequietus.com/)
<i>Re.Framing Activism</i>	(http://reframe.sussex.ac.uk/)
<i>Roz Kaveney</i>	(http://rozk.livejournal.com/)
<i>SafeT</i>	(http://www.safetuk.org/)
<i>Sarah Brown's Blog</i>	(http://www.sarahlizzy.com/blog/)
<i>Sarah Savage</i>	(http://sarah-savage.com/)
<i>Scottish Transgender Alliance</i>	(http://www.scottishtrans.org/)
<i>Sex Matters</i>	(https://sexualitymatters.wordpress.com/)
<i>spacious perspicacious</i>	(http://cassolotl.tumblr.com/)
<i>So So Gay</i>	(http://gayist.co/)
<i>Trans Activist Takes On World</i>	(http://transactivist.wordpress.com)
<i>TransBareAll</i>	(https://transbareall.co.uk/)
<i>TransDocFailAnonymous</i>	(http://transdocfailanon.tumblr.com/)
<i>TransMediaAction</i>	(site expired)
<i>transmedic</i>	(https://transmedic.wordpress.com/)
<i>UK Trans Info</i>	(http://uktrans.info/)
<i>Uncommon Sense</i>	(http://uncommon-scents.blogspot.co.uk/)
<i>Upside Down In Cloud</i>	(http://dru-withoutamap.blogspot.co.uk/)

Facebook

I visited seven trans activist 'Facebook groups' during fieldwork. These were accessible only to existing Facebook users. Most were either 'closed' or 'secret' groups, meaning that new members have to be added or vetted by existing members: this means that they effectively operate as private spaces. 'Secret' groups are hidden from searches and can only be *seen* by an individual if they are directly invited to participate by an existing member. The smallest Facebook group visited for this project contained approximately 30 members and the largest contained approximately 1000; most, however, had approximately 100-300 members. A relatively small proportion of members would post regularly within any given group. I visited two 'closed' Facebook groups, which were run by established trans activist organisations.

Trans Media Watch
Press For Change

I visited five 'secret' Facebook groups, which focused largely upon the following topics.

General trans activism (established group)

General trans activism (new group)

Public health discussions

Trans feminism

Trans student activism

News media

I visited the following news media websites during the fieldwork process, all of which are (or were) publicly available to any Internet user. Opinion articles on trans health issues for these websites were written in long-form prose (typically 200-2000 words in length) by a single author, for the sake of sharing information, stimulating discussion and/or or expounding a point of view.

The Argus

BBC News

The Daily Mail / The Mail on Sunday

The Daily Telegraph / The Sunday Telegraph

Gay Star News

The Guardian / The Observer

London Evening Standard

The Metro

New Statesman

Pink News

The Scottish Sun

Twitter

The majority of fieldwork on Twitter for this project took place on the #transdocfail hashtag (<https://twitter.com/transdocfail>). I also drew on related but less popular hashtags, such as #transdocwin, and followed a number of trans activists. Hashtags are used to organise discussions, automatically filing relevant tweets together. Every tweet observed on #transdocfail for this project is visible to any Internet user, except where Twitter users later deleted or hid particular tweets or their entire account. Hundreds of Twitter users from a wide range of backgrounds were involved in #transdocfail, with

most originating from the UK. Over 2000 tweets were posted to the hashtag, a majority of which written during the first three days (8th January – 10th January 2013).

Miscellaneous

I also looked up several Freedom of Information requests made by trans activists (and responses to these) at *WhatDoTheyKnow* (<https://www.whatdotheyknow.com/>), read a number of online petitions, and played the browser game *A Trip To The Clinic* (<http://aliendovecote.com/uploads/twine/others/chaosjam/Clinic.html>). During the occasional periods of supplementary observation that took place after April 2015, I followed the Women and Equalities Committee *Transgender Equalities Inquiry*, participated in a number of Facebook and Twitter conversations with my contacts, and occasionally looked at activist conversations on sites such as the ‘Transgender UK’ subsection of *Reddit*.

Community sphere

For this area of fieldwork, I looked into discussions taking place within two Internet forums. Some of the activist spaces discussed in the previous section were also arguably communities in their own right (or one constituent part of a larger community). However, I use ‘community’ in this context to refer to the manner in which the forums visited for fieldwork primarily operated as social spaces: their purpose was *specifically* to provide a basis for a ‘community of care’ (Hines, 2007). This differed from the more action-oriented nature of spaces within the activist sphere.

Both forums hosted a mixture of public areas (visible to any visitor) and private areas (visible only to registered members). Neither was dedicated solely to the discussion of trans health; at the same time, conversations on this topic were not confined to specific sub-forums. Instead, health was discussed *alongside* a myriad of other conversation topics, such as personal challenges, family issues, film and television, music, skills and hobbies, discrimination, ableism, racism and/or sexism.

Both forums had a large membership and were highly active as fieldwork began, with many hundreds of registered members and a more active core group of a few dozen regular users. They were based in the UK, with memberships residing largely in the UK also. There was a great deal of diversity in terms of age on both forums, with users’ ages ranging from mid-teens to late 70s. However, the majority of regular users

were aged between 30 and 60, reflecting a shift towards newer social media platforms amongst trans youth (Jenzen & Karl, 2014)⁹¹.

Forum 1

Forum 1 was, in theory, open to members from across the trans spectrum; however, the active membership predominantly identified into the 'male-to-female' spectrum, with trans women particularly common. I read approximately 330 pages⁹² of conversation on Forum 1. As I described in Chapter 4, these were saved to NVivo for analysis using the NCapture plugin.

Forum 2

Forum 2 focused generally on providing space for 'female-to-male' spectrum experiences. However, a small number of users identified themselves as women (this included both trans and cis women). Self-identified non-binary or genderqueer users were somewhat more common here than on Forum 1. I read approximately 700 pages² of conversation on Forum 2. These were saved to NVivo for analysis using the NCapture plugin.

Practitioner sphere

The practitioner sphere consisted largely of information written both by and/or for medical practitioners on the subject of trans health. However, it did include some information produced for trans patients by NHS or charitable bodies. This area of the data corpus included guidance and advice documents for NHS staff and patients, clinical guidance and protocols, GIC websites, and information on public consultations. The majority of this material was, therefore, written by cis professionals working with trans people. However, there were a number of documents written and/or influenced by trans professionals and activists.

⁹¹ At the time of writing, patterns of Internet usage amongst trans teenagers are changing once again. Jenzen & Karl (2014) note that LGBTQ youth tend to operate across a wide range of platforms, with trans youth in particular now favouring more youth-oriented social networking sites such as Tumblr over Facebook; they attribute this to the 'mainstreaming' of the latter platform.

⁹² Each 'page' comprised 1-10 individual posts, with posts ranging in length from 2- 4000 characters.

I acquired a number of materials attributed to this sphere through trans resource sites (such as UK Trans Info) and contacts made within the practitioner and activist spheres. I further obtained access to a number of letters and documents through participation in the NHS England Gender Identity Services GRC consultation process. All other materials were acquired through various websites maintained by NHS bodies, public health quangos, and professional bodies, which variously exist to provide and share information for patients, practitioners and/or health service managers. A brief list of these sites follows.

I sampled from the following **practice/clinic websites** (including both public and private service providers):

Belfast Health and Social Care Trust Gender Identity Service

(<http://www.belfasttrust.hscni.net/services/BrackenburnClinic.htm>)

cliniQ

(<https://cliniq.org.uk/>)

Devon Partnership NHS Trust Gender Identity Services ('The Laurels')

(<https://www.devonpartnership.nhs.uk/Specialist-Gender-Identity-Clinic.wesgic.0.html>)

Gender Care

(<http://gendercare.co.uk/>)

Gender GP

(<https://gendergp.co.uk/>)

Grampian Sexual Health Clinic

(http://www.nhsgrampian.org/nhsgrampian/sexual_health_template.jsp?pContentID=7624&p_applic=CCC&p_service=Content.show&)

Highlands Sexual Health Clinic

(<http://www.nhshighland.scot.nhs.uk/Services/Pages/SexualHealth.aspx>)

Leeds Gender Identity Service

(http://www.leedspft.nhs.uk/our_services/gender_identity/)

Lothian Sexual Health Gender Identity Clinic

(<http://lothiansexualhealth.scot.nhs.uk/services/gic/Pages/default.aspx>)

Nottingham Centre for Gender Dysphoria

(<http://www.nottinghamshirehealthcare.nhs.uk/nottingham-centre-for-gender-dysphoria>)

Northamptonshire Healthcare NHS Foundation Trust Gender Clinic

(<http://www.genderclinic.northants.nhs.uk/>)

Northern Region Gender Dysphoria Service

(<http://www.ntw.nhs.uk/sd.php?l=2&d=9&sm=15&id=240>)

Sandyford Gender Identity Service

(<http://www2.sandyford.org/do-you-want-information-on-sexual-orientation-or-gender-identity/gender-identity/sandyford-gender-identity-services.aspx>)

Sheffield Health and Social Care NHS Foundation Trust Gender Identity Service

(<http://shsc.nhs.uk/service/gender-identity-service/>)

TransHealth

(<http://transhealth.co.uk/>)

West London Mental Health NHS Trust Gender Identity Clinic ('Charing Cross')

(<http://www.wlmht.nhs.uk/gi/gender-identity-clinic/>)

YourGP: Gender Dysphoria Consultation

(<http://your-gp.com/services/sexual-health-gender-clinic/gender-dysphoria/>)

I sampled from the following **public health information websites:**

NHS Commissioning: Gender Identity Services (Adults)

(<https://www.england.nhs.uk/commissioning/spec-services/npc-crg/group-c/c05/>)

NHS England

(<https://www.england.nhs.uk/>)

NHS Inform: Gender Dysphoria

(<http://www.nhsinform.co.uk/health-library/articles/g/gender-dysphoria/>)

Guide to NHS Waiting Times

(<http://www.nhs.uk/choiceintheNHS/Rightsandpledges/Waitingtimes/>)

Healthwatch

(<http://www.healthwatch.co.uk/>)

Live Well: Transgender Health

(<http://www.nhs.uk/livewell/transhealth/Pages/Transhealthhome.aspx>)

Scotland's Health on the Web

(<http://www.scot.nhs.uk/>)

I sampled from the following **professional organisation websites:**

British Medical Association

(<https://www.bma.org.uk/>)

General Medical Council

(<http://www.gmc-uk.org/>)

Royal College of Psychiatrists

(<http://www.rcpsych.ac.uk/>)

WPATH

(<http://www.wpath.org/>)

Finally, I sampled from the following websites **created by and/or for health professionals**. This list includes miscellaneous blogs, news sites, legal advisory services and private health companies.

DSM-5 Response

(<http://www.dsm5response.com/>)

Good Health Suite

(<http://www.thegoodhealthsuite.co.uk/>)

GPonline

(<http://www.gponline.com/>)

Medical Practitioners Tribunal Service

(<http://www.mpts-uk.org/>)

Mind Hacks

(<https://mindhacks.com/>)

Shoosmiths

(<http://www.shoosmiths.co.uk/>)

Therapy Today

(<http://www.therapytoday.net/>)

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Now, head out back into the world. What can we change for the better?