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The *Bulletin of Applied Transgender Studies* (*BATS*) is the leading venue for academic research addressing the social, cultural, and political issues facing transgender and gender minority communities across the globe. The journal offers a platinum open access forum for research of all theoretical and methodological approaches oriented toward the identification, analysis, and improvement of the material conditions of transgender life.

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ORIGINAL ARTICLE

Whither Trans Studies? On Fields, Post-Disciplines, and the Need for an Applied Transgender Studies

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The institutionalization of transgender studies as a field comes just as the academy has decided that "fields" are a less relevant and more cumbersome aspect of professional academic organization that prevents the kind of theoretical and empirical work needed to make scholarship relevant to contemporary society. A number of areas of intellectual inquiry have, accordingly, shifted to a "post-discipline" model of academic organization. But what would it mean to think of transgender studies as a post-discipline? First, it would mean a turn away from a focus on field-building within the humanities. Second, it would mean insisting upon transdisciplinary collaboration despite the academy's failure to encourage such collaboration. But perhaps most importantly, it would mean a turn *toward* addressing the material conditions of transgender existence and the issues transgender people face in the world. In short, it would mean reorienting ourselves toward an *applied transgender studies*.

KEYWORDS trans studies; applied scholarship; postdisciplinarity; academic fields
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The field of communication first began to cohere in the 20th century as thinkers across several established fields and scholarly traditions began applying their respective theoretical assumptions and methodological tools to the same broad set of social questions. Scholars like economist Harold Innis, literary critic Marshall McLuhan, philosopher Theodor Adorno, political scientist Harold Lasswell, psychologist Carl Hovland, and sociologists Herbert Blumer, Paul Lazarsfeld, and Robert Merton converged to study the then-new mass media of radio and, later, television (Herbst 2008). Their new intellectual program was held loosely together by questions about these time- and space-warping technologies and the widespread effects they were having (or might come to have) on every domain of the social world (Peters 1993). Despite their profound intellectual differences (and different departmental homes within the university), these and other scholars eventually established an interdisciplinary core of theories and concepts around which a new field began to orbit as scholars debated these competing explanations for important social phenomena (Schramm 1983). Eventually, they went on to formally come together in newly founded schools and departments of communication at universities across the world. Yet, even as this new field institutionalized, communication scholars struggled to define what *exactly* it was they studied and what held them together as a cognizable discipline (Herbst 2009; Peters 1993; Waisbord 2019).

Transgender studies has faced similar struggles to define itself as a field. Transgender studies emerged in two distinct waves defined by different scholarly paradigms (Schilt and Lagos 2017). The first paradigm, which sociologists Kristen Schilt and Danya Lagos (2017, 426) refer to as the "gender deviance paradigm," dominated transgender studies from the 1970s through the 1990s. In this wave, trans people were treated as *objects* of study, with cisgender researchers regarding trans people as tools to test the limits of sociological theories. The second paradigm, which Schilt and Lagos (2017, 426) call the "gender difference paradigm," emerged in the late 1990s and early 2000s. In this wave, trans people have been centered as *subjects* of study, with researchers regarding trans people's lives as "sociologically important in their own right" (Schilt and Lagos 2017, 426).

It is the emergence of this second gender difference paradigm that has given birth to what we might now refer to as transgender studies *per se*, as transgender activists and scholars have pushed back against the pathologizing lenses of earlier medical and social scientific research, as well as challenged queer and feminist theory for their inability to fully account for transgender experience (Billard and Zhang 2022; Namaste 2000; Schilt and Lagos 2017; Stryker 2004). Instead, trans scholars have sought to give voice to their own lived experiences, "engag[ing] in the kind of identity politics necessary to gain speaking positions within discourse" (Stryker and Aizura 2013a, 3). To this end, much early trans studies writing has taken as its central question, "what does it mean to be transgender?" Trans studies' investment in that question has been less about generating a canon of new theories than it has been about wrestling meaning over what it means to be trans away from other disciplines. And this is not an unimportant question. But its centrality has given rise to ontological and epistemological debates around the expansive and multiple meanings of the prefix *trans-* and what can and cannot be considered a transgender "object," such that it runs the risk of decentering the material conditions of transgender life (Stryker, Currah, and Moore 2008).

Scholars working in transgender studies thus find themselves debating what it means to study "trans" topics and what it is that unites them into a coherent scholarly program. Like the field of communication, the field of transgender studies faces an identity crisis.

While the fields of communication and transgender studies may experience similar tensions over what defines their areas of inquiry, they have taken profoundly different approaches to resolving them. Transgender studies has sought to resolve these tensions by tightly narrowing its scope in ways that exclude topically relevant work from other disciplines, but that give greater cohesion to its theoretical and methodological approaches. Accordingly, for the last decade or two, transgender studies has been undergoing a process of institutionalization within the humanities, where it is defined by its subsidiary relationship to queer theory and, to a lesser extent, cultural studies (Keegan 2020a, 2020b; Stryker 2020). And these disciplinary efforts to establish transgender studies as a humanistic field have borne tremendous first fruits, with a prestigious cultural studies journal, several prominent book series, and a small but growing number of institutional homes.

Whereas trans studies has pursued *disciplinary* efforts, communication has sought to resolve its definitional tensions through *postdisciplinary* efforts at field-building. As former editor of the *Journal of Communication*, Silvio Waisbord (2019), writes, communication is a "post-discipline." In contrast to traditional academic fields, post-disciplines are "primarily concerned with producing knowledge about specific phenomena detached from clear-cut disciplinary allegiances," and they serve as "intellectual trading zones where scholars trained in various disciplines seek to coordinate and synthesize analytic approaches by developing common concepts, languages, and theories around specific problems and questions" (Waisbord 2019, 127). Post-disciplines are characterized by theoretical and methodological pluralism and by fluid boundaries as scholars address the multiplicity of audiences that share their empirical concerns. We can see how communication fits the post-discipline model in the disciplinary diversity of its founders (and current participants) and in its uniting focus on specific questions raised by the empirical phenomena surrounding communication technologies. Other post-disciplines—like development studies, environmental studies, and science and technology studies—anchor themselves similarly, drawing on networks of scholars archipelagated across fields of study, each with their own theories and methods, to address issues of shared pragmatic concern.

Transgender studies is not the field of communication, of course, nor should it be. But the example of communication (among other exemplary post-disciplines) shows us a different way to think about, to define, and to *do* trans studies—particularly where it concerns the field's organization and epistemological orientation. Trans studies could serve as an "intellectual trading zone" for the full diversity of interested scholars (similarly archipelagated across disciplines) to produce new visions of trans life that center on shared empirical and pragmatic questions. Trans studies could—and in our opinion, should—make camp at the intersections of humanistic, social scientific, and biomedical inquiry, incorporating critical and empirical methods from a variety of disciplines to better account for trans materialities. Yet, it has chosen not to. We argue that this choice has been made at great cost to the field and the wider trans community.

Given its opposition to medical and social scientific research—which is understandable, considering how such research has historically worked to pathologize trans people and to gatekeep their access to gender-affirming care and legal protections—trans studies has been at best ambivalent and at worst hostile toward data and empirical methods (Labuski and Keo-Meier 2015; Namaste 2000; Stryker and Aizura 2013a). This ambivalence continues even as state institutions and technologies of surveillance use data to control and discipline trans populations (Beauchamp 2019; Fischer 2019; Scheuerman et al. 2020). As anti-trans movements in the US and globally continually threaten the welfare and life chances of trans people, we contend that transgender studies must recenter the material and open itself up to the empirical.

Our vision of the field thus expands upon the existing, albeit limited, institutionalization of transgender studies in interdisciplinary humanities. We advocate for a multi-theoretical and multi-methodological post-discipline of transgender studies that affords the analytic flexibility and intellectual pluralism needed for trans studies to make itself of importance to addressing the problems of the world. But what would it mean for trans studies to establish itself as a post-discipline? First, it would mean a turn away from a focus on field-building within the humanities, opening up the field of inquiry to interested scholars approaching trans studies from a wider range of disciplinary homes. This would necessarily involve building and maintaining bridges between the hard-won humanistic disciplinary homes where trans studies ostensibly takes place and the newer spaces being carved out across the social, biomedical, and even natural sciences. Second, it would mean insisting upon transdisciplinary collaboration despite the academy's failure to encourage such collaboration. But perhaps most importantly, it would mean a turn *toward* addressing the material conditions of transgender existence and the issues transgender people face in the world (see Billard et al. 2021; Hoffmann 2022; Johnson 2022a, 2022b; Johnson, Rogers, and Taylor 2021). In short, it would mean reorienting ourselves toward an *applied transgender studies*.

In articulating a concept of applied transgender studies, we understand it as a program of research focused on identifiable and pragmatic social, cultural, and political problems of relevance to transgender people, both at the individual and collective level. Importantly, we *do not* understand applied transgender studies as a rejection of humanistic inquiry or as a turn toward social scientific inquiry. Rather, it is about building our field around a pragmatic focus on the improvement of the conditions of transgender existence—which can be achieved through humanistic work, through social scientific work, through a synthesis of humanistic and social scientific perspectives (see, for example, Labuski and Keo-Meier 2015; Singer 2015; and Thomson and King 2015), and through modes of scholarship that fall outside the humanities/social science distinction altogether (such as biomedicine; law; science, technology, engineering, and mathematics [STEM]; etc.). At present, such work is underrepresented in the field of trans studies; yet, without generating this applied research, the laws, policies, and practices that determine the life chances of transgender people are loathe to change. This journal, and the Center for Applied Transgender Studies that publishes it, aims to facilitate this work and, in doing so, to develop a robust area of applied transgender studies.[1]

1 The *Bulletin of Applied Transgender Studies* is published by Northwestern University Libraries

This article, with which we open the inaugural issue of the *Bulletin of Applied Transgender Studies*, lays out our vision for the field more fully. It justifies the importance of a post-disciplinary model of organization and demonstrates how applied transgender studies brings us closer to actualizing the field's promise. Finally, it calls on other trans studies scholars to join us in this intellectual and political endeavor.

THE STATE THE FIELD OF TRANSGENDER STUDIES

Susan Stryker (2004, 212) famously described trans studies as "queer theory's evil twin." Indeed, as Stryker and other scholars (e.g., Bettcher and Gregory 2009; Keegan 2020b; Stryker 2004; 2006) have documented, trans studies has often defined itself by simultaneous kinship with and opposition to queer theory and feminist theory. As a disciplinary endeavor, trans studies struggles against the gravitational pull of queer theory that wants to subsume it as a mere extension of sexual analysis into the realm of gender (Keegan 2020a), yet at the same time it has been harshly accused by its own proponents of being little more than a repackaging of queer theory's central ideas "with the label TRANS hastily slapped over their expiration dates" (Chu and Harsin Drager 2019, 103). Moreover, as Sally Hines (2010, 6) points out, "questions around the position of trans women within feminism cut to the heart of discussions around the constitution of 'woman'." This is particularly evident in the ways trans studies challenges the core model of male–female domination that lies at the heart of much of feminist theory, while also refusing to dispense with it entirely (Billard and Zhang 2022; Billard et al. 2020; Keegan 2020b). Indeed, the question of trans people's inclusion in women's spaces has been one that transfeminists have worked diligently to unpack by insisting on the need for an intersectional perspective (Koyama 2006). The resurgence of these tensions even became the subject of the "TERF Wars" monograph of *The Sociological Review* that sought to contextualize the "debate" within and across feminist circles and highlight the relationship between trans communities and feminist social movements (Pearce, Erikainen, and Vincent 2020).

As trans studies has become more institutionalized, its relationship to the fields of queer theory and feminist theory has complicated its place within the organizational structure of the academy. As trans theorist Cáel Keegan (2020b) shrewdly notes, queer theory and women's studies have worked to coopt transgender experience for their own theoretical ends and professional advancements without attending to the specificities of transgender life and perspectives. Keegan (2020a) further argues that trans studies has been defined in opposition to queer theory because queer theory (alongside gender studies) serves as the primary institutional context through which trans studies enters the academy, and queer (and feminist) theory offers the canon of texts against which trans studies is read. However, trans studies need not (only) be

(NUL) on behalf of the Center for Applied Transgender Studies (CATS). We owe an immense debt of gratitude to NUL's Digital Publishing Librarian, Chris Diaz, for his tireless labor to secure the necessary agreements between CATS and NUL, to get the journal set up, and to manage the journal's ongoing production. We also owe thanks to Northwestern's Dean of Libraries, Sarah M. Pritchard, for believing the in value of the journal and putting the full resources of NUL behind it.

defined in opposition to queer and feminist theory. This positioning is only relevant to the extent that trans studies narrowly traces its origins to debates in queer and feminist theory.

Fields are not natural things; they are constructed by the narratives that scholars craft about the history of ideas and they are enforced through disciplinary institutionalization. The narrative of transgender studies has been shaped in myriad ways by a single scholar, Susan Stryker, who is rightly credited as a (if not *the*) founding figure of the field. Through her scholarship and her herculean institutional service—co-founding *TSQ: Transgender Studies Quarterly* (Stryker and Currah 2014), establishing the Transgender Studies Research Cluster at the University of Arizona's Institute for LGBT Studies (Stryker 2020), organizing the first international trans studies conference, and co-editing three transgender studies readers (Stryker and Aizura 2013b; Stryker and Blackston 2022; Stryker and Whittle 2006)—she has undoubtedly played a pivotal role in the establishment and institutionalization of transgender studies as a humanistic field positioned largely in relation to queer and feminist theory. And trans studies does indeed have a rich lineage in the cultural studies of gender and sexuality (e.g., Prosser 1998; Namaste 2000, 2005; Stone 1991; Stryker 1994)—just as it has lineages in other humanistic areas of inquiry, like Black and woman of color feminisms, disability studies, Indigenous studies, postcolonial theory, etc. (Adair, Awkward-Rich, and Marvin 2020; Bey 2017; Bey and Green 2017; Malatino 2020).

But trans studies can trace its origins to debates in biomedical and social scientific inquiry, as well. Studies of trans people have been conducted, for example, by anthropologists researching Indigenous gender practices that fall outside the Western sex–gender binary (e.g., Williams 1986); by medical researchers studying treatments for transsexualism, including hormone replacement therapy and surgical interventions (e.g., Benjamin 1966); and by sociologists studying the sociocultural construction and maintenance of gender norms and categories (e.g., Garfinkel 1967); among others. The field of transgender studies has understandably disavowed much of this research for its stigmatizing and pathologizing construction of transness, for its sometimes implicit and often explicit racism, for its relationship to colonialism and global flows of capital, and for other related reasons (see, e.g., Everhart forthcoming; Gill-Peterson 2018; Irving 2009; Snorton 2017)—even if the same critiques could (and should) be made of the humanistic field of trans studies as descended from queer and feminist theory (see, e.g., Aizura et al. 2020; Ellison et al. 2017; Namaste 2009; Richardson and Meyer 2011; Snorton and Haritaworn 2013). But where relevant areas of scholarship in the humanities have been recuperated for the purposes of building up a field of trans studies, relevant areas of biomedicine and the social sciences (not to mention STEM) have been cast aside, and scholars hailing from these disciplines have, in some ways, been barred admission from "the field" (Billard 2020).

There is yet another way of thinking about and defining academic fields that may be illuminating for thinking through transgender studies: that of sociologist Pierre Bourdieu's (1983, 1984, 1988, 1993; Bourdieu and Wacquant 1992) field theory. Put simply, according to Bourdieu a field is a social topography, a "configuration of relations" among a set of interacting actors and institutions, which are structured by established power dynamics. In the specific context of academic fields, we can think of the set of actors (researchers, educators, administrators, editors, etc.) and institutions

(professional societies, publishers, departments, schools, colleges, etc.) that occupy various positions vis-à-vis one another, each with different kinds and amounts of capital and power (Bourdieu 1988; Charle 2018). From this perspective, we can understand the field of transgender studies as being primarily defined by the following actors and institutions:

1. the journal *TSQ: Transgender Studies Quarterly*, which is held to be the sole journal dedicated to trans studies, since the *International Journal of Transgender Health* (formerly the *International Journal of Transgenderism*) and *Transgender Health* are excluded from the field of interaction;
2. the two book series dedicated to trans studies currently published by top university presses, namely the "ASTERISK: Gender, Trans-, and All That Comes After" series from Duke University Press and the "Queer / Trans / Digital" series from New York University Press;
3. a small collection of institutional homes for trans studies, including the Transgender Studies Research Cluster at the University of Arizona, the Chancellor's Postdoctoral Research Fellowship in Transgender Studies at the University of Illinois Urbana-Champaign, the Chair in Transgender Studies at the University of Victoria, and (as of 2021) the Center for Applied Transgender Studies; and, finally,
4. the network of researchers and educators who are tied up in the webs of relationality among the actors/institutions listed in the preceding three points—the vast majority of whom are defined by their precarious relationships to the academy (Adair, Awkward-Rich, and Marvin 2020).

This paucity of institutional settings for transgender studies and dearth of actors included in the field of interaction has been—in more ways than one—a significant limitation to the field.

This necessarily coarse assessment of the state of the field sets us up to think more deeply about how the field might be reconfigured in ways that will improve it. But it also does so without considering the problems of theorizing about transness with an eye toward personal scholarly achievement—rather than public service—in the face of the material circumstances most trans people face throughout the world. While we will touch upon this ethical question in passing in our later discussion of what applied transgender studies should be and do, we leave deeper consideration of this point for other work (e.g., Billard 2019).

THE POSTDISCIPLINARY TURN IN ACADEMIA

The institutionalization of transgender studies as a field comes at a strange time. It comes just as the academy, more broadly, is pushing against the limiting boundaries of "fields," as the academy has decided that "fields" are a less relevant and a more cumbersome aspect of professional academic organization that prevents the kind of theoretical and empirical work needed to make scholarship relevant to modern society. This new aversion to disciplinarity—marked by the omnipresence of "interdisciplinary" as a buzzword used to described everything from new PhD programs to departmental seminar series to individual scholars' research agendas to the journal *TSQ*—has several roots. Some of those roots relate to neoliberal discourses of "innovation," which is

said to "*necessarily* occur in the spaces between" disciplines but not *within* them (Chandler 2009, 739). Others relate to the acknowledgement that the issues scholars concern themselves with are multifaceted and thus cannot be sufficiently addressed from one disciplinary perspective alone (Menand 2001).

Regardless of its motivating impulses, the contemporary academy's aversion to disciplinarity has spawned a seemingly endless list of new approaches to scholarship (most of which are difficult to distinguish from one another), including interdisciplinarity, multidisciplinarity, transdisciplinarity, and so on.[2] Of these, interdisciplinarity is likely the most familiar, arguably tracing its origins to the 1920s and becoming dominant in the US academy in the 1960s (Chandler 2009; Klein 1990). By the mid-1990s, however, interdisciplinarity had become a subject of crisis among scholars, even as administrators continued to advocate for it. Competing camps emerged of those who were outright against interdisciplinary and those who were pro-interdisciplinarity but concerned that true interdisciplinarity "wouldn't be possible without strong disciplines" (Chandler 2009, 739). Still others argued that disciplines were collapsing altogether and that new organizations of knowledge were emerging in their place (Menand 2001).

While this may seem like mere semantics, we suggest that learning from this particular intellectual history is useful at a moment where trans studies has reached a zenith in popularity, especially given that this history is contemporaneous to the inception of trans studies. We are convinced by the proponents of postdisciplinarity who argue that what gives scholars unity is their emphasis on and attention to the very real problems facing modern society (e.g., Brewer 2013; Waisbord 2019). Science and technology studies scholar Mario Biagioli (2009, 821) suggests that, in many ways, postdisciplinarity offers the best of what scholarship can do:

> A positive feature of this research model is that, while prizing fine interpretive skills and the ability to make sense of new scenarios… it deemphasizes issues of disciplinary identity. [A post-discipline] employs various methodologies to analyze different [problems], and yet these bricolages do not seem to precipitate identity crises.

While we would contend that Biagioli's is a somewhat sanguine view of postdisciplinarity, we agree that it offers much to be desired as a mode of academic organization. In making the epistemological shift to view theories and methods as *tools* for analyzing and addressing societal problems, rather than as *products* created for disciplinary ends, postdisciplinarity creates new forms of knowledge and new relationalities among scholars. We assert that a core strength of trans studies is precisely this postdisci-

2 While the differences between these various concepts are hard to nail down—particularly because of the inconsistent ways they are used by individual scholars and the tendency to slip between them as synonyms—Choi and Pak (2006, 351) offer the following distinctions:

> Multidisciplinarity draws on knowledge from different disciplines but stays within their boundaries. Interdisciplinarity analyzes, synthesizes and harmonizes links between disciplines into a coordinated and coherent whole. Transdisciplinarity integrates the natural, social and health sciences in a humanities context, and transcends their traditional boundaries.

plinary perspective and ability, and that it could be even further strengthened with a reorientation toward applied scholarship.

A number of areas of intellectual inquiry have already shifted to a post-discipline model of academic organization (or else were formed as post-disciplines), including communication, development studies, environmental studies, and science and technology studies, among countless others. While each of these fields tackles different subjects in different ways and for different reasons, they are united by their distinct visions of the *value* of scholarship. Here we don't mean value in the capitalist sense that often defines assessments of scholarly worth in the modern neoliberal university and justifies the defunding of the arts and humanities. Rather, these fields concern themselves with *public value*, which "is defined in terms of humanitarian futures and societal good," as they work to produce knowledge that is "of use in addressing society's problems" (Delbridge 2014, 106).

Postdisciplinarity, then, necessarily entails political investments and ethical values. As eminent sociologist John David Brewer (2013, 201–02) writes,

> These ethical values are explicit. They are its point… [Postdisciplinarity's] research and teaching agendas are designed to engage with publics, locally organic ones as well as powerful ones, privileged and poor ones, in order to involve all stakeholders affected by the "wicked problems" we are experiencing; and the scientific commitments to analysis, explanation, and understanding are matched with the desire, at best, for solutions and at least amelioration.

In short, a post-discipline approach to field-building affords the theoretical and methodological flexibility and pluralism needed for areas of inquiry to orient themselves to the identification, analysis, and, ultimately, improvement of the material conditions they study.

DEFINING A PROSPECTIVE POST-DISCIPLINE OF "TRANSGENDER STUDIES"

We have argued that if the field of transgender studies has been institutionalized, it has happened within the interdisciplinary humanities and that this disciplining of trans studies is not only at odds with its goals but has also limited the scope and focus of the field. We then argued for the benefits of a *postdisciplinary* approach to scholarly organization, as evidenced by a number of extant areas of academic inquiry. That then brings us to the task of outlining what a post-discipline of transgender studies would look like and detailing how a prospective *post-discipline* of transgender studies would be preferable to the currently emerging *discipline* of transgender studies.

First, a post-discipline of transgender studies must have a clear and unwavering set of political investments. Thankfully, the field has, from its outset, had a clear politics, invested as it is in work that "[contests] the objectification, pathologization, and exoticization of transgender lives" (Duke University Press n.d.). Yet not all scholarship about trans people, especially scholarship by interlocutors who lack lived experience or by those invested in pathologization, has met this low political bar. At the same time, trans studies has a very particular kind of politics: a *politics of theory* that concerns itself with the rectitude of critical inquiry. But what is missing from the field—and what is demanded by a post-discipline—is a *politics of everyday life* that concerns itself

with "contributing our specialized skills and knowledge toward the mitigation of social problems" (Billard 2019, 3514). As the prolific sociologist and advocate for public scholarship Michael Burawoy (Burawoy et al. 2004, 104) writes, researchers must carry their scholarship "into the trenches of civil society, where publics are more visible, thick, active, and local, or where indeed publics have yet to be constituted." If we study issues of domination, marginalization, and social injustice, but do not orient our work toward alleviating them in real, material ways, our scholarship may benefit our careers at the expense of the very communities we research.

Second, a post-discipline of transgender studies must be open to a wider range of actors from a wider array of disciplinary homes, and it must actively foster new forms of relationality among those actors. Rather than building a disciplinary home for scholars working in the humanities, whether implicitly or explicitly, we must instead build a postdisciplinary community that welcomes and values the contributions of scholars from across biomedicine, the humanities, law, the social sciences, and STEM. This means we must recognize, appreciate, and incorporate into our own thinking and practice the theories and methods of scholars trained in disciplines outside our own to the extent they share our topics of focus and political investment in improving the material conditions in which transgender lives are lived. And that requires, as a starting point, that we read and cite across lines of disciplinary difference to a greater extent than we presently do.

Finally, and relatedly, a post-discipline of transgender studies must have a more expansive and more robust institutional architecture. Waisbord (2019, 123–24) writes that the post-discipline of communication is "held together by an institutional architecture of professional organizations, academic units, and journals," rather than by any coherent canon of theories or set of standard methodologies. However, transgender studies is not so lucky as to have such alternative sources of unity outside of the journal *TSQ: Transgender Studies Quarterly*. While *TSQ*'s contribution to the field has been monumental, it has also been critiqued for its narrow focus on humanistic inquiry (see, e.g., Ashley 2020; Billard 2020; Cull 2020; Turner 2020). In some ways, these critiques are warranted, because the journal *has* formally announced itself as the "journal of record" for the field of transgender studies (Institute for LGBT Studies, n.d.). In other ways, these critiques are perhaps asking too much of *TSQ* as a journal focused on cultural studies. Regardless, *TSQ* was, until the launch of the *Bulletin of Applied Transgender Studies*, the only venue dedicated to trans studies research not explicitly focused on health. These health journals—the *International Journal of Transgender Health*, published by Taylor & Francis, and *Transgender Health*, published by Mary Ann Liebert—are the only other journals that exclusively publish research on transgender topics, but they lack any substantive dialogue with the broader field of trans studies.

Importantly, *TSQ* has always been firmly trans-led whereas the *International Journal of Transgender Health* is associated with the World Professional Association for Transgender Health and *Transgender Health* was founded by a scholar connected to, but not a member of the trans community. In this way, the *Bulletin of Applied Transgender Studies* serves as a bridge between these journals that have built up the field at ostensibly opposite ends of a disciplinary spectrum.[3] In so doing, we aim to make further

3 The editorial board of the *Bulletin of Applied Transgender Studies*—developed, as it was, with

space for meaningful and engaged research with trans communities, uplift and center scholarship from trans perspectives, and, importantly, expand transgender studies into the post-discipline that we believe it can become. Our goal is not to carve out an alternative space for empirical inquiry, which is already in many ways valued over and pitted against cultural analysis in the neoliberal university, nor is it to serve as an addendum to the field or parallel avenue for social scientists to publish work that is out of scope for these other journals. Rather, we envision applied transgender studies to be an elaboration upon the existing field of transgender studies that recognizes the painful history of biomedical inquiry and pathologization, as well as the recent interventions from within and outside of the sciences that center the self-determination, agency, and lived experiences of trans people.

What is needed, then, is a greater degree of dialogue among the four journals currently publishing scholarship on transgender topics. The research published in each should meaningfully engage with the work published in the others, and there should be greater overlap in their editorial boards, their author lists, and their scholarly commitments. We may also need to launch additional journals with either more general foci or with a greater variety of specialized foci as the field expands. Additionally, we need to create new intellectual spaces in which to bring together scholars working across the various areas of study that would comprise a post-discipline of transgender studies, and to bring them together in collaborative, rather than combative, ways. The Center for Applied Transgender Studies was established to provide one such space, but it cannot be the only one.

We also need more tenure stream jobs focused on transgender studies and we need programs in trans studies at universities (Adair, Awkward-Rich, and Marvin 2020), though they should be housed independently or crossdisciplinarily, rather than within the confines of queer theory and gender studies programs and departments (Keegan 2020a, 2020b). Finally, as Stryker (2020) has called for, we need a professional society (other than the World Professional Association of Transgender Health), and this society should be steadfast in its commitment to a postdisciplinary field. That society should also host regular conferences, where the kinds of crosscutting conversations a post-discipline requires can be had. These kinds of institutionalization would create opportunities to materially support the kind of applied trans studies scholarship for which we argue.

In short, we must tear down the walls being built, whether intentionally or inadvertently, in the efforts to make trans studies a humanistic discipline. Instead, we must build a robust institutional architecture that can house a flourishing post-discipline of transgender studies.

TOWARD AN APPLIED TRANSGENDER STUDIES

For transgender studies to establish itself as a post-discipline in the manner laid out in the preceding section, it must necessarily orient itself toward an *applied transgender*

the aim of fostering a post-discipline of transgender studies—counts current and former editorial board members from the *International Journal of Transgender Health*, *Transgender Health*, and *TSQ* among its members.

studies. Of course, this does not mean that *all* trans studies must become *applied* trans studies. Certainly not. As Anna Lauren Hoffmann (2022) so clearly articulated in her opening remarks at the Applied Trans Technology Studies Symposium, applied trans studies

> is not some positivistic competitor to trans studies as it has emerged and unfolded in the humanities, but rather a complement—a space where further critical, technical, and social scientific methods can find recognition as we work to address the material and political exigencies of trans life.

What we mean to suggest, then, is that the broader postdisciplinary field of transgender studies must be held together by the same animating impulse that motivates applied trans studies, which is to mobilize the wealth of theoretical and methodological tools available to us to produce scholarship that aims to improve the material realities of transgender existence. In the words of Austin Johnson (2022a, 2022b), we must aspire to "do" trans studies in a way that "builds structural competency" within and for transgender movements for justice. We must find ways to take transgender research out of the tower and into the public, where we can intervene in the dismal state of affairs facing our communities.

This inaugural double issue of the *Bulletin of Applied Transgender Studies* kicks off what we hope to be an enduring effort to foster and facilitate a post-discipline of transgender studies. The journal aims to serve as a venue for the kinds of work we have advocated for in this article. And the scholarship contained within the pages of this issue speaks to the breadth of transgender studies that exists within the academy beyond that which is published in *International Journal of Transgender Health*, *Transgender Health*, and *TSQ: Transgender Studies Quarterly*—scholarship that belongs in and is vital to our post-discipline. The areas of inquiry represented in this scholarship can and should be brought in conversation with each other and coordinated in their aims and mission.

The articles in this issue each represent the possibilities of applied transgender studies in different ways. Aniruddha Dutta's (2022) article, "Surviving COVID-19 in India: Transgender Activism in a Neoliberal–Developmentalist Assemblage," draws on critical theoretical frameworks and ethnographic observation in hijra and kothi communities in eastern India to analyze how trans activists navigate the ambivalences of contemporary governance to sustain their communities throughout crisis. In doing so, Dutta offers an incisive accounting of the institutional and policy landscapes that have created the conditions that make this activism necessary, which will be instructive for activists and policymakers alike.

Next, Cal Horton's (2022) article, "'Of Course, I'm Intimidated By Them. They Could Take My Human Rights Away': Trans Children's Experiences With UK Gender Clinics," offers an important, but underrepresented perspective on transgender health scholarship. Drawing on ten interviews with trans children and 30 interviews with the parents of trans children, Horton details the fraught experiences these children have in gender clinics in the United Kingdom and uses these illustrative data to make clear recommendations for healthcare workers in the UK serving trans youth populations.

Continuing a focus on transgender health, Gayle Brewer, Laura Hanson, and Noreen Caswell's (2022) article, "Body Image and Eating Behavior in Transgender Men and Women: The Importance of Stage of Gender Affirmation," draws on interviews

with 22 transgender men and women in Britain to investigate the causes of disordered eating behaviors in trans populations. Importantly, they find that the roots of disordered eating among trans people differ from those among cisgender people, as trans people employ disordered eating behaviors to pursue a variety of transition-related goals. Highlighting the role that medical providers themselves play in encouraging disordered eating among trans people, Brewer and colleagues provide a clear vision of what must change to promote the health and well-being of trans communities across transition stages.

In the final health-focused study in this issue, Alischer Cottrill and colleagues' (2022) article, "'I Have to Decide How Attached to that Future I Feel': Fertility Intentions and Desires Among Transmasculine Young Adults," draws on 21 interviews with transmasculine people in the United States to better understand the barriers they face to acquiring fertility care. Identifying these various barriers, Cottrill and colleagues lay out the multilevel interventions needed to facilitate access to the full spectrum of fertility-related services transmasculine people need.

Next, Kai Jacobsen and Aaron Devor's (2022) article, "Moving from Gender Dysphoria to Gender Euphoria: Trans Experiences of Positive Gender-Related Emotions," sets aside the culturally dominant emphasis on gender dysphoria and the other negative emotional experiences of trans people to more deeply explore the concept of gender *euphoria*. Drawing on a small, but rich set of interviews with trans young adults in Canada, Jacobsen and Devor illustrate the limitations of purely medicalized models of trans identity and reveal the harms that can come from deficit- and distress-based narratives of transgender experience.

In the penultimate article, "Autistics Never Arrive: A Mixed Methods Textual Analysis of Transgender and Autistic Autobiography," Noah Adams (2022) analyzes 71 English-language autobiographical narratives from autistic-trans individuals since 2003. His analysis reveals the central significant of autistic-specific narratives of gender identity that differ from those dominant among non-autistic trans people, as well as the uncomfortable position autistic-trans people are placed in vis-à-vis the wider trans community. This work will be particularly illuminating for scholars working on issues of identity formation, community building, and group politics as we work to build a more inclusive and accessible transgender movement.

In the closing article of this inaugural issue, "Tipping Points and Shifting Expectations: The Promise of Applied Trans Studies for Building Structural Competency," Austin Johnson (2022b) reflects on his experiences of using research to build up grassroots networks of collective care in trans communities in the American South. Analyzing these experiences in the context of recent political attacks on the trans community in the US, Johnson argues that transformative change requires an increase in *structural competency* in our mainstream social institutions and makes the case for applied transgender studies as a path forward to that end.

Taken together, these articles offer an early glimpse into what applied transgender studies is and what a post-discipline of transgender studies can do. This work is international in its focus. It addresses important social problems through rigorous scholarship, mobilizing diverse theories and methods to better understand these problems and identify potential remedies. When this work addresses health contexts, it places trans voices at the center, building out visions of trans care based on trans

people's needs, rather than cis providers' expectations. Moreover, it deeply considers the non-medical (i.e., social, cultural, and political) factors that shape transgender health in important ways. Finally, this work cuts across disciplinary boundaries to get to the very heart of matters and, in doing so, it aims to inspire change in the laws, policies, and practices that determine the life chances of transgender people.

The *Bulletin of Applied Transgender Studies* will continue to publish such work as we work to build a robust post-discipline of transgender studies. It is our sincere hope that you join us in that endeavor in your own research and institutional service.

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ORIGINAL ARTICLE

Surviving COVID-19 in India: Transgender Activism in a Neoliberal–Developmentalist Assemblage

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Transgender and gender non-conforming people, particularly communities from predominantly working class and Dalit (oppressed-caste) backgrounds such as kothis and hijras, were among those hit hardest during the COVID-19 pandemic in India. The COVID-19 crisis was exacerbated by the policies of the Indian state, which demonstrate an unstable assemblage or conjuncture of neoliberal and developmentalist tendencies, in keeping with long-term systemic patterns in the region. The article situates Indian trans activism during the COVID-19 pandemic within the context of the neoliberal–developmentalist assemblage that characterizes governance in contemporary India and examines the possibilities and limitations of such activism. During the COVID-19 crisis, trans communities and activists contest and negotiate with the state in variable ways, sometimes bolstering and suturing neoliberal and developmentalist modes of governance and sometimes challenging or undermining them, and even playing them against each other. This article traces these varied negotiations and analyzes how they not only enable the survival of trans people through the pandemic, but also demonstrate ways activists may push back against the state's simultaneous regulation and neglect of their communities.

KEYWORDS COVID-19; neoliberalism; India; kothi; hijra
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> "We became destitute… Why? The *jonogon* [general public] had no income. Buses, trains were not running. People were not… able to work." –Mousumi Saha, *guru* or leader of the transfeminine hijra community at Kalyani, West Bengal, India

> "The government evaded its responsibility… It provided relief to our community mainly to earn a good name for itself. If a thousand of us needed relief, it provided only to three hundred… Also, it did not give relief immediately… but only when we had started raising our voices, when they heard that relief was coming in from abroad, that we were doing fundraising." –Silk, transgender activist from Kalyani, India.

As elsewhere in the world, transgender and gender-nonconforming persons, particularly communities from predominantly working-class and Dalit (oppressed-caste) backgrounds such as hijras and kothis, have been among those hit hardest during the COVID-19 pandemic in India.[1] Journalists and scholars have documented a litany of impacts, including loss of livelihood, psychosocial isolation, lack of access to healthcare and relief, and intensified social stigma due to fears of COVID-19 transmission from these communities (Choudhary 2020; Datta 2020; Ghosh 2021a). As Silk's opening quote suggests, these impacts were not merely due to the pandemic itself, but also partly due to the state's response to it.[2] This response was spectacularly exemplified by the first phase of the lockdown declared by the central government on March 24, 2020 with just a few hours of notice, which was meant to contain the transmission of COVID-19 but might have ironically fostered its spread from urban to rural areas due to the exodus of migrant workers who lost their employment in cities (Bhattacharyya 2020). The early phases of India's lockdown, dubbed the harshest and most extensive in the world, imposed an almost complete ban on industrial, commercial, religious, and cultural activity (except some essential services) and exerted severe restrictions on people's movement, which particularly affected the working poor (Daniyal 2020). Ironically, infection rates were low when the lockdown was first imposed and it was gradually eased (though not entirely lifted) when infections were increasing later in 2020, reflecting its poorly planned nature (Bhattacharyya 2020). Harsh restrictions were reintroduced in many places in India during the second wave of the pandemic between April and June 2021, although this time the central government left decisions on specific measures up to the states, given the devastating and widely criticized effects of the first lockdown (The Hindu Net Desk 2021).

1 In keeping with activist usages in India and transnationally, I use "transgender" as an umbrella term for a diverse range of people and communities whose identities and/or expressions differ from the gender assigned to them at birth. However, the transgender rubric has complex implications for gender non-conforming people in India and may serve to circumscribe or exclude preexisting identities through biomedical and binary framings of gender, even as it is adapted and modified by Indian activists and communities (Billard and Nesfield 2020; Dutta and Roy 2014).

2 I have retained the real self-chosen names of trans activists with their consent, rather than using pseudonyms, as a way of recognizing and documenting their contributions during the pandemic, as well as acknowledging their analytic insights that have crucially shaped this article.

While measures related to physical distancing are essential to containing the pandemic, Indian public health activists have critiqued the centralized and top-down imposition of the lockdown, which involved police violence and coercion, and treated unprivileged people like "criminals or subjects under colonial rule" (Jan Swasthya Abhiyan 2020, 3). In perhaps the most notorious instance of such action, migrant workers attempting to leave for their rural homes were sprayed with disinfectant during the early days of the lockdown (Daniyal 2020). Consequently, many leftist, feminist, and trans scholars and activists in India have taken a critical stance toward COVID-related containment measures (Chatterjee 2021; Datta 2021; Ghosh 2020). This markedly contrasts with left-liberal opinion in the West and particularly the USA, which has tended to support state-instituted lockdowns (Green 2021)—although scholars have critiqued various aspects of containment measures in the West, too, ranging from biopolitical surveillance to adverse gendered and sexualized impacts (Brown 2020; Corrêa 2020; Kitchin 2020). In the Indian context, the leftist economist Jayati Ghosh (2020, 519) argues that "the nature of the government response destroyed the economy and forced millions into poverty and hunger, but did not control virus transmission." Further, as suggested by Silk's opening statement, the first lockdown's severity and ultimate inefficacy contrasted with the inadequacy of relief packages announced by central and state governments, many of which merely repackaged or added to provisions that had been already announced before the pandemic (Ghosh 2020; Kapil 2020).

In this context, this article examines the role of transgender activists and communities in addressing the pandemic and negotiating with related governmental measures, based on ethnographic fieldwork conducted in eastern India and particularly focusing on the first wave of COVID-19 in 2020. As Silk indicates, the debilitating effects of the lockdown and inadequate or tokenistic relief prompted a flurry of organizing and fundraising by trans and kothi-hijra (transfeminine spectrum) activists and organizations. Scholars have documented how this burgeoning sphere of COVID-related activism addressed not just their own communities but also other marginalized social groups and thus helped mitigate the intensified socioeconomic marginalization of trans and other vulnerable people during this period (Chatterjee 2021; Ghosh 2021b; Goel 2020). However, this process also highlights how, in Silk's words, "the government evaded its responsibility," which was instead transferred onto civil society and non-state entities—a phenomenon also noted in other regions during the pandemic (Hossain 2022; Morelock, Listik, and Kalia 2021). As Ayona Datta (2020) notes based on research in South India, "in this absence of state, civil society stepped in to address… the knock-on effects of subsistence rupture to the urban poor and their families." Since the immediate need for relief took precedence over challenging state policies, such mobilizations may be seen as inadvertently accelerating the process of responsibilization—a phenomenon wherein "civil society" and individuals take up responsibility to make up for the decline of state infrastructure, welfare, and social security that characterizes neoliberal capitalism (Burchell 1996; Morelock, Listik, and Kalia 2021; Sharma 2008).

However, as I argue, trans, kothi and hijra mobilizations during the pandemic also evidence several ambiguities and contradictions, rather than completely fitting into the narrative of responsibilization within neoliberalism. As Sayan Bhattacharya (2021, 6) notes, working-class, Dalit, and trans activists "fiercely contested this neo-

liberal orthodoxy through consistent grassroots-led movements and have forced the state to commit back to some of its welfare roles." Yet, the grassroots-led contestation of neoliberalism is also but part of the story, given that the Indian state has long instituted authoritarian forms of developmentalism and welfare from above (Sinha 2021). Indian central and state governments utilized the pandemic period to establish or rebuild developmental mechanisms for trans welfare, such as transgender development boards and councils (Anandabazar Patrika 2020; Dhrubo Jyoti 2020). Following long-term patterns of state-led development in India, such mechanisms were constituted in non-transparent and hierarchical ways, and thus, working-class and/or Dalit trans activists also had to contest and negotiate with the developmentalist facets of the Indian state, sometimes leveraging their expanded welfare roles within neoliberal responsibilization to do so.

Against this backdrop, I build on extant scholarship on neoliberalism and developmentalism in India and the Global South to argue that the functionings of the Indian state, and its relation with marginalized communities during and beyond the pandemic, belie any universalizing conception of neoliberalism, and rather, suggest a patchy—though impactful—incorporation of certain typically neoliberal policies such as deregulation, privatization, and reduction of social safety nets alongside continuing ideologies of the developmentalist and welfarist state (Legg and Roy 2013; Sharma 2008). Studies of governmental measures related to COVID-19 note contextually varied tendencies of neoliberal responsibilization and authoritarian or technocratic forms of state-led development during the pandemic (Leach et al. 2020; Morelock, Listik, and Kalia 2021; Ngcayisa 2021). Exploring how the specific conjuncture of neoliberal and developmentalist policies in the Indian context have impacted structurally marginalized groups, I argue that both independent trans initiatives that substitute for state welfare and the incorporation of trans activism into the state's developmental mechanisms have reinforced profound inequalities among activists and communities based on class, caste, and geographic location, as evident in unequal access to private funding, as well as in the prioritization of elite trans activists within undemocratically-constituted state bodies for trans welfare. However, I show that trans activism has also directly challenged or subtly counteracted both neoliberal and developmentalist modes of governance—and even played them against each other where possible—in order to maximize opportunities for survival and empowerment, which suggests how trans communities ensure their sustenance through improvisatory, contingent, and uncertain engagements with the state (Bhattacharya 2021). Not all trans people or activists, however, occupy similarly uncertain terrain vis-à-vis the state; some are in more secure positions. Indeed, a relatively small section of privileged trans activists have tended to bolster and suture neoliberal and developmentalist modes of governance and thus help consolidate state power, whereas activists in more precarious positions have utilized fractures in state governance to push back against the state's simultaneous regulation and neglect of their communities, even as they must compromise with the state for survival.

The following sections explore these contradictory and frictional tendencies based on qualitative research, specifically ethnographic fieldwork and interviews, conducted in the eastern Indian state of West Bengal in 2020 and 2021. I particularly focus on a spectrum of feminine-identified people usually assigned male (or less com-

monly intersex) at birth, who go by various names including transgender, kothi, and hijra. Kothi is a term used by a spectrum of gender-variant people, including those who describe themselves as feminine males, as women, and as a third or separate gender, as well as those who express fluid or mixed identities (Dutta 2013; Dutta and Roy 2014). Hijra communities comprise a similar range of subject positions but are more typically associated with formalized kinship systems organized around *guru–chela* or leader–disciple hierarchies, and also with certain typical professions such as blessing people for money during auspicious occasions like childbirth or in public spaces like streets and trains, based on their cultural association with the power to confer fertility on people (Reddy 2005). Some kothis and hijras also do sex work, which generally occupies a lower status among community professions (Reddy 2005). There is also considerable overlap between these communities: some kothis may join hijra kinship systems and professions either temporarily or permanently (Dutta 2013). My cumulative ethnographic engagement with these communities stretches over a period of fourteen years, and as a nonbinary transfeminine person, I have come to be included as a community member, although my interlocutors are cognizant of my relatively privileged position as a middle-class, dominant-caste, and English-speaking person. For this article, I draw on participant observation conducted in several spurts between June 2020 and December 2021 in three districts of West Bengal, as well as interviews of key activists in these regions. My long-term involvement and partial inclusion within these communities allowed me a close look at how they negotiated with the COVID-19 crisis, and also enabled me to collaborate with them in some COVID-related activist initiatives.

In the first section, I build on the work of scholars such as Aradhana Sharma, Srila Roy, and Stephen Legg, who have theorized the Indian state as being simultaneously neoliberal and developmentalist, to argue that governance during the COVID-19 pandemic has functioned as an assemblage or unstable conjuncture of neoliberal and developmentalist policies and strategies (Legg and Roy 2013; Sharma 2008). Andries du Toit (2018, 4) argues that an "assemblage of discourses, practices, institutions and projects that… we could call 'late liberal' or 'neoliberal' developmentalism" has played an important role in "the government of subaltern populations… in the 'postcolonial' world." In drawing from such theorizations of neoliberal developmentalism as an assemblage, I differ from approaches that either subsume developmentalism as a stage of neoliberalism (Arsel, Adaman, and Saad-Filho 2021) or see the two phenomena as opposed (Abers, Rossi, and Bülow 2021; Rugitsky 2020). Sharma (2008, 2) argues that neoliberal and developmentalist ideologies of empowerment in India form an assemblage in the sense of a "conjunctural and evolving ensemble-like formation… made up of heterogeneous elements that are not necessarily internally coherent but are brought together for specific strategic ends." Sharma's approach to empowerment may be extended to a broader gamut of neoliberal and developmentalist tendencies which, rather than functioning as a unified whole or as oppositional forces, are related in contingently shifting ways—both converging in some cases and presenting tensions or ruptures that may be used to contest state governance. I contend that the evolution of state policies and its relation with marginalized communities during the pandemic suggest the continuing reconfiguration of neoliberal and developmentalist elements within the assemblage of governance practices in India in keeping with long-term sys-

temic patterns, rather than being either wholly contained within or marking a radical departure from neoliberalism.[3] The second section draws upon ethnographic observations and interviews to specifically situate trans communities and activism within this neoliberal–developmentalist assemblage, and it explores the resultant contradictions and opportunities negotiated by these groups and activists. I conclude by suggesting some structural limitations and potentials of trans activism in context of the COVID-19 crisis and beyond.

SITUATING INDIA'S COVID-19 GOVERNANCE: A NEOLIBERAL–DEVELOPMENTALIST ASSEMBLAGE

The Indian state's heavily interventionist response to COVID-19 citing the collective end of public health, combined with inadequate welfare provision, require some contextualization of India's position vis-à-vis neoliberalism. As a term describing transformations in the relation between states and markets since the late 20th century, neoliberalism has been debated and critiqued as an imprecise, multivalent concept that may become vaguely totalizing in being mutably used across vastly different geopolitical contexts (Eriksen et al. 2015). While there are varied articulations of the concept, definitions tend to commonly stress the deregulation of capital, privatization of public services, and the reduction of state support for development and social welfare programs, even as the state might take on strong roles to secure the interests of capital (Abramovitz 2012; Fouskas and Gokay 2020). As Kiasha Naidoo (2020) states, neoliberalism "promotes individualism and includes the belief that unregulated free markets yield efficiency and prosperity… the state is expected to act minimally (to secure) the conditions necessary for the market." Neoliberalism is often distinguished from developmentalism—itself a broad label for a set of ideologies and policies wherein the state plays an active role in managing capitalist production, income redistribution, national economic development, and/or social transformation (Prates, Fritz, and Paula 2020). However, as scholars such as Aradhana Sharma (2008) and Aihwa Ong (2006) have argued, despite transnational tendencies of market liberalization over the last few decades, relationships between the state, market, and society are articulated unevenly across the Global South, and variations in the nature and extent of state interventions trouble the supposed global homogeneity of neoliberalism and its seeming break from developmentalist paradigms.

Commentators on COVID-19 point out how the pandemic has exposed the paradoxes and limitations of neoliberal economic logics that prompt the state to depart from its expected role (Naidoo 2020). Neoliberalism is typically associated with the propagation of individual liberties, entrepreneurship, and responsibilities over the collective or social good, and with a shift in the state's role from the provider of social services to the financier and regulator of so-called "free markets" (Mehra 2020; Naidoo 2020). However, Naidoo (2020) notes that the COVID-19 pandemic compelled governments across the world to take strong "decisions in collective solidarity." Puja

3 This point echoes the argument made by Siddharth Sareen and colleagues (2021) in their study of the reconfiguration of governance in India and other nations. However, they do not specifically study the articulation between neoliberal and developmentalist tendencies.

Mehra (2020) describes how the pandemic caused states to ramp up welfarist measures and even flirt with socialist policies. For instance, in India, "the Narendra Modi government will foot the bill for the Employees' Provident Fund (EPF) contributions… for 8 million organized sector workers… [although] the package leaves out millions of informal workers" (Mehra 2020). Some assert that the return of state interventions to provide social security portend the decline of neoliberalism (Rugitsky 2020). In contrast, such measures may also be seen as a form of "emergency Keynesianism" marking a temporary resort to social provisioning rather than a long-term departure from neoliberalism as such (Šumonja 2021, 216).

While theorizations of the pandemic as prompting a temporary or long-term departure from neoliberalism might well be valid in certain contexts, they inadvertently totalize a particular idea of neoliberalism as the overarching current phase of capitalism from which countries are now compelled to deviate due to the pandemic-induced crisis. Countering the idea of the state's retreat in late capitalism, some scholars argue that governmental bureaucracy and spending might even increase in neoliberal regimes, although this serves "not to promote majoritarian objectives but values like 'competition' and 'efficiency'" and the "outsourcing of public services to capitalist enterprises" (Jones and Hameiri 2021, 6). Some scholars further argue that the developmental state has become repurposed to serve neoliberal aims and that an authoritarian form of developmentalism, led by right-wing leaders such as Donald Trump and Narendra Modi, marks the latest stage of neoliberalism (Arsel, Adaman, and Saad-Filho 2021). Governmental intervention during the pandemic might, then, mark not a break from neoliberalism but an intensification of neoliberal developmentalism. Others, however, note a more contested negotiation between developmentalist and neoliberal political camps during the pandemic in countries such as Argentina, which belies the generalized subsumption of contemporary developmentalism as a stage of neoliberalism (Abers, Rossi, and Bülow 2021, 341).

Such uneven theorizations suggest that the relation between neoliberalism and developmentalism is perhaps better understood as contingently evolving, evidencing both convergent and conflicting tendencies depending on context.[4] Scholars note how the contemporary Indian state evidences complex and ambiguous negotiations between developmentalism, state welfare, and select neoliberal principles (Legg and Roy 2013; Raonka 2016; Sharma 2008). Drawing on Sharma's work, Legg and Roy (2013, 468) state that even after the liberalization of the Indian economy in the late 1980s and early 1990s, the Indian state has continued to be both "developmentalist *and* neoliberalizing." Under pressure from international financial institutions like the International Monetary Fund (IMF), successive Indian governments have profoundly, yet selectively adopted certain policies typically associated with neoliberalism, while deviating from other elements. Conformity with neoliberal principles is clearly evident in cases like the deregulation of markets to enable greater foreign investment, privatization of sectors like banking and aviation, and the reduction of agricultural subsidies (Murthy 2013).

However, the Indian state has evidenced a more fluctuating treatment of wel-

4 This articulation is adapted from Amrita Chhachhi's (2020, 50) exploration of the "convergence and contradictions" between Hindu right-wing politics and neoliberalism.

fare, as well as socioeconomic individualism. Sharma (2008) notes the numerical increase in quasi-state and non-state actors such as non-government organizations (NGOs) in post-liberalization India, sometimes aided by the state itself, which serves to shift the direct responsibility and "burden of poverty relief and grassroots development" to non-state bodies. This translates to a gradual responsibilization of non-state actors for social services (Sharma 2008). However, as she states, "the contemporary Indian state cannot fully relinquish its development and welfare functions because its legitimacy rests on precisely such functions. … The developmentalist imperatives of the state have meant that the Indian government continues to run, and has even expanded some large-scale welfare-based programs" (Sharma 2008, 43).

The state's wavering stance towards welfare becomes clear with respect to India's Public Distribution System (PDS), which delivers subsidized food grains to about two-thirds of the population and was a crucial part of COVID-19 relief measures (Boss et al. 2021). Post the liberalizing economic reforms of the 1990s, the Indian central government seemingly followed a typical neoliberal path in trimming the PDS system from universal to targeted coverage aimed at poorer demographic sections who had to show Below Poverty Line (BPL) cards to qualify for subsidized prices, which led to the exclusion of large numbers of working-class and Dalit people from the system given errors in documentation and the low poverty line (Bedamatta 2006; Murthy 2013). However, in the 2010s, several state governments, particularly Chhattisgarh, moved back to a less targeted and almost universal PDS following electoral pressures and push from social movements like the Right to Food campaign, which eventually led the central government to adopt the 2013 National Food Security Act which propelled the PDS system back toward broader coverage (Kishore and Chakrabarti 2015).

After the current Hindu right-wing and corporate-friendly National Democratic Alliance (NDA) government took over from the previous regime in 2014, there were indications that the PDS might be replaced with a targeted direct benefit transfer or DBT system that would require beneficiaries to open bank accounts and obtain biometric Aadhaar cards, which again would potentially exclude many poor people with uneven access to such documents (Kapoor 2017). However, the in-kind distribution of food grains through the PDS has remained and, in fact, its coverage has been expanded in scale and made free in many states during the COVID-19 pandemic (Pandey 2020). The NDA government also threatened to dismantle the rural employment guarantee act instituted by the previous regime which guarantees employment to the rural poor for a fixed period per year, but in the end, it rebranded the act as a gift from the Prime Minister Narendra Modi as a benevolent patriarch (Chhachhi 2020). This demonstrates how the idea of the state and politicians providing welfare has remained ideologically important and how Indian state policy has repeatedly touted welfarist claims contra neoliberal ideology (Raonka 2016), while also reducing public expenditure in some sectors in typical neoliberal fashion (Chandrasekhar and Ghosh 2019).

Developmentalist and neoliberal tendencies might work in both tense or frictional and conciliatory or convergent ways. On the one hand, developmental mechanisms may work to counteract or temper the effects of neoliberal principles. Pallavi Raonka (2016) argues that the exigencies of electoral democracy and people's movements compel the post-liberalization Indian state to "temper the excesses of neoliberal claims by maintaining and extending welfare programs," allowing the growth of

corporate capitalism while mitigating "the ill-effects of primitive accumulation… with anti-poverty programs."

On the other hand, developmental and welfare initiatives might also work in tandem with or extend certain neoliberal policy agendas. Aradhana Sharma (2008, 44–45) notes how government-sponsored rural women empowerment programs reconfigure the "state's commitment to national development… through its ability to empower marginalized subjects to care for themselves and to participate in the project of self-rule," thus ultimately serving the end of individualized responsibilization. Amrita Chhachhi (2020) notes that the current government has redesigned welfare mechanisms to draw in unprivileged populations into webs of finance capitalism by mandating beneficiaries to apply for the so-called JAM trinity of bank accounts, biometric identification or Aadhaar cards, and mobile phones, which increasingly brings the rural poor into the ambit of private and public banks and credit schemes. This also suggests how developmentalist and neoliberal tendencies work in tandem to extend state surveillance of recipient populations through biometric identification and digitized records. Relatedly, the state has also linked some government schemes with the provision of credit meant to encourage individual entrepreneurship among cisgender women and Dalit people (Chhachhi 2020). The use of developmental mechanisms to foster neoliberal ideals is also evident in recent schemes for transgender people, particularly the central government's Garima Greh project, which funds selected transgender community organizations to run shelters for homeless trans people where residents cannot take part in sex work or begging and are trained through skill development programs to become "productive" independent entrepreneurs (Social Defence Bureau 2020).

However, the typically neoliberal push towards economic individualism and entrepreneurship is accompanied by a contentious relation with individual liberties and freedoms associated with late capitalism, as is also true also of right-wing forces in the Global North (Davidson and Saull 2017; Tambe and Tambe 2013). Exclusionary forms of Hindu collective belonging and solidarity and related social moralities have been encouraged during the rule of the NDA government, leading to the curtailment of individual and group rights for religious and gender/sexual minorities (Tambe and Tambe 2013). These varying tendencies suggest that the overall trajectory of Indian society and polity in the post-liberalization period does not neatly fit any overarching concept of neoliberalism but is perhaps better understood as an assemblage of several "heterogeneous elements that are not necessarily internally coherent but are brought together for specific strategic ends" (Sharma 2008, 2). These ends, ranging from corporate appeasement to electoral gain, are sometimes convergent and sometimes more frictional.

Neoliberal and developmentalist elements in the COVID-19 lockdown

The Indian state's governance during the COVID-19 crisis might be seen as an evolving moment in the long-term assemblage of neoliberal, developmentalist, and welfarist policies in India. Critics of neoliberalism note that the lack of adequate state expenditure on healthcare, and policies promoting privatization of and individual responsibility for healthcare, precipitated the COVID-19 crisis across many countries including India (Fouskas and Gokay 2020). Yet, during the pandemic-induced crisis itself, the

government took on a strong interventionist role in enforcing lockdowns and collective behaviors for the putative social good, contra the elements of neoliberal ideology that valorize individualism and a minimized state (Naidoo 2020). The public health activist network Jan Swasthya Abhiyan (2020, 3–5) points out that the Indian state's lockdown in 2020 generalized containment strategies that were not well suited to the Indian context and ultimately did not promote safer behaviors, and recommends that local populations be treated as partners in controlling COVID-19 rather than as subjects of power. Discussing similar lockdowns in parts of Africa, Lumanyano Ngcayisa (2021, 96) argues that they constitute a form of developmental authoritarianism characterized by "illiberal measures" such as banning vehicle movement and "invasive surveillance systems," intensifying pre-existing modalities of state intervention that prioritize socio-economic development over civil rights. The imposition of abstract technocratic models without regard for context is a hallmark of such authoritarian developmentalism. Drawing on Rob Kitchin (2020), Ayona Datta (2021) suggests that the reliance on lockdowns and digitized surveillance for disease control, while neglecting the multi-dimensional issues faced by the poor in the period, suggests an approach of "technological solutionism" towards COVID-19. While some technological aspects of pandemic control are new, the top-down application of abstract and putatively objective professional knowledges and technologies without adequate local input or partnership is a hallmark of pre-neoliberal developmentalist policy (Escobar 1988). Development scholars point out that standardized "top-down measures" undertaken during the pandemic that did not heed the diverse situations and needs of marginalized groups reflect the "blindness to inequality and social difference of much technocratic development" (Leach et al. 2021, 5). Further, the import of abstracted containment models from other nations (such as China) invokes the idea of modular development, which, as Sharma (2008, 107) says, "entails building models of programs that have succeeded in a particular Third World location and transferring these models to other Third World settings," often through institutionalized networks of professional and expert knowledge. Andreas du Toit (2018, 7) contends that the institutionalization of expert knowledges "held to be politically neutral and transportable from context to context" is a central feature of the assemblage of neoliberal developmentalism.

While the lockdown was typically developmentalist in some ways, it also demonstrated some key neoliberal elements. As Jan Swasthya Abhiyan (2020, 1) points out, the Indian state enforced the lockdown as its main strategy while not adequately backing it up with other expert recommendations such as investment in healthcare, large-scale testing, or resource provision for lockdown-affected people. Thus, in effect, the government evaded or minimized its responsibility for healthcare and other social provisions but unleashed state power to enforce the responsibility of ending the pandemic on people affected by it. This reinforces the tendency of neoliberal responsibilization, which renders "subjects [as] individually responsible for a task which previously would have been the duty of another—usually a state agency" (O'Malley 2009, 263).[5] As Che Gossett and Eva Hayward (2020, 528) note in the US context, "the socially distant subject of neoliberal health care is under an injunction to enact proper conduct

5 This tendency parallels Mohan Dutta's (2020) description of COVID-19 management in Singapore as a form of authoritarian neoliberalism.

and protocols figured through personal responsibility alone. … [A] neoliberal response is necessitated through a lack of a state response." In the Indian context, responsibilization is not just enforced at the personal level, but collectively on oppressed-caste and working-class people, who were the ones punished most brutally for violating the lockdown (Daniyal 2020).

Neoliberal tendencies were also evident in developmental and welfare measures meant as pandemic relief. While the has state touted its welfarist image during the crisis by announcing a slew of relief packages including the provision of free food grains to the poor through the Public Distribution System (PDS) for over six months, commentators have noted that more than half of the measures announced during the 2020 lockdown were merely repackaged versions of support that had been already included in the pre-pandemic budget (Ghosh 2020; Kapil 2020). This suggests that such relief measures were a temporary, insincere effort at crisis management. Moreover, there were significant exclusions in the delivery of services and benefits, for instance, due to the use of outdated census data in selecting PDS recipients (Kapil 2020). Reports note that for several direct cash transfer schemes, the state required recipients to hold bank accounts and biometric identity cards, which excluded significant sections of the rural poor from these packages (Kapil 2020). This also specifically affected transgender and kothi-hijra communities, since many trans people do not have updated identity documents or bank accounts (Amnesty International India 2020; Choudhary 2020). The routing of relief through biometric identity cards and bank accounts also continued the process of extending digitized surveillance through welfare (Chhachhi 2020). Apart from parsimonious and exclusionary welfare measures, the leftist activist Harshvardhan (2020) critiques how the state also used the pandemic period to roll back environmental regulations on businesses and to relax labor laws, especially in states ruled by the right-wing Bharatiya Janata Party (BJP) that leads the NDA government. The state is thus rolled back in the case of relief provision, labor law enforcement, and corporate regulation, but enhanced in thecase of surveillance and regulation of (especially poor) people (e.g., through the control of public mobility). This combines the worst of neoliberal responsibilization with top-down developmentalism and welfarist posturing.

However, a more fraught negotiation between neoliberal and developmentalist tendencies is evident in the state's aborted attempt to introduce "far-reaching neoliberal reforms" in Indian agriculture during the pandemic through laws meant to deregulate agricultural markets, withdraw minimum price support for farmers, and facilitate corporate control over agricultural supply chains (Sinha 2021, 330). Facing stiff resistance from farmers, the ruling regime initially responded with brutal suppression but eventually withdrew the laws, with Prime Minister Modi issuing a quasi-apologetic address stating that he had failed to convince farmers that these laws would ultimately serve their economic interest (Moneycontrol News 2021). The eventual retention of mechanisms such as government support prices that guard against high price volatility, a legacy of developmentalist planning in agriculture, suggests limits to the state's neoliberal ambitions and its ability to combine developmentalist and neoliberal forms of governance during the pandemic.

TRANS ACTIVISM IN THE NEOLIBERAL–DEVELOPMENTALIST ASSEMBLAGE

Transgender activism in India during COVID-19 fits within the process of responsibilization by filling in for the aforementioned lack of adequate state support, but it has also linked up with the state's developmentalist mechanisms through which sporadic welfare has been provided to these communities. Reports note that the direct cash transfer relief packages announced by the central government for the general public were inaccessible to a lot of transgender people due to their lack of required documents (Amnesty International India 2020). While some essential food grains have been provided free of cost to eligible recipients through the Public Distribution System (PDS) during the pandemic through a combination of central and state government allocations, Silk, a trans activist based in Kalyani, told me that many trans and kothi-hijra people in her area did not have ration cards (required to access the PDS) or had left them at home under male names prior to migrating to undertake hijra professions. In this scenario, some transgender activists have advocated for specifically targeted schemes for trans people through several appeals to central and state governments, including two letters signed by trans activists and community members that were submitted to the central government early in the pandemic in March and April 2020 (Shiraz 2020). The second of these letters explicitly references the welfarist functions of the state: "in a welfare state, it is important that vulnerable populations are… entitled to equal rights and share in the schemes… declared due to the lockdown" (Banu et al. 2020). These efforts may be seen as pushing the state to uphold its welfare roles at a time when it was evading them, thus contesting neoliberal tendencies (Bhattacharya 2021). They also extend a longer history of trans mobilizations, accelerating after a 2014 judgment by the Indian Supreme Court that recognized transgender identity and rights, that have resulted in "some concrete gains and developmental rights" such as legal promises for trans-specific welfare mechanisms despite "neoliberal… reductions in welfare" (Kumar 2021, 236).

The state did partially respond to such advocacy, and sporadic trans-specific welfare measures were announced by both central and state governments, though falling short of activist demands for regular support (Banu et al. 2021). This response manifests both parallels and discrepancies relative to the state's treatment of other structurally marginalized groups during the pandemic. Central and state governments, for instance, have also announced relief packages specifically directed toward cisgender women and farmers, even though the poorest among these groups often remain excluded (Kapil 2020). This suggests that retaining the state's welfarist image has remained important for ideological and electoral reasons (Sharma 2008), which trans activists can evoke to contest the neoliberal retrenchment of welfare. The state, however, has taken a more hardline stance to the demands of other communities, such as Muslim protestors against the Citizenship Amendment Act 2019, a law that facilitates fast-track citizenship for Hindus from neighboring Muslim-majority countries but withholds such eligibility from Muslim immigrants (Sinha 2021). The central government did not give in to demands for the act's withdrawal and brutally persecuted protestors as "anti-national," which marks the continuing construction of binaries between the "people" and its putative "enemies" that has characterized Hindu right-wing authoritarianism in India (Sinha 2021, 330). Subir Sinha (2021, 331) notes that while Muslim-led mobilizations become subject to such violent exclusion, other people's

movements, such as the aforementioned farmers' protests, have proved to be harder to reduce to a people–enemy dichotomy. Although the context of trans activism during the pandemic is rather different from the farmers' protests, the state's relative openness to trans mobilizations suggest that they, too, benefit from their irreducibility to an absolute otherness despite the presence of Muslims within trans-kothi-hijra communities, given that the right-wing has cited Hinduism's putative tolerance of gender variance in contrast to Islam's supposed intolerance to shore up Hindu nationalist agendas, even as Dalit and Muslim trans activism has resisted such cooptation (Upadhyay 2020).

While trans activists face a relatively more receptive state compared to some other mobilizations, relief measures announced during the 2020–21 period have been largely tokenistic. The central government's National Institute for Social Defence (NISD), housed under its Ministry for Social Justice and Empowerment, announced a cash transfer package of Rs. 1,500 (less than $50) per head for transgender applicants, which was first disbursed in April 2020 during the first wave of COVID-19, and then again in June–July 2021 during the second wave. Individual state governments also announced relief measures. For instance, the West Bengal government provided relief packages thrice over 2020 and 2021, comprising the distribution of essential food items to trans people in the state: once over late April and early May 2020 during the first phase of the lockdown, then in September–October 2020 during the annual religious festival of Durga Puja, and also in June–July 2021 during the second wave. These packages thus provided sporadic relief and not regular monthly support.

There were also many layers of exclusion and hierarchization in the ways these welfare schemes were designed and implemented. Only about 4,500 people, or less than one percent of the trans population counted in the 2011 census, received the minuscule NISD grant of Rs. 1,500 in April 2020 (Shiraz 2020), even though a governmental official claimed in May 2020 that 6,000 beneficiaries had been reached (Sharma Tankha 2020). By the end of the year, the number had expanded to only about 7,000 (Dua 2021). Further, applicants were required fill out online Google Forms in English or Hindi. This reinforced longstanding linguistic hierarchies that have historically favored languages associated with transnational capital (English) and North Indian nationalism (Hindi), despite the inaccessibility of these languages to a large number of Indians and the equal recognition of so-called "regional" languages in the Indian constitution (Kuffir 2014). Such linguistic hierarchization meant that those not well-versed in these languages, or lacking internet access, had to rely on more formally educated and internet-enabled activist intermediaries to fill out the form, thus reinforcing hierarchies of class and caste given that such access is more typically available to middle class, dominant-caste community members. In the district of Murshidabad in West Bengal, a trans- and kothi-identified community member told me that no one received the NISD grant in the entire district in 2020 because such an intermediary was not available. In the Coochbehar district in northern West Bengal, Sumi Das, a transgender activist from an oppressed-caste background, told me in an interview,

> in 2020, I filled the NISD form for 60 to 70 people, but about 30 to 40 people got it; not everyone did. In 2021, I sent in a list of about 80 to 90 people, but no one got it!

Meanwhile, in the district of Nadia in southern West Bengal, Heena, a Dalit trans- and

kothi-identified activist, told me: "in 2021, I filled in the details for 105 people for the money from NISD, but only about 45 people got it; about 50 percent did not." Both activists critiqued the complete lack of transparency regarding the disbursement of the NISD relief; there was no explanation why so many were denied despite applying with the required details. Such gaps in the disbursement of welfare are consistent with the overall parsimony of COVID-19 relief packages (Ghosh 2020).

In keeping with the aforementioned tendency of expanding digital surveillance through welfare, applicants also had to supply their biometric Aadhaar card number and bank account details. Although NISD released a version of the form in March 2020 for trans persons without Aadhaar and bank account details, several community activists, such as Heena in Nadia, told me they did not receive any information about how to access this version. The labor that these activists had to perform in filling out the forms was totally uncompensated. In effect, this amounted to an outsourcing of government work to the unpaid labor of activists who became responsible for the implementation of state welfare and subsidize related costs, which suggests how strategies of neoliberal responsibilization are incorporated into welfarist schemes. Such incorporation reconfigures and extends preexisting forms of exploitation of trans, kothi, and hijra workers from oppressed-class/caste backgrounds within the Indian and transnational development sector. For instance, Heena and Sumi have both worked within transnationally funded HIV-prevention projects overseen by the Indian state, where low-tier staff are typically paid below minimum wage (Dutta 2013).

The intensification of class and caste hierarchies through a combination of developmentalist and neoliberal strategies becomes even clearer in the case of the relief packages provided by the state government in West Bengal. The first round of relief distribution over late April and early May 2020 was mediated through the West Bengal Transgender Development Board (WBTGDB), housed under the state government's Department of Women and Child Development and Social Welfare. The WBTGDB was initially formed through exclusive and restricted consultations with larger metropolitan NGOs in 2015 (Bhattacharya 2015) and subsequently reconstituted without consultations at all in 2020 (Anandabazar Patrika 2020). In both iterations of the board, mostly metropolitan and/or relatively elite activists were selected to represent the communities at the state level. Several community members and activists told me confidentially that they suspected that board members had been chosen on the basis of their prior closeness and contact with the government and ruling party. Activists have also critiqued the manner in which national-level bodies such as the National Council for Transgender Persons were formed undemocratically during the pandemic. In one media report, Santa Khurai, an activist based in Northeast India, states: "there was no transparency in the manner in which the members were selected" (Dhrubo Jyoti 2020). The undemocratic selection of certain activists as members of transgender development boards and councils parallels a transnational tendency within developmentalism where select cadres of experts and professionals become authorized to guide developmental policies and institutions (du Toit 2018; Escobar 1988).

Predictably, the selection process for the National Council for Transgender Persons favored Savarna (dominant-caste) and middle-class activists, especially Brahmins (the putative highest caste). As Kanaga Varathan, a trans activist and computer engineer based in South India, stated in a public post on social media: "[the] Trans

movement built on the sweat, blood and body's [*sic*] of DBA [oppressed-caste] trans people, especially trans women, gets their first national council full of savarna members, mostly brahmins" (Varathan 2020). Similar to the aforementioned linguistic hierarchies between putatively global or national languages like English and Hindi and so-called regional languages, the constitution of developmental mechanisms that incorporate relatively elite trans persons as members reinforces multilayered hierarchies between "national," "regional," and "local" levels of scale (Dutta and Roy 2014). Relatively privileged transgender activists often get to represent the "national" (the National Council for Transgender Persons) or the "regional" (the West Bengal Transgender Development Board) and occupy positions of greater proximity to the central and state governments, whether consciously or inadvertently. Meanwhile, activists with less fluency in English or Hindi and located in small-town or rural areas—who are also, often, working class and/or Dalit—are relegated to "local" levels of activism and lower tiers of institutional power.

This hierarchization became particularly clear in April 2020 when two representatives of the West Bengal Transgender Development Board, dominant-caste trans activists based in or around the metropolitan city of Kolkata, sent an e-mail to activists and community-based organizations (CBOs) across West Bengal. Their e-mail urged "all CBOs and NGOs who are working on TG [transgender] welfare in the state to partner in this Covid Response and come forward as nodal organisations at your area who will lead this distribution."[6] CBO activists from districts were asked to volunteer to draw up lists of names of needy community members and to take rations to them—often at personal risk, since the state did not provide them with any protective equipment, paralleling a transnational tendency where health workers are expected to take uncompensated risks to serve "the social good" during the pandemic (Morelock, Listik, and Kalia 2021). While CBOs and activists working in non-metropolitan areas were called in for channelizing COVID-related relief at the local district level, they were neither consulted on the state-level process of board formation nor during the design of COVID-related measures.

This combines the process of neoliberal responsibilization through the outsourcing of state functions to unpaid trans-kothi-hijra workers with hierarchies of scale reinforced through top-down and non-consultative developmental mechanisms. Whether consciously or not, the relatively elite trans activists who were selected for the WBTGDB thus served to bolster neoliberal and developmentalist modes of governance and suture them together.[7] Significantly, one of the WBTGDB members who wrote the aforementioned e-mail leads a CBO that was selected during the pandemic to run a transgender shelter under the central government's Garima Greh scheme, which, as noted earlier, seeks to train trans people as productive workers and entrepreneurs, and thus again sutures developmental schemes to neoliberal ends (Social Defence Bureau 2020).

6 I accessed this e-mail through members of Nadia Ranaghat Sampriti Society, a trans-kothi-hijra CBO, which I assisted by translating and explaining the e-mail.

7 My use of suture is adapted from Vinay Gidwani's (2008, 198) theorization of capitalism as an uneven formation where "heterogenous value-creating practices" are "sutured together," applying this concept to heterogenous modes of governance.

A more contested negotiation with developmental mechanisms is evidenced in the ways that less elite trans and kothi-hijra activists challenge the potential forms of surveillance and exclusion implicated in the state's use of the transgender category to demarcate and qualify gender-nonconforming persons for COVID-related relief. As mentioned earlier, kothi-hijra communities in eastern India encompass a variety of gendered subject positions, including feminine males, trans women, people identifying as a third or separate gender, and various fluid combinations of such identities (Dutta 2013; Dutta and Roy 2014). While South Asian communities have adopted and hybridized the transgender category for purposes such as gaining transnational funds and building solidarity networks, the state's definitions of transgender identity tend to presume a binary between cisgender and transgender categories, which tends to separate kothis as feminine males who have sex with males from hijras as transgender, thus eliding overlapping subject positions within such communities (Dutta 2013). Since the process of legal transgender recognition began in the 2010s, the Indian state has also attempted to police inclusion in the transgender category through psychological and even anatomical criteria, despite activist protests and limited legal recognition of gender self-determination (Orinam 2019).

In this context, there was much ambiguity and confusion in activist circles regarding whether legal proof of transgender identity would be needed for accessing relief, particularly the NISD grants provided by the central government. The Google Form for direct cash transfer released by NISD in March 2020 asked for the Aadhaar card numbers of applicants. As both Sumi and Heena noted, many community members in their respective districts have their Aadhaar cards under the "male" rather than the "transgender" category. The form also asked if the applicant was associated with any transgender community-based organization. While filling out the form for applicants who did not have their Aadhaar card as transgender, Sumi and Heena indicated that the applicant was associated with their respective CBOs. This trick seemed to work, as some such applicants did receive the money despite their legal identification as male; their CBO affiliation seemed to qualify them as transgender for purposes of receiving state aid. However, as Sayan Bhattacharya (2021, 7) points out, the reliance on CBOs for the disbursement of aid also meant that "those transgender individuals not within the circuits of NGOs did not know about these various measures of relief and were left high and dry."

In the case of the distribution of the state government's relief packages, district-based activists were the people actually disbursing the relief on the ground, and they used this position of responsibilization to exert their agency in choosing a wider range of recipients than those who might be recognized as transgender by the state. Several activists across districts told me that they extended relief to community members who lacked trans identity documents or did not fit official understandings of trans identity (e.g., kothis who mostly wear male attire or are heterosexually married but are recognized as sisters within the community). Aruna Nath, a trans activist based in Murshidabad, recounted: "during the second round of aid, I reached over 80 people in my area. 30 or 40 were visibly kothi; others were hidden. So many kothis had beards, some were married. Government officers only reached visibly feminine hijras." She laughed at this recollection, suggesting pleasure in the subversion of normative assumptions regarding trans identity. In Nadia, where some officers expected photo

Figure 1. Disbursal of relief by the community organization Nadia Ranaghat Sampriti Society in May 2020

documentation of aid disbursal, I saw activists casually passing around an *orna* (a scarf typically worn by women) for kothis in male attire to loosely drape over their shirt when posing for pictures. These instances show how activists are not merely passive responsibilized actors but might use their enhanced role within responsibilization to counter the state's regulation of transgender identity and frustrate the exertion of surveillance through trans-related developmental mechanisms in whatever limited ways possible. Activists also utilized these opportunities to further expand their diverse community networks beyond the confines of official trans identity in ways that potentially outlast the pandemic. For example, Aruna noted that her increased contacts with both "visible" and "hidden" kothis provided a useful base for future activities of her CBO. As Sharma

(2008, 43) notes, responsibilization is often seen as a shift of governance from the state onto the society. However, these negotiations and ruptures show how responsibilized agents may exceed or subvert their stipulated roles to challenge both neoliberal and developmentalist modes of governance.

Non-state trans initiatives for relief

Beyond activities conducted under the aegis of the state, there was much trans-hijra-kothi mobilization separate from the state in the 2020–21 period, encompassing relief distribution, fundraising, and advocacy, given the inadequate and sporadic nature of state aid. Some of this mobilization, as noted above, addressed the state and directly challenged the framework of neoliberal responsibilization by appealing to the developmentalist and welfarist promises of the government, such as a petition signed by more than 2,000 trans activists that critiqued the inadequacy of the NISD grant and urged the central government to provide greater and more consistent relief (Shiraz 2020). However, since such appeals went largely unheeded, in many cases activists had no option but to step in and fulfill responsibilities towards affected communities that the state did not. However, rather than a unilateral case of responsibilization, this activism both reinforced and sometimes ruptured or challenged neoliberal–developmentalist frameworks.

In the districts of Coochbehar and Nadia, the CBOs Moitrisanjog Coochbehar and Nadia Sampriti Society provided support on a more continuous basis and reached many more community people than those covered by central and state government schemes, relying on money raised through online fundraisers. Sumi, an activist from Coochbehar, told me:

> The rations from the state government reached about 120 and 60 people over two times in 2020. … We reached out about 15 times. … We covered about 400 to 500 people total across the two districts of Alipurduar and Coochbehar. We also provided cash support of Rs. 1,000 per head to 80 people… [and] ran a community kitchen for four days per week for four months from June to September, feeding 30 to 45 people regularly."

Sumi added that during the second wave of COVID-19 in 2021, neither central nor state government relief reached the community at Coochbehar, whereas her CBO provided relief to almost 1,200 people across Coochbehar and two neighboring districts. Similarly, the activist Silk in Nadia described how her CBO, Nadia Ranaghat Sampriti Society, ran a six-month long community kitchen in 2020, regularly serving about 25 of the most vulnerable hijra and kothi community members who had lost their livelihood of blessing people for money on public transport. This CBO also provided relief three times to about 200 people in 2020 and expanded its operations further to cover around 1,000 people in 2021, reaching them much more frequently than the state. As Sumi noted, such fundraising initiatives allowed them to network and build contacts with people and organizations both inside and outside India: "our *jogajog* (connections) increased a lot!"

This mobilization of funding and support networks allowed both Sumi and Silk to explicitly critique metropolitan and dominant-caste activists who dominated development mechanisms like the WBTGDB in public posts on social media. Further, Silk noted that the mobilization of non-state support also permitted her to refuse pa-

Figure 2. Community kitchen for hijra-kothi community members at Madanpur, West Bengal, India in June 2020

tronizing offers of relief from local politicians, which she suspected they were extending only to gain political credit before the 2021 assembly elections for the West Bengal state legislature. As she told me:

> a BJP leader told me that they would give us *chaal-daal* (rice and pulses); I told him, we won't be able to take it if you give it in your political capacity. If you give us non-politically as an individual, we can take it.

Sharma (2008) observes that state development programs in India are often conceptualized through a gendered script of paternalistic benevolence extended by representatives of a masculinized state toward rural and Dalit communities who occupy a relatively feminized position. Welfare may also be branded as a gift from politicians like Modi, projected as benevolent patriarchs (Chhachhi 2020). The success of Silk's CBO in raising funds for relief enabled her to disrupt this gendered script by refusing the benevolent welfare extended by a male BJP leader toward the trans-kothi-hijra community, even as she remained critical of the state's evasion of its responsibilities, as evidenced in her statement cited at the beginning of this article. Silk noted that the CBO's fundraising and relief work, which was covered in local media, also granted them leverage in negotiating welfare from the state: "we gained respect from the local administration. The name of the organization was highlighted." Building on this recognition, Silk successfully lobbied the district administration in Nadia to provide free COVID-19 vaccines to over a hundred community members in 2021.

These negotiations demonstrate how neoliberal and developmentalist modes of governance may be played against each other. Activists such as Silk not only carry out their neoliberal role as responsibilized agents who fill in for inadequate state relief, but also build on and exceed this role to both contest paternalistic forms of development or welfare and to lobby the state into performing its developmentalist and wel-

farist responsibilities, countering the neoliberal retrenchment of such functions and the resultant neglect of their communities. While, as noted earlier, elite activists may serve to suture neoliberal and developmentalist tendencies, such negotiations with the state capitalize on the frictions between neoliberal and developmentalist logics of state power.

Of course, such responsibilized activism also comes with its dangers. Just like inclusion within the state's developmental mechanisms like transgender boards and councils, access to private funding is also hierarchically striated in terms of class/caste status and the national and transnational reach of activists. For instance, Laxmi Narayan Tripathi, arguably the best-known transgender and hijra activist in India, is from the dominant Brahmin caste and is publicly supportive of the Hindu right-wing government's policies (Upadhyay 2020). In 2020, Tripathi was able to mobilize celebrity endorsement by the Bollywood actor Vidya Balan for her fundraiser for COVID relief, and Balan's image accompanied sponsored posts of Tripathi's fundraiser on Facebook. Meanwhile, activists like Silk and Sumi had to rely on social media posts made from their personal profiles and word-of-mouth publicity. Some sections of the hijra community, particularly *badhaiwali* hijras, who perform during auspicious occasions like childbirth for money, also tend to be better off than their kothi or hijra counterparts who ask for money in streets or trains and/or do sex work. Such *badhaiwali* hijras, such as Mousumi Saha, the aforementioned hijra *guru* or leader in Kalyani, were able to draw on their savings to do welfare work for other poor people beyond trans communities, and even gained media attention for doing so (Goel 2020). As Mousumi Saha told me: "when the corona pandemic started… we also provided rations like rice, pulses, soap, [and] sanitizer to people." Meanwhile, many *chhallawali* hijras and kothis, who solicit money in public spaces, were dependent on CBO initiatives like the aforementioned community kitchens for sustenance and survival through the pandemic period.

Such inequalities of access, income, and privilege have prompted individualist competition and jealousy among activists and ruptured collective solidarity, bolstering the tendency of individualism and economic competition associated with neoliberalism. Kothi and trans-identified activists like Sumi and Silk, who had less access to savings than relatively secure trans or hijra leaders and thus had to reach out for aid for their communities, were sometimes accused of self-promotion through their fundraisers. (Ironically, such accusations were leveled by metropolitan, dominant-caste activists with much greater skills in English proposal-writing and thus greater access to transnational funds.) Such critiques miss that the imperative of self-promotion and advertisement is part of the limitations imposed by the hegemonic framework of trans representation in the media and public sphere. Rural, working-class, and/or Dalit trans activists typically gain media coverage when they can assert themselves as pioneers, as manifested in reports on the "first transgender judge" or the "first transgender police officer" (India Today Web Desk 2018). Such narratives suggest that trans persons from unprivileged locations must be framed as exceptional achievers to get public recognition. Neoliberal and capitalist individualism restricts how working-class and/or Dalit trans people can access representation, even as activists who do gain attention on these terms may use their position to shore up welfare and relief for collective ends.

CONCLUSION

The article has sought to situate the Indian state's management of the COVID-19 pandemic in terms of an evolving assemblage of neoliberal and developmentalist policies and strategies, and to analyze the role of transgender activism within this neoliberal–developmentalist assemblage. While trans negotiations with state power and governance are diverse and sometimes contradictory, I have contended that they demonstrate the potential of utilizing tensions and gaps in the neoliberal–developmentalist assemblage of COVID-related governance to both push the state towards fulfilling its developmentalist promises and responsibilities on one hand, and to push back against statist surveillance, top-down mechanisms of development, and paternalist relationships of welfare on the other. These potentials are endangered and structurally circumscribed by tendencies toward individualist fragmentation and competition. Significantly, despite the success of several community-based organizations (CBOs) in both raising funds for independent initiatives and negotiating with the state to expand welfare, there is a conspicuous absence of collective networks in eastern India led by non-metropolitan, working-class activists that could build on these gains beyond the pandemic. Transgender activism is also threatened by the Indian state's recent amendments to the Foreign Contribution Regulation Act (FCRA), which has tightened the hold of the state on foreign funding for non-government organizations and CBOs, even as political parties and corporations enjoy increased freedom in the transnational movement of capital (Singh 2021). The efflorescence of both domestic and transnational funding for trans activism during the pandemic might thus be a short-lived phenomenon. Trans activism in India is therefore positioned between a tumultuous present fraught with multifarious possibilities and a precarious future.

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ORIGINAL ARTICLE

"Of Course, I'm Intimidated by Them. They Could Take My Human Rights Away": Trans Children's Experiences with UK Gender Clinics

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Gender clinics engaging with pre-pubertal trans children are divided between those that endorse a gender affirmative approach and those that do not. Little evidence is available on how trans children experience non-affirmative gender clinics in early childhood. This study aimed to understand pre-pubertal trans children's recent experiences in non-affirmative gender clinics in the UK. Data focused on a cohort of trans children who socially transitioned under age eleven. Data were drawn from semi-structured qualitative interviews with ten trans children and 30 UK-based parents of trans children, focusing on children's pre-pubertal engagement with UK gender clinics. Themes are presented on 1) inappropriate assessment of gender; 2) trans children under pressure; and 3) distress and trauma in UK gender clinics. The article presents evidence of continued pathologisation and problematisation of childhood gender diversity in UK children's gender clinics. It demonstrates the harms pf the status quo and the need for systemic reform, providing modern affirmative care for younger trans children.

KEYWORDS assessment; transgender; children; qualitative research; clinical care
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Across the 20th century medical establishments problematised childhood gender diversity (Gill-Peterson 2018). Gender clinics across multiple countries embarked on the control and coercion of trans and gender diverse children, applying practices of physical, emotional, and psychological abuse (Bryant 2006; Gill-Peterson 2018). Childhood gender diversity was pathologised in the Diagnostic and Statistical Manual of Mental Disorders (DSM) with the diagnosis of "gender identity disorder" prominent until 2013 (Davy and Toze 2018). Gender clinics assessed children's nonconformity, scrutinizing

interests or behaviours that they considered gender atypical, and therefore pathological (Bryant 2006). Treatment for gender identity disorder managed by psychologists, psychoanalysts, and sexologists included control of children's access to toys, friends, or clothing, and withdrawal of parental, and particularly maternal, affection (Ehrensaft 2012; Gill-Peterson 2018). Such techniques aimed to prompt a shift in behaviour to fit into normative expectations (Bryant 2006). Gender nonconforming children exposed to such pathologising approaches reported experiencing feelings of rejection, shame, and stigma, with short- and longer-term impacts on their mental health, self-esteem, and wellbeing (Bryant 2007; Williams 2017).

In 2013, the DSM-5 brought forward a revised diagnosis: "gender dysphoria" (American Psychiatric Association 2013). This diagnosis required more than just gender nonconformity, yet continued to require assessment of children's gendered preferences, interests, and friends (Davy and Toze 2018). Since then, approaches that clearly state a goal of trying to change a transgender child's identity, or trying to deter a child from identifying as trans, have moved into the fringes of psychological practice, with mainstream medical and rights bodies repudiating conversion practices (American Psychological Association 2021; Ashley 2022; Rafferty et al. 2018; Substance Abuse and Mental Health Services Administration. 2015; UN Human Rights Council 2020). Two prominent approaches to working with trans children remain: a "gender affirmative" approach and an approach of "delayed transition" (Ehrensaft 2020; Turban and Ehrensaft 2018). The former is supported by a growing body of evidence that demonstrates the high levels of mental health of supported trans children (Durwood, McLaughlin, and Olson 2017; Durwood et al. 2021; Olson et al. 2016), that acknowledges trans children's self-knowledge (Fast and Olson 2018; Olson, Key, and Eaton 2015), and that shows the protective effects of affirmed name use and family support on wellbeing and mental health (Katz-Wise et al. 2018; Klein and Golub 2016; Pullen Sansfaçon et al. 2018; Simons et al. 2013; Travers, Bauer, and Pyne 2012; Veale et al. 2017). Delayed transition, also termed "watchful waiting," is not supported by such evidence, and is critiqued for the harms inherent in an approach that places age-based barriers on when a child can be accepted and supported (Ashley 2019a; 2019b; Ehrensaft 2020; Keo-Meier and Ehrensaft 2018; Turban and Ehrensaft 2018).

In 2018, the World Health Organization's International Statistical Classification of Diseases and Related Health Problems (ICD) removed gender diversity from categorization under mental illness, recognizing the importance of destigmatising diverse identities, noting that being trans is not a pathology or disorder (World Health Organisation 2018). This followed a paradigm shift across a wide range of modern trans healthcare standards, moving from gender diversity as a pathology to gender diversity as something to be celebrated or normalized (AusPATH 2021; Endocrine Society and Pediatric Endocrine Society 2020; Murchison et al. 2016; Oliphant et al. 2018; Rafferty et al. 2018; Telfer et al. 2018). Alongside and in advance of a paradigm shift in clinical practice, community-driven discourse has increasingly challenged pathologisation and problematisation of childhood gender diversity (Tosh 2011). In the twentieth century, only a small number of trans children received support and affirmation in childhood (Gill-Peterson 2018). In recent years, more trans children are finding support and acceptance in childhood, as legal protections, awareness, and trans-positivity amongst families with trans children has grown (Kuvalanka et al. 2014; Kuvalanka and Munroe

2021; Roche 2020). Families of trans children have built support networks, learning from each other's experience, learning from trans adults, and seeing substantial benefits of childhood support and affirmation in place of rejection and shame (Kuvalanka and Munroe 2021).

Despite a significant global medical shift towards affirmative care for trans children, a number of clinics remain tethered to an older approach, including UK children's gender services (including, the Gender Identity Development Service [GIDS] at the Tavistock and Portman, covering England and Wales, and the Sandyford Clinic, covering Scotland; Akkermans 2018). Within the UK, the structure, staffing, and leadership of Children's gender clinics has not significantly changed since the years when childhood gender diversity was pathologised and problematized as a disorder in need of fixing (Akkermans 2018). Within healthcare systems such as the UK, there is no literature on how approaches have adapted to ICD-11, or on whether such gender services are moving away from pathologisation of gender diversity.

A number global and national medical bodies (from countries including Australia, the US, and New Zealand) have published affirmative guidelines for clinics and services working with trans children, outlining the priorities, approaches, and support to be offered to pre-pubertal trans children within an affirmative care framework (Keo-Meier and Ehrensaft 2018; Murchison et al. 2016; Oliphant et al. 2018; Telfer et al. 2018). Within healthcare services that are not affirmative, such as is the case in the UK, the priorities, approaches, and support offered to trans children are less well documented. Limited insights are available into gender clinic practices with younger trans children and their families, with a majority of publications on this cohort written by clinicians themselves (Pullen Sansfaçon et al. 2019). Clinical accounts rarely centre the voices and perspectives of trans children. Moreover, recent articles from children's gender services in the UK have raised ethical concerns, with work described as "judgemental, intrusive… and harmful" and its presentation being experienced as "triggering trauma" (Pearce 2020, 816).

From the UK, a small number of publications have captured experiences and perspectives of trans adolescents and families attending UK National Health Service (NHS) gender clinics (Carlile 2020; Carlile, Butteriss, and Sansfaçon 2021; Pullen Sansfaçon et al. 2021; Horton 2021). These publications have highlighted a range of challenges encountered by trans adolescents, including healthcare interactions characterized by "dissatisfaction, frustration, and distress" (Carlile 2020, 7); youth dislike of "painful" GIDS assessment processes (Carlile, Butteriss, and Sansfaçon 2021, 6); and delays and barriers in access to gender affirming healthcare (Carlile, Butteriss, and Sansfaçon 2021; Children's Right Alliance for England 2016). In terms of trans children's engagements with gender clinics pre-adolescence, no UK research has specifically given voice to the experiences of trans children who engage with gender clinics pre-puberty, with this cohort's experiences and perspectives entirely missing from the data. This research aims to address this knowledge gap, seeking to understand the experiences of trans children in UK gender clinics pre-adolescence.

METHODS

The wider research and study sample

As part of wider PhD research, data were collected from a primary sample of parents of trans children who socially transitioned pre-adolescence in the UK. Inclusion criteria focused on 1) being based in the UK, 2) being a parent of a trans child who socially transitioned under age eleven, and 3) their child currently being under age 16. This primary sample was accessed through advertisement in six closed support groups for parents of trans children in England, Scotland, and Wales, and supplemented through snowball sampling. Access to hard-to-reach families and children was enabled by the author's positionality as a parent of a trans child, and member of four of these closed parent groups, helping overcome trust related barriers to hearing from this cohort. Thirty parents were interviewed, discussing experiences with 30 trans children who socially transitioned at average age 7 (range 3–10) and whose current average age was 11 (range 6–16). This dataset was then supplemented with direct data from ten of their trans children, average age 12 at time of interview (range 9–16). All parental interviewees were cisgender (not trans), 90% were white, 93% were female, and 23% were disabled. Seventy percent were aged 40–50 years old and 10% were immigrants to the UK. Interviewees had a wide range of levels of household income and a range of levels of education, with 20% reporting secondary education as their highest qualification, while 37% reported a graduate degree and 43% a post-graduate degree as their highest qualification. In terms of sexual orientation, the parental cohort was diverse; 60% of parental interviewees were heterosexual, 7% gay or lesbian, 10% bisexual, and 23% pansexual.

Data collection

In depth interviews, lasting an average of 2 hours for parental interviews and 30 minutes for children's interviews, generated a rich qualitative dataset. Interviews covered a broad range of topics including experiences in education, experiences with social transition, and interactions with healthcare, including children's gender services. Further research data on parental sessions at gender clinics and experiences in gender clinics as trans children within this cohort reached puberty are explored by the author elsewhere (Horton 2021). This article examines a subset of this broader dataset focusing on trans children's experiences in children's gender clinics before the onset of puberty. Broad exploratory questions included "have you/your child attended an NHS gender clinic?" and "can you tell me about your experience attending the gender clinic in the time before puberty?" These were supplemented by additional interview prompts asking about their initial appointments, their later/recent appointments, how the interviewees felt, or how parents perceived their child's experience. The interview methodology with trans children was flexible and bespoke, with child-friendly unstructured and semi-structured interviews, with data collection approaches adapted to individual child preference, with some interviews conducted one-on-one, some conducted with their parent present, some with their parent asking questions and recording the interview, and one child providing written responses to questions that they chose to answer. Interviews were conducted remotely on a secure encrypted platform between November 2020 and September 2021, during periods of Covid-related lockdown when in-person interviews were not feasible. Interviewees received

research information sheets in advance of participation, with one version tailored for child participants. Parents provided written informed consent. For younger interviewees, parents provided written consent on behalf of their child, with children of all ages additionally providing either written consent or verbal informed assent (Lundy et al., 2011; World Medical Association, 2013). Interviews were transcribed, and transcripts were anonymised, removing identifiable information, including names and locations. Anonymised transcripts were uploaded into NVivo for qualitative data analysis.

Data analysis

Data were analysed through inductive thematic analysis (Braun and Clarke 2006) to understand interviewee experiences and perspectives, with data-driven development of codes and themes. The analysis comprised re-reading each transcript to become familiar with the data and generation of initial codes through line-by-line or section-by-section coding, coding diversely without pre-conceived coding categories. The initial codes were then reviewed to identify broader themes, with all extracts for each theme collated and re-read. The initial themes were then reviewed, and themes and sub-themes revised to ensure they were internally coherent, consistent, distinctive, and accurately captured the dataset. Each sub-theme was analysed and interpreted, including with reference to existing literature. For each sub-theme, indicative quotations from a range of interviewees were selected to accurately illustrate each sub-theme. The analysis accompanying the quotations is recognised as the author's interpretation, acknowledging the role of any researcher in actively interpreting data (Braun and Clarke 2006; Charmaz 2006).

Research ethics

The research received ethical approval from the author's university, with research ethics informed by best practices in research with trans communities, alongside best practices in research with children (ITHF, 2019; Lundy et al., 2011; Moore et al., 2018; Vincent, 2018). This included recognition of the harms of past pathologising research on trans children and efforts to avoid such pathologisation (Ansara and Hegarty 2012). Additional consideration was given to the ethics of inclusion of parental accounts, use of quotations, and use of terminology, as discussed below.

Parental and child accounts

This research aims to fill a critical knowledge gap, learning about trans children's experiences in paediatric gender clinics, listening to trans children directly, as well as listening to indirect reports and impressions via the parents who accompanied them to gender clinics sessions. The strengths and weaknesses of including parental accounts are acknowledged. Centring parental voices in trans youth narratives reinforces a history of cis-splaining, paternalism and cis-dominance that has shaped trans discourse, with implications on whose voices are listened to, and whose experiences and views are considered valid (Ashley 2020; Serano 2016; 2018). Trans youth are too often sidelined to a supporting role in their own story, with risk of parental over-simplification, miscommunication, and misunderstanding of trans youth experiences. Trans-antagonistic parental accounts continue to be used to validate pathologising and trans hostile concepts, like the recently coined "Rapid Onset Gender Dysphoria" (ROGD), a dis-

credited theory that appeals to non-supportive parents, that infantilises trans youth, and that is used to discourage support for trans adolescents (Ashley 2020; Restar 2020; Serano 2018; WPATH 2018).

While remaining cognizant of these significant concerns, parental accounts are nonetheless proposed as a valuable complementary data source, particularly for pre-pubertal trans children attending gender clinics, for reasons that are both practical and ethical. In terms of practicalities, the primary sample focused on parents of socially transitioned trans children. Parents of young trans children have significant trust and privacy concerns; accessing primary accounts from young trans children without first engaging with their parents would not have been possible for a majority of this sample, with many parents clearly wanting to understand the researcher's positionality and approach before engaging. Research with younger trans children without engaging via parents would have been challenging, with most young trans children isolated from wider trans communities. The sample's average current age is 11, range 6–16, and a majority of UK trans and LGB youth groups only support youth from 13+. Engaging with younger children without parental involvement would also have been practically difficult in terms gaining parental consent for younger interviewees. Other considerations for starting with parental interviewees were ethical.

One ethical consideration was a duty of care to trans children's wellbeing. It was judged important to be aware in advance of children's current context in relation to healthcare, before interviewing on these topics. In the UK, a high proportion of this younger cohort face challenges and traumas in terms of access to healthcare, with ongoing trauma particularly acute at the time of this research. A majority of the children within this sample were directly impacted by the December 2020 Bell vs Tavistock verdict (de Vries et al. 2021), a legal case whose judgement and subsequent interpretation curtailed access to healthcare. The case had immediate and profound impacts on the children in this cohort, and, despite being overturned at appeal, its impacts are still in effect at time of writing.

Awareness of the profound distress caused by this case, and the acute fears and uncertainties surrounding access to essential healthcare, prompted me to adopt a cautious approach, interviewing parents alone first, and then discussing with parents whether they felt their child would benefit from speaking on the topic of pre-adolescent engagements with gender clinics. Several parents, with children in current distress struggling with the impacts of denial of healthcare, advised against interviews with their children while their dysphoria and distress was high. This adult gatekeeping, while admittedly paternalistic, was a decision taken to protect vulnerable children from distressing questions at a time when distress was already high. The author's positionality as a (nonbinary) parent of a pre-pubertal trans child likely influences this approach, having seen from a parent's viewpoint the past and ongoing challenges faced by my own trans child, and knowing (indirectly, to some limited degree) the emotional burden life in a cisnormative and cis-dominant world places on a young trans child's shoulders. Priority was given to avoiding this research being a potential trigger or additional emotional burden on those young trans children who were already dealing with multiple traumas. While some readers will doubtless disagree with this approach, it was in balance the approach selected, bearing in mind the current context of removal of essential healthcare.

A second ethical consideration concerned autonomy and coercion in research with trans children. My positionality as a parent of a trans child and active member of communities of parents of trans children has provided insights into the lack of autonomy, the coercion, and the control that trans children can experience in the UK. I placed a significant emphasis in conversations with parents on highlighting that my desired approach was to open a door to any children who wanted to speak with me, while taking pains to ensure there was no coercion or pressure, and with clarity that there would be no negative consequences of children not participating. A wide number of children within this sample did not opt in to being interviewed, with 10 out of 30 opting to be interviewed. This rate of engagement could be indication of lack of trust in the interviewer; it could equally be indication of the success of a non-coercive approach to research, with many children choosing other more enjoyable activities above participating in an academic interview.

A third ethical consideration for research with trans children was recognition of the harms of pathologisation and problematization. Through my positionality as a parent of a trans child, I am sensitive to the ways in which conversations related to gender or minority status can implicitly pathologise or problematise, especially where trans children receive scrutiny or questions that they are aware their cis peers do not. I wanted to avoid explicit or implicit problematisation in interviews with children, and this informed a child-driven interview approach that shifted away from a semi-structured interview approach to open listening to the topics trans children wanted to talk about. In particular, this entailed avoiding direct questioning on potentially traumatic topics, for example, experiences in gender clinics, unless the child chose to speak on that topic. The approach in this research was to provide space and opportunity for children to share their experiences where they wanted to, while creating space and legitimacy for them to not do so. While I introduced the background to the research at the start of the interview, the interviews focused on topics that the children wanted to talk about. For some children, this moved swiftly on to issues relating to being trans, to gender clinics, to schools, to healthcare. For other children, the conversation focused on subjects such as Pokémon or Roblox, which was an equally a positive outcome. While a majority of trans children did not choose to be interviewed, this was unsurprising, and confirmed the success of an opt in rather than opt out approach to research participation.

These ethical considerations will have reduced the quantity of data provided directly from trans children. Where children did not wish to be interviewed it was important to include insights from parents. In the UK, parents accompany pre-adolescent children to gender clinics, and can be a useful second-hand source of information on children's experiences in those sessions. The risk of parental accounts inappropriately representing trans children's experiences was reduced through a number of considerations: 1) parents spoke about what they saw and experienced themselves while accompanying their child at pre-pubertal child and parent sessions in UK gender clinics; 2) parents spoke about the conversations they had had with their child immediately after clinical sessions, reporting what their child had shared with them about the session; and 3) parents shared their own interpretation of impacts on their child. These parental accounts are particularly important where data would otherwise be missing. Limitations of this approach are revisited in the discussion section.

Quotations

Research ethics influenced the way in which results are presented, in particular influencing the use of quotations. In qualitative literature, quotations are used to evidence the validity of findings, to illustrate and bring findings to life, and to demonstrate how findings emerge from the dataset (Denzin and Lincoln 2018). Trans children and families attending gender clinics have long experienced control, coercion, pathologisation, and harm—a harm that was easy to perpetuate while those in power both controlled who were able to access healthcare, and simultaneously controlled the narrative, including whose voices were heard within clinical and academic publications. The vast majority of accounts of paediatric gender clinic sessions are written by those in positions of power within those facilities (Pullen Sansfaçon et al. 2019). Trans children and their families' voices are rarely heard in clinical literature, and where their perspectives are included, they are framed and interpreted by those in power. Families of trans children are extremely limited in their ability to speak out about their experiences, needing to safeguard their children's right to privacy and safety, and being unable to critique those with direct power over their lives and their child's healthcare (Carlile 2020; Horton 2021).

This research went to lengths to build trust and ensure anonymity, enabling interviewees to speak up on their experiences. The author's positionality as a (nonbinary) parent of a trans child in several ways is a positive, helping building trust with a hard-to-reach cohort. The author's positionality also risks replicating the aforementioned challenges of those with more power interpreting the words of those with less power, recognising my own relative power as an adult and recognising my outsider status as someone who has not been a child attendee of a gender clinic. Informed by these considerations, the research adopts an approach of giving weight and space to interviewee words, presenting a larger than average number of direct quotations, and enabling readers the opportunity to hear directly from the children and families involved in this research. This is part of a research ethics commitment to a) redress the balance of whose voices are heard, challenging the dominance of clinician voices in this arena; b) fulfil a trust-based commitment to interviewees who wanted their voices to be heard, and for whom knowing they would be heard offered cathartic value; and c) recognize the intrinsic value in first person narratives.

Terminology

This paper uses the term "trans child" throughout—a term that resonates with a majority of this sample. Trans youth, a term typically describing those aged 12–24, would omit and erase younger trans children, who make up the majority of this sample. There are instances where those on the upper age end of this sample might be better described as trans adolescents, teenagers, or youth. However, in a small sample, this distinction makes individuals within the cohort more identifiable. In this research, steps were taken to prioritise anonymity, including dis-attributing statements to specific interviewees. An additional consideration was respecting privacy between child and parent interviewees, with some children interviewed in knowledge of their parent, but in privacy from their parent. For this reason, anonymity was afforded precedence over use of more specific and potentially more appropriate terminology, using the term trans child throughout rather than specifying where an interviewee was a trans teen-

ager. Likewise, for the nonbinary children within this sample, use of a more specific descriptor of "nonbinary child," would reduce anonymity between child participants, and therefore the term "trans child" is used as an umbrella term including children who describe their identity as trans and/or nonbinary.

RESULTS

Three major themes are presented: 1) inappropriate assessment of gender; 2) trans children under pressure; and 3) distress and trauma in UK gender clinics. Each theme is explored in turn, illustrated with quotations from parents [P] and children [C].

Inappropriate assessment of gender

The first theme encompasses parent and child perceptions of inappropriate assessment of trans children's identities, with sub-themes on conflation of gender identity, expression, interests, and sexual orientation; and on the problematization of gender diversity.

Conflation of gender identity, expression, interests, and sexual orientation

The first sub-theme examines perceptions of a conflation of gender identity with gender expression, gendered interests, or sexual orientation, in clinical assessments. Parents and children interviewed in this research displayed a nuanced understanding of gender, distinguishing between gender identity, gender expression, and gender stereotypes. A number expressed surprise or frustration at gender clinicians conflating diverse aspects of gender. One parent was critical of assessments that asked about their child's hobbies or hairstyle preferences:

> Some of the assessments are troubling. They're obsessed with the stuff and choices—which I just don't think has really any real relation to your gender identity at all. Sports and hairstyles—I don't think that has anything to do with who we are, I think that's just what we enjoy. [P]

Another parent, described sessions where their trans child was asked detailed questions on their preferred gender expression:

> Then my child would be given worksheets about gender expression… and, like, which of these stick figures with particular hairstyles and clothes do you most identify with. And so, you know, we were trying to stay really patient and calm. [P]

Both of the above examples highlight parental frustration at clinicians assessing gendered aspects of their child's interests or presentation. A number of parents raised concerns that their child's clinician seemed to hold stereotyped and outdated views on gender diversity.

As trans children in this cohort became slightly older, but still before the age of puberty, clinicians increasingly focused on a child's sexual orientation. Parents in this sample were surprised to see clinicians questioning pre-pubertal trans children on sexual orientation. For example, one parent stated, "I mean, the obsession with sexuality is bizarre" [P]. One parent considered conflation of gender identity with sexual orientation as misplaced: "[Clinicians have said] you have to wait until you're a teenager til you know who you're sexually attracted to before you can decide who you are. And

like, I've called that out as bullshit" [P]. Other parents questioned the appropriateness of expecting pre-pubertal children to identify or articulate their sexual orientation, a task not demanded of cis children, nor indeed of cis adults, as articulated by this parent:

> He [the clinician] said …we'd need to understand his sexuality… [We couldn't start affirmative care] until we've definitely identified [Child's] sexuality. And I was like, whoa, wait a minute. I'm a grown woman. And I don't quite know exactly what box I'd want to tick. So why the hell are you asking him to pigeonhole? …it's totally inappropriate. [P]

Problematisation of gender diversity

A second sub-theme considers problematization of gender diversity in children's engagements with gender services. The children in this cohort, socially transitioned and supported at home, engaged in assessments that stretched over many years. One child described gender clinic sessions as "awkward and boring" [C]. An 11-year-old who had been socially affirmed for many years, described it thus:

> Often, I just think it's a bit pointless, because like, what is the aim of this, like to make sure that I'm definitely trans, because I know that. But you, kind of, like, need to do that, to like get hormone blockers and stuff, right? [C]

This 11-year-old found the process unnecessary and unhelpful. Parents of other trans children in this sample felt the same:

> [Child] is like, what am I meant to talk to him about? Like, I've got nothing to talk about, like, do I tell him that I've been like skipping in the garden like … shall we talk about [hobby]? And it's like, literally they have nothing to talk about. [P]

Another parent highlighted the undefined scope and lack of clarity on purpose of prolonged assessment:

> We've been going since [Child] was 8, and he's 12. And it was only when I said, "How is the assessment coming along?" And they said, "Oh right, well, we need to have six appointments in order to do the assessment? And I said, "Well, what have we been doing all these years then?" And they couldn't really answer me. [P]

Parents described children with self-confidence and trans-positivity, who saw no problem in being trans, with such children seeing no purpose in clinical conversations about identity.

> [Child] doesn't really understand what the point of her being there is. She just thinks she's gone for a chat. She doesn't feel a need to talk about her being transgender, because she doesn't really see it as an issue. [P]

Children and parents alike in this cohort were not clear why prolonged questioning was required, seeing this as an indication of entrenched problematisation of gender diversity. Trans children themselves shared their frustration of having to explain their gender to (cis) clinicians who saw the world in very cisnormative and heteronormative terms. One child commented:

> I'm pretty sure everybody working there is a cisgender heterosexual person, which is surprisingly normal for clinics that care for not cis-

> gender not heterosexual people, which is kind of really scary. [C]

Another child felt adult clinicians were unenlightened and unqualified to understand or give advice to them, saying "I think my friends are better than counsellors. Yeah, they'd probably understand" [C]. Trans children questioned the assumption that clinicians they regarded as cis and straight would be at all qualified to talk to trans children about gender or identity or about the challenges of being trans in a cis-dominant world.

The findings across this theme highlight experiences of inappropriate assessment of gender, with children and families raising concerns about assessment of gender expression, interests, and sexual orientation. These findings align with literature on trans adults' experiences, with examples of a need to simplify or perform a stereotyped gender to meet the expectations of cisnormative clinicians (Pearce, 2018; Vincent, 2020). Research has highlighted examples where trans adults deviating from a normative trans narrative faced additional scrutiny from clinicians, including potential denial of access to healthcare (Pearce, 2018; Riggs et al., 2019; Vincent, 2020), or past criticism of adult gender clinics categorising and (de)legitimising gender based on an individual's sexual orientation (Pearce 2018). The findings examined here also echo experiences shared by trans teens in current UK gender services, who highlight areas of inappropriate assessment of gender (Carlile 2020).

Trans children under pressure

The second major theme considers experiences of trans children being under pressure, with sub-themes on trans children forced to defend their interests and identities; "proving themselves" trans; enforced questioning; and children being assessed to an unknown standard, by clinicians who they did not trust.

Trans children forced to defend their identities and interests

The first sub-theme considers experiences of trans children placed under pressure, required to defend or justify their identity or interests. One parent shared an example, describing a gender clinic session with a then 7-year-old trans boy, a child who had asserted himself as a boy from a very young age, who at that time had been socially transitioned and affirmed as a boy for a year.

> She took him next door, and was showing him videos of strong women, so women who did, you know, strong athletes or women who did very manly things, and was telling him that it was okay, he could still be a girl and do manly things. And did you know that you don't have to—you don't have to change your gender to do these things. [P]

The clinician undertook this in a room away from his parents, and they only learnt about it afterwards, when their son reported it back to them. The parent felt this approach was inappropriate for their child on a number of levels. For one, they felt it conveyed a clear message to their son that the clinician considered him to be a girl; there was no parallel discussion on the diverse ways in which boys can express themselves. The parent felt this invalidation from an authority figure was potentially harmful for their child. Secondly, the parent reported that their gentle child, who was uninterested in strength, found the clinician's focus on strength or athleticism bewildering. The parent also perceived in the encounter an unspoken assumption: that a strong six- or

seven-year-old girl might find it easier to identify as a trans boy than a sporty girl. The parent felt this assumption displayed no understanding of the immense cisnormative and transphobic pressures on a young child, including often from parents, not to assert a trans identity. Overall, the encounter created a breakdown in trust, raising serious concerns amongst the parents, who thereafter refused to let the clinician see their son alone. The parent speculated that this clinician's approach could have a far greater negative impact on any trans children who were vulnerable, especially those facing rejection and dismissal from their family.

Other families reported clinicians challenging children to defend their hobbies, clothing or friends.

> They'd ask how's your weekend, and she'd mention, you know, having a lightsaber battle in the garden with her brothers. And they would just jump on that. And she would say to them, but all of my friends who are girls play lightsabers, and Pokémon, and climb trees, why can't I? Why are you asking me about it? That doesn't mean I'm not a girl. And yet, that's what they were fixated on every time. [P]

This parental experience raises an important point: that trans children face clinician-directed scrutiny of their interests or hobbies in a manner that would not be accepted for cis children. Trans children were expected to perform gender, or to defend their gender, to an unknown and unmeetable standard. Another parent noted their daughter being challenged on her clothing choices: "They'd challenge her] if she was wearing jeans, despite the fact she was sat next to her cis mother in jeans" [P].

Proving yourself trans

A second sub-theme relates to trans children being required to "prove themselves" trans. A majority of parents spoke about this theme, as exemplified by this parent: "It's always about to kind of prove that she's really trans" [P]. Another parent contrasted a "prove yourself" approach with the provision of emotional support: "Tavi [Tavistock Gender Clinic] aren't offering emotional support, because actually, that doesn't seem to be what their remit is. They seem to be about picking you apart and making sure that you prove yourself trans enough" [P]. Parents raised concern that a process centred primarily on assessing their child's identity was not beneficial to their child's wellbeing:

> There's never been a focus on "We believe who you are. What are the things in your life that make it difficult? And how can we enable you to cope with those things better?" The stuff that would actually be helpful. None of that, none of that. [P]

Another parent described the identity assessment as debilitating for their child: "This combative 'prove yourself trans enough' approach… it's intensely debilitating to go through their process" [P]. Parents knew their child was being assessed on their transitude (Ashley 2018) and felt that any area of deviation from a stereotyped narrative of their affirmed gender, or any deviation from a stereotyped trans narrative, would be counted against them. A number of clinicians had expressed opinions that trans children who were friends with children of all genders, who enjoyed toys or activities that are enjoyed by a range of genders, or who did not dress in a stereotyped manner, were not likely to be 'really' trans.

Several trans children and parents also raised concern that clinicians expected a stereotyped narrative about gender dysphoria. One child commented: "Because I don't have enough dysphoria, because I don't act trans, or because whatever reason, they think is valid to invalidate someone" [C]. A number of clinicians challenged children on the legitimacy of their gender dysphoria, arguing that non-typical accounts of dysphoria would make them ineligible for future medical interventions. Clinicians challenged children if their dysphoria manifested in individualised ways, delegitimizing their experience if their dysphoria related to social dysphoria, or if their dysphoria related to future secondary sexual characteristics more than dysphoria with primary sexual characteristics.

Enforced questioning

One parent referenced an expectation that their child would answer any and all questions put to them: "I think he would say that he feels that he has to" [P]. One parent expressed frustration at her child being expected to answer questions in a clinical context on topics that would not be expected of cis children:

> But it's the clunkiness of the way that they do things like that. The fact that they feel that that is appropriate. I think any other child, you know, a cis child, being expected to sit with someone that they've met a couple of times, or maybe never met before, and be asked those kinds of questions. [P]

Another aspect of pressure noted by parents, was a tendency for clinicians to return to the same questions appointment after appointment, with parents making a comparison to interrogation. Parents felt that discussions were shaped by the topics that clinicians felt children needed to be pushed on, not driven by the challenges children wanted to talk about, as shared by one parent:

> Every time it was that push with them, having that conversation, well, you know, you've got a friend, why don't you tell your friend. You know, he sounds like a really good friend, I'm sure he'd be fine with it. And you know, [Child] having to defend his right to not say anything. [P]

A parent summarised the approach of returning to questions where a clinician was dissatisfied with a child's answer as "like torture. Drip, drip, drip" [P]. Parents pointed out that their cis children, and cis children in general, are not pushed so hard to answer (repeated) questions in such a clinical encounter.

Assessment to an unknown standard, by clinicians who they did not trust

A fourth sub-theme, was children being assessed to an unknown and unclear standard, by strangers with whom they did not have a trusted relationship. Several children found the experience of being expected to talk about sensitive and personal topics with adults who were complete strangers both invasive and emotionally exposing. In a large number of cases, clinicians changed frequently, due to the high staff turnover in UK children's gender clinics, and children were expected to open up on demand to new clinicians who were complete strangers, who had not earned their trust. These sessions were likely to repeat ground that children had already faced questioning on from earlier clinicians. One child commented: "There were two people I was talking to, and they were both strangers, I didn't know them… I don't really want to talk about being

trans to complete strangers" [C]. Parents talked about the additional challenges and stresses on children who could not open up in clinical interviews. One parent spoke of the pressure on their autistic child to speak openly in front of strangers:

> There's additional stress with her being autistic. The expectation that she should be able to talk very openly. I mean, for any young person, to talk really openly to strangers about something as intimate as their body and their gender identity… [P]

Parents felt that clinical encounters were insufficiently child-friendly, with children expected to speak in situations where they were uncomfortable. A parent described clinicians with little understanding, or little care, of the need for a child-friendly safe environment:

> [Child would have their teddy] cuddling it, or sit on my lap, and [the clinician would say,] "Why you sitting on—you don't need to sit on your mum's lap. Go on, get off your mum's lap. Go sit on your own chair. You don't need your teddy. Put your teddy bear away." And I just think, do you know what? He's [age], you're taking him to a really strange place, and you're asking him all these questions. And he's a child. I think that's where the relationship that was supposed to have been built didn't happen. Because it was very judgmental. [P]

The topic of trust was raised by a number of interviewees, both parents and children, with children's trust in their clinicians decreasing over time. Children who disliked and distrusted their clinicians were expected to continue engaging with the service or face withdrawal of eligibility to access healthcare at puberty. As one child said, "I have zero trust in Sandyford [Gender Clinic] whatsoever. And I would say that to their faces" [C]. A parent concurred: "I've said that really clearly to them: she doesn't trust you. You've lost all her trust" [P].

The findings across this theme highlight experiences of pressure in clinical interactions, with children pushed to defend their interests, children expected to prove their transitude, children feeling forced to answer (repeated) questions, and children being assessed to unknown standards by clinicians who they did not trust. These findings align with wider literature on experiences of coercion and control in trans healthcare, as well as literature on trans normativity in psychology, and the persistence of a stereotyped trans narrative (Pearce, 2018; Riggs et al., 2019; Vincent, 2020).

Distress and trauma in UK gender clinics

The final theme in the dataset was trans children experiencing distress and trauma in pre-pubertal gender clinic assessments. A number of parents described their child finding sessions traumatic or upsetting. One parent referenced that repeated distress and trauma resulted in their child completely refusing to engage: "She was five and a half when we first went. I think between five and a half and nine, we went six monthly. … It was so traumatic. … The last few sessions [Child] refused to engage with them at all" [P]. Parents described a pattern of distressing sessions: "We know coming out of it, probably one or both of us is going to cry. … Something's going to be upsetting. Or something really stupid is going to be said or asked of us" [P]. Other parents used emphatic language to describe their child's dislike of the gender clinic. As one said, "[Child] won't leave me. She hates being there" [P]. And another: "We still unfortunately

have got the same therapist now who [Child] absolutely hates with a passion. … She's very judgmental" [P].

Parents also referenced their child's need to recover emotionally after each session. As one said, "It always takes it out of her emotionally. She always goes very quiet. … It's very draining, the appointments. … They are a bit of an endurance test. I can't say we ever look forward to them" [P]. Another expressed similar experiences: "On the way home, we would rant about how awful it had been. Because it was so unpleasant, and get it all out of our system. It's quite a long drive, so it was sufficient time" [P]. One child commented similarly: "[After a gender clinic session] I used to feel neutral, now I feel worse" [C]. A parent described gender clinic sessions having a significant negative impact on their child: "It was an emotional unpicking of who she was. It's never been therapeutic for her. It's always caused massive fallout. The build-up before and after appointments have been some of our most stressful periods" [P].

A number of interviewees described children feeling compelled to answer questions they found uncomfortable or inappropriate. One child emphasised: "[Sessions are upsetting] when we talk about genitals and bodies" [C]. A number of parents emphasised the distress their children displayed when forced to talk about their bodies in ways that made them uncomfortable, with no clear rationale for putting children through such questioning. One parent, themselves experienced in working with vulnerable children, found their child being questioned on underwear inappropriate"

> So, when he was like, okay, so what pants are you wearing today? I was like, my whole kind of like, all of my safeguarding training and all that kind of stuff like just prickled of like, how dare you sit and ask my child about their underwear? Like, why is that appropriate? Why has it got anything to do with you? [P]

Other parents noted their child being asked intrusive and distressing questions about their body. For instance, one parent reported their child being told "we've got to talk about your genitalia. We've got to talk about do you touch them in the shower or not when you're cleaning" [P]. Another parent emphasised that trans children are routinely put through questioning that would not be accepted outside of a gender clinic:

> That's a traumatic experience. Like, if that was any other stranger. You'd be calling the police. You wouldn't just be going, oh, yeah, we've got to do this. And we're gonna have to tolerate it because we want to get support. It's disgusting. It really is disgusting. [P]

A majority of interviewees described incidents of trauma, distress and discomfort; yet trans children were presented with few options to enable them to disengage from harmful processes, distressing questioning, or toxic individuals. Several parents speculated on the harm embedded in a system that taught trans children to endure poor or abusive treatment. One child summarised their experience of powerlessness and intimidation: "Of course, I'm intimidated by them. They're terrifying. They have all this power to control my life. Who wouldn't be scared of that?" [C].

These accounts of how trans children in the UK experience engagements with gender clinics bring to mind literature from those who attended, and were harmed by, children's gender clinics in past decades (Bryant, 2006). Bryant wrote of his experiences many years afterwards, whereas this research enables at least some insights into how trans children in the UK are experiencing gender clinics in the present.

DISCUSSION

The themes emerging from the dataset highlight a range of concerns trans children and their parents have with current paediatric gender clinics in the UK, namely the sole NHS children's gender clinic for England and Wales (GIDS at the Tavistock) and the sole children's gender clinic for Scotland (Sandyford). Interviewees raised concerns on the what they saw as an inappropriate focus on broad aspects associated with gender, including clothing preferences, hobbies, toys, and hairstyles. Interviewees perceived these questions as outdated, stereotyped, and unrelated to trans children's needs. Trans children were put under pressure, challenged on their identity and interests, and left feeling the need to prove themselves and their identity. Trans children were expected and required to answer questions from strangers to pass an unknown assessment standard. Children were expected to do this in stressful environments, where they were expected to open up and answer any and all questions, regardless of their relevance, appropriateness, or the child's comfort. Interviewees highlighted a range of examples of distress or trauma, with trans children finding pre-adolescent assessments upsetting, invalidating, or harmful. Areas of questioning that would not be accepted for cis children, including on bodies, on sexuality, on clothing, and on hobbies or interests, appeared standard for trans children.

A cross cutting issue that is not directly explored in this paper is the power dynamic between UK paediatric gender clinics and trans children. Many parents within this sample spoke of the potential consequences of disengagement from the gender service, mentioning a wide range of potential repercussions for a trans child and their family, including potential social services involvement, potential problems with schools and GPs, and potential custody issues for children in separated families, alongside an ever-present fear of denial of access to NHS medical care at puberty. These issues are further explored in a separate paper (Horton, forthcoming). Trans children and families were forced to choose between accepting harmful prolonged assessments, assessments that spread across many years without end, or risking the uncertainties associated with disengagement from paediatric gender services. This power dynamic between gender clinicians and trans children places the aforementioned experiences of harm into a broader context of cis-dominance over trans children.

The above insights into UK pre-pubertal children's gender services reveals a system that is not centring the wellbeing of trans children. The service prioritises an extended assessment of trans children's identities, with a greater emphasis on assessing hobbies, expression, or interests, than on listening to and affirming trans children's self-conception. Extended coercive assessments reduce trust between child and clinician, with clinicians appearing uninterested in supporting trans children in the areas where they might be struggling, such as dealing with cisnormativity or transphobia. The approaches highlighted above suggest a continued problematisation of childhood gender diversity—after all, cis children are not required to attend gender clinics to have their hobbies, interests, or identities scrutinised. This continued problematisation of childhood gender diversity appears to run counter to recent global developments, in particular the de-pathologisation of gender diversity as endorsed by the World Health Organisation in ICD-11 (World Health Organisation 2018). The UK's approach also runs counter to a growing body of research on supporting trans children's wellbeing. Research emphasises the importance of family support (Katz-Wise

et al. 2018; Simons et al. 2013; Travers, Bauer, and Pyne 2012), the protective value of use of affirmed name (Pollitt et al. 2019; Russell et al. 2018), and the importance of reducing gender minority stress (Tan et al., 2020; Tan et al., 2021; Veale et al., 2017; Watson and Veale, 2018). There is no evidence that extended identity assessment enhances trans children's wellbeing, prompting questions on its place in modern, de-pathologised healthcare for trans children. The UK would do well to draw lessons from health services across the globe who have committed to depathologisation of trans children, providing child-centred affirmative care for trans children of all ages.

Implications for practice

This research extends previous literature in useful ways, providing parent and child perspectives on trans children's interactions with gender clinics in pre-adolescence. The themes described in this paper paint a picture of a children's gender service that does not centre trans children's wellbeing. This has implications for a wide range of actors, in the UK and globally. For those currently reviewing children's gender services, this research provides evidence of harm and evidence of outdated, stereotyped, and pathologised approaches to childhood gender diversity. The insights presented here raise important questions on how fit for purpose the current system in the UK is for trans children. Lessons can be learnt from gender services in other countries that take an affirmative approach, embracing rather than problematising childhood gender diversity (AusPATH 2021; Endocrine Society and Pediatric Endocrine Society 2020; Murchison et al. 2016; Oliphant et al. 2018; Rafferty et al. 2018; Telfer et al. 2018).

For clinicians currently working within UK children's gender services, this research provides child and parental perspectives on the experience of attending pre-pubertal assessments. Ethical and child-centred clinicians can learn from these accounts and adjust their care accordingly. For those involved in governance, leadership and review of the UK's approach to paediatric care for trans children, these accounts demonstrate the harms built into the status quo, and the critical need for reform. This research highlights the distance UK paediatric gender services need to travel to deliver modern, depathologised healthcare for trans children, as necessitated under ICD-11.

For parents supporting younger trans children, and for trans children and adolescents, this research highlights poor experiences in children's gender clinics. Trans-positive families and supported trans children might take strength from these accounts to challenge cisnormative or transphobic clinical practices. This research may help parents and children consider in advance and communicate to clinicians what they consider appropriate or inappropriate areas of questioning in clinical engagements with younger trans or gender diverse children. For authority figures interacting with trans children and families, including social services, Child and Adolescent Mental Health Services (CAMHS), primary care practitioners (GPs), and schools, this research may provide useful insights into the problems within children's gender clinics, and the reasons some children and families may wish to disengage.

Limitations

One limitation of this research is the inclusion of parental accounts alongside child accounts. Parental contributions may be shaped by parental and, at times, cisnormative framing, with a risk of parents misunderstanding, misrepresenting, or misinterpret-

ing their child's experience. Parental accounts are also limited by parents only being able to share the experiences that they witnessed, or the experiences, emotions and impacts that their children were willing to share or reveal to their parent.

A second limitation is that the experiences captured in this sample centre on trans children who have socially transitioned under the age of eleven and children who, to differing degrees, have found support and trans-positivity at home, with affirmation from at least one parent. A number of parents in this sample had taken proactive steps to reduce harm, such as offering solidarity in joint de-stressing conversations after harmful appointments; preventing their child from being left alone with trans-negative clinicians; and challenging clinicians on inappropriate questions. Several families had entirely disengaged from NHS gender services in an attempt to protect their child's well-being and self-esteem. Even with parental support, trans children in this sample described gender clinicians as "terrifying" in the power they wield over trans children. This study cannot, however, draw any conclusions on how trans children with less parental support, or trans children in hostile and abusive homes, are impacted by engagements with paediatric gender clinics.

CONCLUSION

This research has provided unique and important insights into recent and ongoing practices in children's gender clinics in the UK. Trans children and their parents shared examples of the harms, injustice and trauma imbedded in the current system. These children's and parental accounts raise important questions on the purpose, benefits and harms of the current UK system. The current system prioritises extended clinical assessment and problematisation of childhood gender diversity, an approach that sits uneasily alongside recent global health commitments to de-pathologisation of gender diversity (World Health Organisation 2018). As other health services across the globe build upon existing commitments to child-centred affirmative care for trans children of all ages, the UK risks being left further behind, with trans children bearing the cost.

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ORIGINAL ARTICLE

Body Image and Eating Behavior in Transgender Men and Women: The Importance of Stage of Gender Affirmation

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Previous research suggests that transgender men and women are more likely to experience body dissatisfaction and disordered eating. Few studies have, however, investigated the manner in which body dissatisfaction and eating behavior are affected by the gender affirmation process. To address this issue, semi-structured interviews were conducted with transgender men and women (N = 22) recruited from British support groups. Participants were aged 19–71 years. Participant sexuality included heterosexual, homosexual, pansexual, and asexual orientations and all participants identified themselves as white. For both transgender men and women, analyses revealed a shift from a focus on psychological wellbeing in the early stages of gender affirmation to physical wellbeing in the later stages. While body dissatisfaction appeared to dissipate as gender affirmation progressed, a common theme across the gender affirmation process was that both transgender men and women engaged in risky behaviors related to transforming body shape and size. Findings highlight the need to consider the influence of gender affirmation when researching the interconnections between attitudes, behavior, and emotions relating to gender identity.

KEYWORDS body dissatisfaction; eating behavior; gender affirmation; wellbeing
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Previous research has established that transgender men and women experience poorer physical and psychological health than cisgender populations (e.g., Connell 2021; Downing and Przedworski 2018; Reisner et al. 2015). Health behaviors that increase the likelihood of ill health are also more prevalent in the transgender community (e.g., Bishop et al. 2020). The prevalence of disordered eating (Romito et al. 2021; Uniacke et al. 2021) and risky body change strategies such as laxative use and self-induced vomiting (Diemer et al. 2015; Guss et al. 2017) have attracted particular attention. Behavior negatively impacting physical or psychological health may, in part, reflect separation from the primary social support network (Pflum et al. 2015) and increased exposure to social stigma, discrimination, and abuse in the transgender community (Bradford et al. 2013; Miller and Grollman 2015; Watson, Veale, and Saewyc 2017).

It is important, therefore, to acknowledge the transphobia and minority stress experienced by the transgender community (Cusack et al. 2021; Gordon et al. 2016) and the extent to which disordered eating or risky body change strategies may serve as a defense mechanism or coping strategy (Coelho et al. 2019). In addition, body dissatisfaction and disordered eating may reflect the discomfort with body shape prior to gender affirmation which characterizes gender dysphoria. Few studies have, however, considered the manner in which body dissatisfaction and associated health behavior vary across stages of the gender affirmation process. The present study was conducted to address this issue.

Case reports have documented the relationship between gender dysphoria, body dissatisfaction, and eating behavior. For example, Surgenor and Fear (1998) report the case of a transgender woman who expressed a belief that her eating disorder symptoms and gender identity were closely connected, and that her desire to obtain and maintain an idealized feminine shape triggered food restriction and purges. In addition, symptom remission was only experienced during a six-month period which involved an attempt to live as a woman. Similarly, Winston et al. (2004) reported on patients referred to an eating disorder service whose weight loss was motivated by a desire to achieve a more feminine shape and who during therapy began to present with symptoms of gender dysphoria. More recent cases involving young transgender women aspiring to achieve thin feminine body shapes and subsequent development of disordered eating have also provided evidence to support earlier reports (Couturier et al. 2015; Ewan, Middleman, and Feldmann 2013).

In contrast to transgender women, it has been argued that transgender men may perceive weight loss to be desirable because it leads to the suppression of secondary sexual characteristics and menstruation (Avila, Golden, and Aye 2019; Couturier et al. 2015). Large scale studies are consistent with these assertions and demonstrate that some members of the transgender community engage in disordered eating because it facilitates suppression of physical features or accentuates characteristics aligned to their gender identity (Ålgars, Santtila, and Sandnabba 2012). For example, disordered eating behavior may be focused on muscularity in transgender men (Kamody et al. 2020). There appears to be increasing evidence, therefore, that transgender men and women are at greater risk of developing disordered eating than cisgender populations and that this risk is likely to be intrinsically linked to their gender role identification, gender-specific ideals, and body image pathology (Jones et al. 2016; Murray, Boon, and Touyz 2013).

The effects of gender affirmation—i.e., the "process whereby a person receives social recognition and support for their gender identity and expression" (Sevelius 2013, 676)—on body image and eating pathology are less clear (Strandjord et al. 2015). However, it would seem likely that body dissatisfaction and disordered eating decline as a person's body and role in society become more closely aligned with their gender identity. Previous research indicates that increased access to medical and legal gender affirmation reduces the risk of body dissatisfaction and disordered eating in transgender populations (Gordon, Moore, and Guss 2021; Kamody et al. 2020). Further, it has been argued that surgical treatment helps to reduce body image concerns and psychological distress (Bandini et al. 2013; Khoosal et al. 2009; Winston et al. 2004). Indeed, both hormonal and surgical treatments may be associated with improved psychological wellbeing and quality of life (Agarwal et al. 2018; Motmans et al. 2012; White Hughto, and Reisner 2016).

Other research indicates that eating disorder symptomatology continues post-surgery (Hepp and Milos 2002; Winston et al. 2004). The inconsistency between studies may reflect the complexity of the gender affirmation process. For example, an analysis of interview data (Ålgars et al. 2012) uncovered themes relating to both positive change such as improvements in body image and reduction in disordered eating, and negative change for example, unwanted weight gain from hormone therapy and continued eating pathology. In addition, current understanding has been limited by the tendency for research to consider one aspect or stage of gender affirmation only. It is, of course, important to note that there may be substantial variation in the gender affirmation process. For example, while some transgender men and women may want hormonal therapy and/or surgery, others may not pursue or have access to this medical intervention. Therefore, gender affirmation should not be regarded a linear process or one in which all transgender men and women seek or actually experience all stages.

In recent years, there has been greater consideration of conceptual and theoretical models in relation to body image and disordered eating in the transgender community. For example, Gordon et al. (2016) apply ecosocial theory and a gender affirmation framework to disordered eating among young transgender women, while Gordon, Moore, and Guss (2020) apply a conceptual model of risk and protective pathways to risky body weight and shape control behaviors among transgender and gender diverse populations. In the present study, a critical realist framework was adopted to identify, understand, and report the reality of the participant experience. This framework acknowledges that the world as we understand it has been constructed through our perspectives and experience (Bhaskar 2010) and has been applied to previous health behavior research employing thematic analysis (Bower, Perz, and Conroy 2020). Therefore, we focus on the reality of body image and disordered eating as experienced by transgender men and women rather than a more reductionist approach to documenting the incidence of such behavior. It is important to note that the critical realist framework should be regarded as a philosophical or ontological approach that guides the research approach rather than one that determines the specific factors increasing the likelihood of body dissatisfaction or disordered eating (Gorski 2013).

The experience of body dissatisfaction and eating behavior in transgender men and women requires further investigation, and research recognizing the importance of the stage of gender affirmation may be particularly beneficial. Therefore, the pres-

ent study investigated the extent to which gender dysphoria influences body dissatisfaction, attitudes to food, and eating behavior at various stages of gender affirmation.

METHOD

Participants

Transgender men and women (N = 22) aged 19 to 71 years were recruited. Seventeen participants identified as female, however five were not living "full-time" as women. Of these five, two individuals had only just "come out" as transgender, were "dressing part-time," and self-medicating with female hormones; two were "dressing part-time" and had not "come out" as transgender women; and one individual who lived "part-

Table 1. Participant Information

Pseudonym	Gender Identity	Age	Dressing	Hormone Therapy Desired	Receiving Hormone Therapy	Surgery Desired	Post-Surgery
Helen	Woman	58	FT		Y		Y
Chantelle	Woman	35	PT	Y	Self-medicating	Y	
Nathan	Man	19	FT	Y		Y	
Josie	Woman	—	PT		Self-medicating		
Jane	Woman	65	FT		Y		Y
Robert	Man	41	FT		Y		Y
Katerina	Woman	40	FT	Y	Herbal	Y	
Rosie	Woman	49	FT	Y		Y	
Daisy	Woman	38	FT	Y	Self-medicating		
Molly	Woman	66	FT		Y		Y
Elizabeth	Woman	61	PT				
Dale	Man	50	FT	Y	Bridging T shot	Y	
Penny	Woman	55	FT		Y		Y
Kelly	Woman	52	PT				
Darren	Man	—	FT		Y		
Tanya	Woman	—	FT		Y		Y
Hope	Woman	55	PT		Y		
Cassie	Woman	47	FT		Y	Y	
Lorna	Woman	53	FT		Y		
Sally	Woman	64	FT		Y		Y
Jill	Woman	71	FT		Y	Y	

time" (PT) as a woman was receiving hormone therapy and classed herself as a "lapsed transvestite." Four participants were transgender men, all living as men "full-time" (FT), but each at different stages of gender affirmation. One volunteer identified with both male and female genders; their interview differed markedly from interviews with other participants and was therefore excluded from final analyses. Participant sexuality included heterosexual, homosexual, pansexual, and asexual orientations. The sample was not ethnically diverse, and all participants identified themselves as "white." Participants were at varying stages of gender affirmation at the time of the study. See Table 1 for full participant information.

Procedure

Previous research investigating body image and disordered eating in transgender populations has typically compared quantitative responses to standardized questionnaires to cisgender populations, recruited transgender women only, or not fully considered the impact of stage of gender affirmation (e.g., Ewan, Middleman, and Feldmann 2014; Khoosal et al. 2009). Hence, in the present study, each participant completed a private interview which addressed each stage of gender affirmation experienced. Interviews focused on participant's own experiences and as some participants had not experienced later stages of gender affirmation (i.e., hormone therapy and mid- to post-surgery) they were not asked about this aspect of gender affirmation. All interviews were conducted by the second author. Qualitative research is particularly effective when recruiting marginalized or underrepresented populations such as transgender men and women, and for providing opportunities for participants to raise issues not previously considered by the researchers.

Semi-structured interviews were conducted to provide both consistency and flexibility. Interview questions were developed in collaboration with a member of the transgender community following attendance at LGBTQI+ awareness events and completion of online training courses provided by the Gender Identity Research and Education Society (GIRES). Questions were designed to elicit information relating to stressors, health behavior, and physical and mental health. For example, "What did you do in order to cope with these experiences" and "Can you tell me about your current experience living in your true gender identity." Though a topic guide was developed, in a number of instances, the interviewer consciously stepped back from the initial questions to allow participants to tell their stories.

Interviews began by asking participants to discuss their early experiences of gender dysphoria and their responses shaped subsequent questions and prompts. For example, if participants described a specific event that was important to them, they were asked to expand on this (e.g., whether they received support and how they coped with the event). This approach allowed the interviewer to explore core issues specified in the topic guide while providing participants the opportunity to focus on those issues and events that were most important to them in a meaningful way rather than adhering to a stricter question format and order. Participants also completed a brief demographic questionnaire (e.g., sexual orientation, ethnicity, etc.).

Participants were recruited at transgender support group meetings in Northwest England, either via distribution of information sheets by the group coordinator or attendance by the second author. People were eligible to take part if they self-iden-

tified as transgender and were at any stage of the gender affirmation process (i.e., intended to begin gender affirmation, were currently in the process of gender affirmation, or had completed their intended gender affirmation). Social support groups provide access to a diverse transgender sample, including older transgender men and women, previously described as "an invisible population" (Shankle et al. 2003, 159). Indeed, relatively few studies have considered transgender experiences in older populations (e.g., Fredriksen-Goldsen et al. 2014). All interviews were recorded and transcribed verbatim. Non-verbal behavior such as sighing and laughter were indicated in brackets, grammar was not altered, and participants' idiolects were preserved. Pseudonyms replaced real participant names and any identifying information (e.g., support group name and location) was removed at the time of transcription. All participants provided informed consent and were given the opportunity to review a transcript of their interview.

The analytic strategy was based on Braun and Clarke's (2006) six phases of thematic analysis and therefore involved familiarization with the data, generation of initial codes (completed on a line-by-line basis), searching for themes, reviewing themes, defining and naming themes, and producing the report. As the key research question involved a comparison of themes at various stages of gender affirmation, data codes were collated (adopting an inductive approach) with regard to their place within the narrative. Salient themes and subthemes were then identified. Codes and themes were reviewed in a systematic, iterative, and reflexive way (Braun, Clarke, and Terry 2015). Initial codes and themes were identified by the second author, and confirmed with the first and third authors, all of whom are cisgender women.

Calculation of an inter-coder reliability is not consistent with our methodological approach (Braun and Clarke, 2013) and we note that intercoder reliability is "a somewhat controversial topic in the qualitative research community, with some arguing that it is an inappropriate or unnecessary step within the goals of qualitative analysis" (O'Connor and Joffe 2020, 1). Instead, we focus on other measures of research quality intended for use with qualitative data including confirmability and credibility (Leininger 1994). For example, where information revealed by participants during interview was unclear or ambiguous, the researcher sought clarification to check understanding. Further, we have no reason to doubt the credibility of their personal accounts and there was a significant cost to participants providing their time and energy to discuss personal and sensitive issues.

RESULTS

Findings are organized by stage of gender affirmation: pre-gender affirmation, coming out and early gender affirmation, hormone therapy, and mid- to post-surgery.

Pre-gender affirmation

All transgender men ($n = 4$) and women ($n = 18$) interviewed reflected on their pre-gender affirmation experiences. Emerging themes were "managing gender," "stress and depression," and "consequence of other coping mechanisms." Each theme appeared to be characterized by an ambivalence towards physical health coupled with a motivation to prioritize psychological wellbeing. Findings suggest transgender men and women

are at increased physical risk during this stage of gender affirmation.

Managing gender

Relationships between gender identity, body image, and eating behavior were complex. For some participants, eating behavior provided an opportunity to actively change their body shape and size as a response to their gender dysphoria. For example, a larger body could deflect attention from gender and from sexual orientation. In particular, Helen discussed the advantages of a larger body prior to gender affirmation. She stated, "you get jokes about being overweight but jokes about, from your classmates, and things about being overweight are so much less painful about being effeminate, and much less risky from being misunderstood as homosexual." She used her larger body size to cope better with her pre-gender affirmation body, explaining,

> If you're largely overweight you can sort of sculpt your body a bit in private, dress and behave as you really need/want to and in public just be someone who is not going to be assumed to be doing typically male activities. It acts as a very good protection and it's easy to deflect conversations into areas that are not gendered…It becomes very helpful as a sort of part of the disguise of being overweight. Probably not consciously, but subconsciously.

In contrast, though Katerina also associated body fat with femininity, she described reducing her food intake, purging, and excessive exercise. For example, she stated,

> I tried to get rid of as much fat as I could by just doing a lot of running, a lot of weights, but when running I passed out because I wasn't eating properly and I was doing too much gym, quite a few times.

This behavior arose because Katerina felt ashamed of her gender identity and was attempting to demonstrate her masculinity. She explained,

> I was trying to overcompensate for being feminine… I thought that would stop the feelings I had inside, but it didn't it just made them worse. … I think I was trying to let others know that I was more of a man really, but everyone could see because of the way that I acted that I wasn't, cos I've always very feminine anyway, in my actions and stuff.

Ultimately her behavior can be theorized as an attempt to manage her dual genders—to suppress her female identity, she purged herself and attempted to lose weight, and to enhance her physical appearance, she tried to become more muscular. Similarly, Rosie used body size as part of an attempt to hide her female gender identity. She reported,

> I used to be an eighteen stone bodybuilder because I used to train six days a week, two and a half hours a night, and I had a really big muscular body, again trying to mask the fact of who I actually was.

Of the four transgender men, two described restricting eating to manage gender. For example, Nathan commented "I have quite a big problem with my weight anyway. I don't like it. … A lot of it was to do with not liking how I looked, so not eating was kind of the way forwards." He also acknowledged practical issues, explaining that "it's really hard to bind when your chest is really big" and restricted eating allowed him to modify "the bits I didn't like." Hence, Nathan's motivation to lose weight was

also related to his need to suppress feminine bodily features. Overall, transgender men and women appeared to use weight gain and loss to manage how they felt about their bodies and gender identities, as well as influence how others perceived them. In this sense, weight control formed part of an overall strategy for coping with dysphoric feelings. This theme was also associated with the emergence of disordered eating, indicating that individuals at this stage may be at risk of developing eating disorders.

Stress and depression

The incidence of stress and depression was clear and references to depression, anti-depressant medication, self-harm, or suicide were common among participants. As described by Sally,

> it's only two and a half years since I last felt suicidal completely. … Dysphoria gets you. It's little things, they add up and add up and add up, and then something triggers the whole thing and you just go into a depressive cycle.

Similarly, Tanya commented,

> I got heavily depressed, very depressed in fact. … They had a counsellor and the counsellor sort of helped, but they also then went bankrupt and I got very depressed—suicidal, you know. I come very close on more than one occasion.

Participants that did not specifically identify a history of depression, anti-depressant medication, or suicidal ideation ($n = 6$) also often discussed their mental health. For example, comparing her current mental health to earlier experiences, Jill stated, "my mental health has changed. There was things going on in my head. Was I mentally ill? Was I not mentally ill?"

These issues often impacted on eating patterns. For example, Darren recalled, "when it's a struggle to get out of bed and it's a struggle to get through the day, the last thing you're going to think about is 'Right well, what do I need nutritionally?'" Similarly, Nathan stated, "I don't really eat. If you see me eating, you know it's a good day. It's like, yesterday I think I lived off a tube of pringles," and ,"My head is all over the place most of the time anyway, but when I'm having a good day I'll eat, when I'm not having a good day I just won't eat." This suggests that although Nathan's motivation to lose weight can be traced to his desire to suppress secondary sexual characteristics, it was his mood which dictated whether he ate and what he ate.

Both transgender men and women talked specifically about weight gain through emotional eating and the use of food as a source of comfort. For example, Darren described, "If I had any money, I would then buy voluminous food such as pasta, any kind of cakes, anything that, you know, that would fill me very quickly. It was almost like a comfort kind of food." His emotional eating could be traced back to traumatic experiences of transphobic bullying at school and subsequent isolation and depression, highlighting how transphobic harassment can trigger a depression which drives a range of health risk behaviors. Chantelle described her binge eating and purging. She related this pattern directly to the person she saw in the mirror. She explained,

> When I look in the mirror and I see me looking back at me that I don't think is me—it's a big fat hairy horrible man looking back at me. That's how I feel—disgusted. That's what it makes me feel. It's horrible. I hate

> it, cos I look stunning as a woman and that's how I see, when I look out of my eyes, that's how I think… It's like a stranger looking back at you.

Self-loathing stopped Chantelle from caring about the effect of eating on her body. For example, she admitted,

> I'd get really, really depressed, yeah, and I did, I did, what the hell—stuff your face. Do you know what I mean? Stuff your face, comfort eat, and it doesn't matter what I look like cos it's not what I want to be anyway.

Many participants spoke about emotional eating indirectly. For example, Jane described the stress of hiding her transgender identity from her wife as "just like a big knot inside me" and reported that she was overeating in regular binge eating episodes. For example, she described "Chocolate, fries, chips. You know, I'd fry chips at midnight, yeah. Just a—just a chocolateaholic, yeah, and it would be a full box." Similarly, Robert described overeating, stating,

> I was eating about seven or eight packets [of crisps] a week and biscuits, maybe two or three packets, and bread—you know extra sandwiches that I shouldn't be eating… [because] I was very depressed cos I didn't like what I saw in the mirror. I didn't like the way I felt when I walked.

Overall, these accounts demonstrate that stress and depression arising prior to gender affirmation have the potential to lead to substantial disturbances in eating behavior.

Consequences of other coping mechanisms

The misuse of recreational drugs ($n = 3$) or alcohol ($n = 5$) was also apparent, which impacted eating behavior and body shape and size. For example, Rosie recalled that she lost weight because she often "wouldn't eat for days." However, this was a by-product of a cocaine addiction, which developed while dressing in secret. She explained

> I went through years of buying cocaine, not to go out and have it, but to have it in my bedroom and I— It was… I could only say, to describe the feeling, it would probably be like having, you know, an injection of female hormones instantly. It—the feeling—was just amazing. I mean, I'd be going out, if I had a line with friends, I'd just wanna stay in and dress up.

Her story demonstrates how the desire to be feminine can be so powerful for some transgender women that it leads to risky health behavior, and again supports the hypothesis that prior to gender affirmation psychological needs often take priority over physical health.

A comparable example can be drawn from Daisy's interview, as she gained substantial weight prior to gender affirmation, though she did not cite emotional eating. Rather, she related this to her alcohol consumption, explaining, "I started just buying lots of alcohol, for the last six months or something like that. I started buying lots of, you know, things like vodka. It'd be bottles and sort of, like, having too much, really." Like Rosie, Daisy's abuse of alcohol was clearly associated with her need to be feminine, as she related her alcohol consumption to

> when I was in the home, I was dressing all the time and it was kind of like, probably longing to be out there, kind of… sort of like it was to, kind of like, numb it or something.

Daisy's weight gain is therefore arguably a by-product of a coping mechanism which

involved alcohol.

Conversely, coping mechanisms can also help prevent weight gain. For instance, Josie, Tanya, Lorna, and Sally engaged in non-team, traditionally masculine sports to cope with their dysphoria. For example, Sally stated "I was pretty fit, by that time I was scuba diving, rock climbing, parachuting, so I've been fairly fit all my life." She acknowledged that

> it may have been beneficial in that I suppose in a lot of respects I was overcompensating. So, the sort of higher energy pastimes might've been a compensation for gender dysphoria and so I became fitter rather than the other way around.

Similarly, Lorna commented "They loved me because I was a great athlete… won its league and everything, all the cups for every year right the way through and broke all the records." She added "I thought it would… The more masculine I tried to be, the more I thought that that would go away." These coping mechanisms are not, of course, mutually exclusive. While Tanya and Lorna engaged in a range of sporting activities, they also reported binge drinking and recreational drug use respectively.

Coming out and early gender affirmation

Participants described how being discovered or "coming out" as transgender led to vicissitudes in their appearance, lifestyle, and relationships. For example, over half the transgender women interviewed experienced transphobic discrimination or abuse during this period. The themes emerging from this phase were associated with the management of individual and interpersonal changes, both positive and negative. Three themes—"new motivation," "managing gender," and "Stress and Depression"—dominated accounts of this stage. Overall, these themes suggest that this stage of gender affirmation necessitates managing a myriad of personal and social changes, and that this has both positive and negative implications for eating behavior.

New motivation

Participants embarking on the gender affirmation process were generally feeling positive about their bodies and were keen to eat a nutritious diet, reach a healthy weight, or maintain it. Rosie (at this stage when interviewed) reported she was "so conscious now of my body and keeping my figure, which is a size eight to ten, which I'm happy with." Chantelle had recently come out as transgender when interviewed and reported she had begun to diet and exercise. She explained,

> I want to look after myself when I'm Chantelle. I've got clothes, I like skinny fit jeans and stuff like that, that I want to get into. I want to look good, but as a man in a pair of baggy jeans and a baggy top, it doesn't matter. I'm not bothered what anybody looks at me and thinks about, because I'm not happy anyway. I don't care.

She further commented, "I've lived thirty-five years as a complete stranger to me. It's my time to shine now," and "I'm bursting now. I want to be out. I want to start living." Her motivation was that "I've got too many nice clothes to fit into—well, Chantelle does anyway—so I want to start getting a nice figure." These comments demonstrate Chantelle's desire to safeguard the wellbeing and appearance of her emergent feminine figure. Weight loss strategies may not always be healthy. For example, although

Chantelle spoke of diet, she also admitted to recently "taking T5 fat burners and all this rubbish." This motivation may, of course, extend to other (non-health or eating) aspects of life. For example, Jill described her experience since coming out, "Since I've discovered who I am, what I am, you can't stop me, just totally different."

Managing gender

Managing gender was evident in transgender men who seemed motivated to lose weight in order to suppress feminine bodily features. In particular, two of the four transgender men interviewed had attempted weight loss at this stage, with the explicit goal of suppressing feminine bodily features. For example, Darren stated,

> The guys that I know, they all lost weight to try and hide their chest, but then they had, they had the bad posture because they would then walk round hunched everywhere to try and hide it. … Me and my mates, we all lost weight in order to hide better.

Dale recounted,

> I started using laxatives a lot because I didn't want to put on weight, because, you know, if you put on weight, then, as you know, with the female and male body differences, I will get female fat distribution, so I'll get big on top. And so, I think "I want them gone," so get rid of body fat. So, I was eating very little and I was using laxatives two, three times a day to try and not have any fat on my body at all.

His disordered eating is unsurprising given the distress having breasts had caused him in the past. For example, he recalled

> When I was twelve, I was—I developed sooner than all the other girls at school and I had my first period when I was only ten. So, by the time I was twelve, I was developed up top, which was horrible, horrific time. And then I took a bread knife from the kitchen and tried to cut them off.

These findings suggest that transgender men may be at risk of developing eating disorders early in the gender affirmation process when they are reliant on binding and weight loss to mask their feminine bodily features.

Stress and depression

This theme reflected negative aspects of gender affirmation, such as the loss of close relationships and the manner in which distress impacted maladaptive behavior. In particular, participants engaged in emotional eating and selected poor-quality food at this time.

The impact of stress and depression on eating behavior was apparent in Josie's interview. She explained how her gender identity triggered the breakdown of her marriage and bullying at work. She explained,

> I was really, really heavy, because you're comfort eating. You're eating, you're drinking, you're trying to mask pain. You're in pain all the time. The stress of going to work, stress of being laughed at, being joked at, being humiliated, you know all that stuff. Then you have your marriage break down and it's all because of me—it's all because of being transgender. So, if I didn't have all this being transgender, all these things that I'm talking about, wouldn't have happened to me. I'd have sailed

along.

Transphobic abuse could also cause stress and weight gain. Tanya described, "I was beat up several times—assaulted with people with baseball bats. An entire street come out at me, attacked me. Even when that happened the police didn't turn up." She continued,

> I moved to my last address because people was uncomfortable with the way I was and were trying to force me out. I've had an arson attack at the house where somebody filled the letterbox with shredded paper, put lighter fuel or something—an accelerant—in and then put matches through the letter box.

She admitted that when she became stressed, she ate:

> I would prob, probably each sommat fairly sweet or high carbs when I got stressed, yeah. Not necessarily bad food, I would just eat food with quite high carbs in. I would eat things like meat pie, cos I was so—I didn't really feel like cooking, so I'd eat things like pies and pasties and maybe go and have fish and chips quite regularly or pizza.

Cassie developed severe depression during her early gender affirmation, she reported:

> I just wanted my life to go away. I wanted to kill myself, but I was just too cowardly. You know, I wished I was dead, but there was no way of doing it, so best thing is just sit there and let myself rot.

Cassie also developed disordered eating, stating, "there was two cases where, like, I did starve myself completely for ten days a time over a six-month period." Her self-destructive behavior can be understood as a reaction to long delays accessing treatment and feeling trapped. For example, she explained that while she was coming out as a transgender woman, she was anxious disclosing to others: "the last thing I wanted to do was tell anyone. … I was ripped up inside. I couldn't, and the more I couldn't do, the harder it was because I still wasn't there. Nothing was moving." Cassie insisted that she had no previous issues with food or weight, however she admitted that "there was a part of me liked getting thinner."

Receiving hormone therapy

Seventeen participants reported experience of hormone therapy, either delivered through formal healthcare providers or self-medication (often involving acquisition via internet sources). Two themes emerged for the hormone therapy stage: "increasing awareness and control" and "preparation for surgery." The theme "increasing awareness and control" can be regarded as a continuation of the "new motivation" theme from the previous stage of gender affirmation. Both transgender men and women focused on either losing weight gained during earlier stages of gender affirmation or were anxious about gaining weight as a consequence of the hormone therapy. Participants discussed a variety of weight control strategies. Narratives regarding weight loss in "preparation for surgery" suggest that transgender men and women may be at risk of engaging in disordered eating behavior in a quest to meet criteria for surgery.

Increasing awareness and control

Some of those engaging in hormone therapy were concerned about elevated hunger and weight gain resulting from hormone therapy. Hence, participants discussed increased awareness of their appetite, healthy eating, and weight control. For example, Darren, who had been on hormones for an extensive period, described in detail his experience that "hormones change your eating habits massively." He reported that "You have a massive appetite increase er because you need to fuel all the changes that are happening" and that "for the lads you have a massive, massive appetite increase, but it's really, really hard, because if you don't train you get all the aggression and you put on loads of weight." He described the cyclical process of hormone injections, stating,

> I'm every three weeks, so about one and a half weeks I'm at my peak. So, at my peak I've got more energy, so I need to eat a lot of protein. I need to feed it a lot of carbs. And then you start going back down ready for your next injection, but then you start getting sluggish so you just need to eat foods that will give you more and more energy. And you just need… You get used to it because your body will crave certain foods.

Likewise, Hope claimed hormone therapy had a significant impact on her appetite, which she compensated for by periodically missing meals. She stated,

> The biggest problem I've had, I suspect—and I blame this on something else and I shouldn't really—and that is with being on estrogen has really increased my appetite somewhat chronically. I'm famished all the time! I'm hungry all the time and you put some—if my wife ever puts some food in front of me, I eat it, all of it, every bit! And then I'll raid the fridge and whatever. So, weekends are a bad time for me because I'll tend to eat a lot of food and come Tuesday morning, is about the next time I weigh myself when I'm at the hotel, gone to work and whatever. And then that's when I'll miss a meal out and just have a salad for tea. So, I'll have my breakfast, nothing for lunch, and then a bit of a salad for tea and a couple of slices of toast and that's enough to ensure that I lose this weight.

This suggests that some transgender women may attempt to control weight via risky calorie restriction strategies. Those taking herbal hormones were cautious that prescribed hormone therapy would impact body weight. As described by Katerina "hormones might put weight on me as well," suggesting that the side effects of such medication may influence healthcare decisions at this stage of gender affirmation.

Transgender women who did not desire surgery (Josie, Kelly, Hope) were generally motivated to control or lose weight so that they could fit into particular clothes or styles. For example, having had a larger body, Josie stated

> Now I want to reduce dress size. Now I want to get into better dress sizes, you know, and panties—get smaller panties and things. You know, that sort of thing. So, I'm very conscious now, cos I want to get my figure, you know, into proper shape and a proper waist, so I'm looking to lose another stone and get my—get my, you know, a good figure. … You know, I want to have a slender waist, nice fitting skirts and things, you know. Tight fitting and that, as well.

Overall, comments reveal how the self and body are intertwined, and also how

reductions in bodily discomfort and increases in hormone fueled appetite led to increased awareness of eating behavior, body weight, and shape.

Preparation for surgery

Of the seventeen transgender men and women taking hormones, twelve either desired or had undergone surgery. Four of the five participants taking hormones and anticipating surgery discussed the implications of larger body size in relation to gender affirmation surgery. For example, Chantelle considered "the risks of being overweight, and it causes problems with the surgery cos there's too much excess skin when they do the surgery. There's higher risk of it not going to plan." As a consequence, those preparing for surgery typically placed greater emphasis on physical health in preparation for her future surgery. Cassie commented,

> I'm thinking about that a lot now, yeah. Diet and stuff. I'm trying to just eat fish and veg and stuff. I don't eat any other meat other than fish. Exercise. I do a lot of walking and that, but I wanna get more healthy. I just wanna get my metabolism as good as it can be so when I… I can have a good shot at it [surgery].

Similarly, Dale discussed his current exercise regime, which was directly linked to his plans for surgery. For example, he stated,

> They do say that the more upper core strength and more muscle you build—chest muscle you build up—then the much more successful the top surgery is when they do the male contouring. They do the double mastectomy, but also the male contouring. … So, I'm thinking, okay, you know, if I lose the weight and do all the exercising, hit the weights and things and just build up my strength and upper core, then that is preparing for the surgery, so then at least even if I've got a way to go before the surgery, I feel as though I'm still progressing and heading towards something.

The relationship between body weight and preparation for surgery was echoed by transgender women who had undergone surgery. In particular, they reported the challenges presented by body mass index (BMI) targets and employing strict diets beforehand. Tanya stated,

> I'd got the hormone treatment, transitioned, done everything ready for surgery. Got to see the surgeon and he said my BMI was too high and gave a target that was unreachable for me. Literally completely unreachable. It was less than I'd weighed when I was fourteen and I used to do all the sports and stuff like that. So. I mean I'd actually worked it out, I'd have to cut a leg off to reach that BMI, and I was actually seriously considering doing that, and I'm not joking.

Molly described how in order to lose weight for surgery she made substantial changes to her diet. She recalled,

> I was getting towards the end of my counselling I need. I'm getting a bit too much. I need to cut down for my surgery, so I cut out meat and potato pies and went on cuppa soups at lunch times and got my weight down nearly two stone.

The same motivation to lose weight was evident in Sally's interview. She explained,

> I suddenly discovered before I was due to have the operation that maximum measurement around the widest part of your abdomen was thirty-seven inches because obviously a lot of the work is done around the abdomen and mine was forty. I was frightened to death! So, four weeks I had a five hundred calorie a day diet.

She further described a routine of

> five hundred calories a day and a cycle at the local gym. I was down there for two hours a day, as well. I mean, going to the gym doesn't actually lose you much weight at all, but it does tone things up and basically, I was trying to get this down.

Interestingly both Sally and Molly described putting weight back on post-surgery. This is suggestive of the potential for extreme dieting to trigger fluctuations in weight.

Mid- and post-surgery

The recurring theme for the mid- and post-surgery stage of gender affirmation was "contentment versus control." There were fewer interviewees ($n = 8$) from this stage of gender affirmation. All participants reported feeling more positive about their bodies and there appeared to be a reduction in emotional eating. Participants were cognizant of how their bodies and health had changed during gender affirmation and were generally keen to control their weight. Transgender women were more likely to discuss the use of restrained eating, whereas transgender men tended to endorse physical activity and weight training as a form of weight management or body shape control.

Contentment versus control

Participants expressed feelings of wellbeing and increased contentment both in general terms and with their body since engaging with surgery. For example, discussing their general contentment, Tanya asserted, "I'm happy with myself" and Sally commented, "it's infinitely better, there's none of the things associated with gender dysphoria—you know, depression, misery, heartache, arguments." Similarly, Molly stated, "I feel more content. I'm becoming what I want to be, what I should be," and Penny explained, "I do feel a lot more confident in myself, a lot more relaxed and a lot more open. … Nothing's really changed, just me, just being the person I always thought I was." Illustrating greater contentment with body shape, Helen stated, "it's quite nice seeing the fat distribution being more appropriate to one's internal image of oneself. And yes, so, it's a kind of balance of looking appropriate, feeling appropriate."

At later stages of gender affirmation, transgender women ($n = 6$) described various weight control strategies. For example, Helen stated, "I try not to eat too much. I try to eat more slowly," and Jane commented, "I weigh myself regular so I keep—make sure it's not creeping. … If I notice the scales are creeping in the wrong way, I live on porridge for a couple of days." Like her counterparts, Sally also stated that she was happier with her body. However, this was juxtaposed with comments that "There are bits obviously that I would prefer not to have. I'd prefer this mummy tummy to disappear completely" and "I would love to lose another stone, but I don't seem to be able to get round to it." As a consequence, she described weight control strategies such as "eating more salads these days and eating—I tend to get things in bulk now and freeze them." In part, Sally's desire to lose further weight may reflect the common association be-

tween being feminine and being thin.

The transgender men (n = 2) also expressed contentment with their bodies and discussed controlling weight and physical health through diet. Darren who was midway through surgeries at the time of the interview, spoke at length about his new approach to food, with eating oriented towards nutritional value. For example, he explained,

> I personally have problems with internal bleeds and things like that. That's one of my things, so I need to then eat a lot of green veg to combat, because you know the properties in the green veg, especially like cabbage and spinach and things like that, the iron and all the other properties do really well for your healing process.

Similarly, Robert approached food from a functional perspective commenting, "my iron's low so I have to eat a lot of vegetables" and "I have to drink a lot of water because I used to suffer—I used to suffer a lot with urinary infection through stress." Both transgender men discussed weight control strategies. For instance, Darren commented,

> I'm on quite a strict diet,—quite a strict training regime. So, I'm working to improve my health and everything that goes with it. Obviously, my physique, as well. I'm working on that slowly. I've set myself—I've got a goal for a year, so in a year's time I want to be a lot slimmer but have bulked—gained muscle.

These commentaries highlight the importance of controlling weight and maintaining health at this stage.

In contrast to the transgender women, whose focus tended to be on calorie restriction, Darren and Robert talked enthusiastically about exercise, weight training, and building muscular physiques. For example, Robert commented, "The most I can do in a week of tummy exercises is 2,500." Darren also explained,

> Obviously, you've spent all your life being female and now all of a sudden you've got all this testosterone and you've got—no matter how much you trained before, your muscle structure is never the same. But now obviously I build muscle. So, my arms—because you get really obsessed about muscle. Like, some guys don't, but more often than not we get really obsessed with body shape and muscle.

Participant commentaries on food and weight during this stage of gender affirmation provide evidence of a balancing of contentment with awareness of a need to control or lose weight. This does not necessarily mean all participants were successful in achieving this, however attitudes at this stage contrast starkly with pre-gender affirmation and reveal a shift in priorities which favors the safeguarding of physical health.

DISCUSSION

In the present study, the body dissatisfaction and disordered eating reported by transgender men and women were closely related to the pressures experienced at each stage of gender affirmation. Findings highlight the need to consider the importance of stage of gender affirmation when investigating the interplay between gender dysphoria,

body dissatisfaction, and eating behavior (McGuire et al. 2016; Staples et al. 2020) and have important implications for transgender health research and practice.

At the pre-gender affirmation stage, three themes emerged: "managing gender," "stress and depression," and the "consequence of other coping mechanisms." In terms of managing gender, disordered eating was used by transgender men and women to manage self-perceptions and emotions in relation to their body and gender identity (e.g., to create or mask female anatomical features) and to influence the perceptions of others. This is consistent with previous research documenting the use of food restriction or compensatory eating behavior to prevent puberty onset or progression (Coelho et al. 2019). Disordered eating in order to achieve these goals could increase health risks for transgender men and women. Health professionals should be aware of these issues and ensure that appropriate support is provided at the pre-gender affirmation stage.

Similarly, negative affect (stress and depression), arising as a consequence of bullying/harassment, hiding one's transgender identity, or hatred towards their body was linked to food consumption (either under-eating or emotional overeating), the consumption of nutrient deficient foods, and bulimic strategies. Indeed, the emotional aspects of eating behavior and relationships between mental health and eating behavior are well-established (Aoun et al. 2019). Maladaptive behaviors, adopted in order to cope with gender dysphoria (i.e., cocaine use, alcohol abuse, and exercise addiction), also influenced food selection and intake. Findings highlight the importance of contextualizing high-risk eating behavior in transgender populations (Sevelius 2013) and of supporting those experiencing distress during the pre-gender affirmation stage to develop adaptive coping strategies. Findings also contribute to evidence demonstrating the consequences of delays to gender affirmation treatment and the extent to which a lack of support can impact the health of transgender men and women (Carlile, Butteriss, and Sansfacon 2021; Ellis, Bailey, and McNeil 2015).

The coming out and early gender affirmation stage saw the re-emergence of two of the pre-gender affirmation stage themes: "managing gender" and "Stress and depression." In terms of the former, here again the primary motivation (for transgender men) was food restriction leading to weight-loss in order to conceal breast tissue or self-harming behavior (i.e., attempting to remove them altogether). Stress and depression at this stage for transgender women was linked again with transphobic abuse, but also with having to cope with problematic interpersonal relationships (i.e., loss or conflict with spouses, family, and friends) or frustration associated with the speed of access to treatment, leading to either a starvation feeding regimen or emotional overeating. Findings are consistent with previous research documenting the relationship between stressful life events and health behavior in the transgender community (Miller and Grollman 2015; Peltzer and Pengpid 2016) and highlight the importance of developing adaptive coping strategies and accessing appropriate support.

The coming out and early gender affirmation stage also revealed the emergence of a new theme: "new motivation." Transgender women expressed the wish to eat healthily and control portion sizes for two main reasons: to lose weight or maintain a low body weight in order to create and display a more feminine figure or to reduce risk in the light of anticipated surgery. However, risky weight loss strategies were evident (e.g., self-medication with weight-loss pills). Researchers must examine the relation-

ships between femininity, body weight, self-identity, and societal acceptance further, for example, the extent to which transgender women in Western societies believe that a low body weight is part of the "ideal" feminine body shape that must be reached in order to feel or be treated as attractive and feminine. Practitioners supporting transgender men and women during the coming out and early gender affirmation stage should be aware of the potential for both positive and negative associations with eating to develop in this phase.

For transgender men and women at the receiving hormone therapy stage, there was an increase in awareness and control of appetite, weight, and body shape. Consistent with the previous stage, there remained a "new motivation" to lose weight or maintain a low weight. However, hormone therapy was reported to be linked to a large increase in appetite, with the potential for weight-gain. As reported elsewhere (Ålgars, Santtila, and Sandnabba 2010), this creates anxiety in relation to the desired body shape and in relation to meeting weight criteria for surgery. This was sometimes dealt with by employing risky calorie restriction and exercise strategies in order to achieve the required pre-surgery weight. Findings are consistent with literature on the emergence of risky dieting behavior in transgender populations (Diemer et al. 2015; Witcomb et al. 2009) and contribute to existing research (e.g., Fisher et al. 2014) examining the impact of hormone therapy on transgender body image.

Greater acknowledgement and discussion of this issue is required, especially as the body mass requirements for gender affirmation surgery vary, data relating body mass and surgical outcomes are lacking, and body mass requirements for surgery may negatively impact patient health and wellbeing (Brownstone et al. 2021). The relationship between body weight, body dissatisfaction, and disordered eating should, of course, be considered in the context of weight related stigma (both from health practitioners and the general population) and the impact of this stigma on health and wellbeing (e.g., Major, Eliezer, and Rieck 2012; Puhl and Brownell 2006). For example, weight related stigma may increase unwanted attention that is especially problematic when experiencing gender dysphoria and in the context of discrimination and abuse targeted at the transgender community (Bradford et al. 2013).

At the final stage, mid- and post-surgery, the theme that emerged most strongly was "contentment versus control," and a shift in priorities from a motivation to focus on psychological wellbeing to a focus on physical health. For some, contentment in relation to body image emerged, along with a reduction in emotional overeating. Transgender women expressed an increased feeling of wellbeing and greater satisfaction with body image. However, there was also a desire to be thinner, possibly because transgender women associate being thin with being feminine (Gordon et al. 2016). This stage was therefore also characterized by stringent weight control strategies for some people and further research exploring relationships between feminine body ideals, body dissatisfaction, and weight control in transgender women is required.

Similarly, transgender men expressed a greater contentment with their body image and used food in relation to physical health (e.g., consuming vegetables to promote healing after surgery or drinking lots of water to treat urinary infections). Though weight control was still a major concern, this time a stringent diet and exercise routine were combined to achieve the desired slender-but-muscular physique. This is consistent with recent research suggesting that transgender men become more mo-

tivated to care for their body as they progress through stages of gender affirmation (Linsenmeyer et al. 2021) and suggests that measures should be introduced to address existing delays to the gender affirmation process. Transgender men and women have important nutritional requirements that change across the gender affirmation process. There has, however, been little recognition of this issue or formal guidance for transgender men and women. Indeed, previous research has documented the use of social media to obtain transgender relevant nutrition information (Schier and Linsenmeyer 2019). Additional research and guidance are required to support the nutritional needs of transgender men and women at each stage of the gender affirmation process (Rozga et al. 2020).

Findings demonstrate the importance of considering the extent to which gender dysphoria influences body dissatisfaction, attitudes to food, and eating behavior at various stages of gender affirmation. Clearly, each stage of gender affirmation presents specific issues that must be understood and accommodated by health professionals. Further, it is important to recognize important barriers to effective healthcare. For example, weight has become a core issue for those addressing the health of transgender men and women and weight-based stigma can impede health provision, with a tendency for healthcare providers to attribute health issues to body weight (Paine 2021). Interventions intended to improve patient healthcare should ensure that they do not increase existing health inequalities by encouraging weight-based stigma, which reduces engagement with healthcare services and exacerbates the discrimination already experienced by the transgender community (Paine 2018).

Limitations and future research

Findings are, of course, limited by reliance on a relatively small sample, precluding the extrapolation of findings to the transgender community at large. In particular, all participants identified as white, and these findings cannot inform our understanding of the intersections of racism and transphobia in this context (e.g., Ghabrial 2017; Sevelius 2013). Further, it is important to acknowledge that gendered standards of beauty are racialized, such as through privileging thinness and non-Black hair types (Bryant 2019; Kelch-Oliver and Ancis 2011). These racialized standards may negatively impact the body image and eating behavior of non-white transgender women, especially where gender affirmation focuses on racialized aesthetic ideals (Gonsalves 2020). Additional research in this area is required. Similarly, future research should consider cultural variation in the gender affirmation process, including the influence of societal acceptance of transgender men and women and social support (Elischberger et al. 2018). Indeed, research indicates that there is considerable cross-cultural variation in transgender experiences (Reisner, Keatley, and Baral 2016).

Future research should ideally be prospective in nature, so that individual differences and changes in emotions, thoughts, and health behavior can be captured throughout the gender affirmation process, together with those factors exacerbating or lessening body dissatisfaction and disordered eating. These studies may elucidate the nature and timely implementation of interventions to offset the mental distress, negative body image, and maladaptive coping behavior reported here. Research investigating the effectiveness of treatment delivered to transgender clients with body image or eating disorders is particularly important as previous research indicates that

these services and wider mental health services are often inadequate (Duffy, Henkel, and Earnshaw 2016; McCann and Sharek 2016).

To conclude, the present study highlights the need to consider the influence of stage of gender affirmation when researching the interconnections between attitudes, behavior, and emotions relating to gender identity. For both transgender men and women, a shift was evident from a focus on psychological wellbeing in the early stages of gender affirmation to physical wellbeing in the later stages. While body dissatisfaction seems to dissipate as the gender affirmation progresses, a common theme at each stage was that both transgender men and women engaged in risky and often maladaptive behavior related to transforming body shape and size (although motivations changed across the gender affirmation process). It is, therefore, essential that transgender men and women are provided with support in these areas throughout the gender affirmation process.

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ORIGINAL ARTICLE

"I Have to Decide How Attached to that Future I Feel": Fertility Intentions and Desires Among Transmasculine Young Adults

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Though many transmasculine individuals pursue pregnancy, childbirth, and parenthood in their lifetimes, research on the reproductive health needs of this population remains limited. This study aimed to explore the fertility intentions and desires of transmasculine young

adults, as well as the multilevel factors that influence their pregnancy-related decisions. We conducted in-depth interviews with transmasculine young adults aged 18–29 (N = 21) in Boston, MA, USA between February and July of 2018. Interviews were transcribed and analyzed using a thematic analysis approach involving inductive and deductive coding via a codebook applied by two independent coders. While many participants reported no lifetime desire for pregnancy, a sizable minority expressed some desire to become pregnant in the future. Fertility intentions were shaped by a range of anticipated barriers, including gender dysphoria, difficulty navigating gendered stereotypes about pregnancy, inadequate information about fertility and pregnancy for transmasculine individuals, and a lack of health providers with the training and experience to offer high-quality pregnancy-related care to transmasculine patients. Multilevel interventions that address cisnormative stigma and discrimination in reproductive health care settings, improve patient-provider communication, and increase provider fluency with transmasculine health needs are necessary to facilitate access to the full spectrum of fertility-related services among transmasculine young adults.

KEYWORDS transgender, transmasculine, reproductive health, fertility, pregnancy
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Many transmasculine people—namely, transgender men and other individuals who are assigned female at birth (AFAB) and whose gender identity falls along the masculine spectrum—count pregnancy, childbirth, and parenthood among their lifetime goals (Besse, Lampe, and Mann 2020; Ellis, Wojnar, and Pettinato 2015; Hoffkling, Obedin-Maliver, and Sevelius 2017; Light et al. 2014; MacDonald et al. 2016; Obedin-Maliver and Makadon 2015; Stark et al. 2019; Sterling and Garcia 2020). Though much of the current literature on this topic has focused exclusively on transgender men, efforts to expand this research to include nonbinary AFAB individuals have reported a similar diversity of intentions and desires around fertility and pregnancy (Ellis, Wojnar, and Pettinato 2015; MacDonald et al. 2016; Moseson et al. 2021; Stark et al. 2019). A survey of transgender men following gender-affirming surgery by Wierckx and colleagues (2012) found that 22% of participants had children and 54% desired them in the future. Likewise, a survey of transgender and gender nonconforming youth by Chen and colleagues (2019) found that 60.9% of participants were interested in exploring options for family formation and 35.9% desired biological children. Though research on pregnancy prevalence among transmasculine individuals remains scarce, a survey of 1,694 transgender men and nonbinary AFAB adults by Moseson and colleagues (2021) found that 12% had been pregnant at least once, 11% desired a future pregnancy, and 16% were undecided about their pregnancy goals.

While some transmasculine people may choose to pursue gender-affirming surgeries that impact their fertility (e.g., hysterectomy/salpingo-oophorectomy), not all transmasculine individuals desire fertility-related medical interventions (Abern, Cook, and Maguire 2019). Those who do may opt for oocyte or embryo cryopreservation to preserve their fertility prior to any such surgery (Cheng et al. 2019; Sterling and Garcia 2020), or choose to delay surgery until after pregnancy has been achieved

(Ellis, Wojnar, and Pettinato 2015). Though high levels of endogenous testosterone are associated with infertility in people with ovaries, the long-term effects of exogenous testosterone as part of gender-affirming hormone therapy remain understudied. Limited research on transgender men has shown that some individuals can experience pregnancy during or after testosterone use (Light et al. 2014; Obedin-Maliver and Makadon 2015). Indeed, prior research on the pregnancy experiences of transgender men, and transmasculine patients more broadly, has consistently identified a group of respondents who report a lifetime history of testosterone use prior to pregnancy, and many who choose to take a hiatus from testosterone use for the purpose of becoming pregnant (Ellis, Wojnar, and Pettinato 2015; Hoffkling, Obedin-Maliver, and Sevelius 2017; Light et al. 2014; MacDonald et al. 2016).

The decision to pursue pregnancy and childbirth is a complex one regardless of gender identity, and transmasculine individuals cite many of the same motivations as cisgender women for choosing this route to parenthood, such as social recognition, intimacy with a romantic partner, and positive engagement with the capabilities of one's body (Besse, Lampe, and Mann 2020; Ellis, Wojnar, and Pettinato 2015). Nonetheless, limited research shows that transgender men and other transmasculine individuals face unique barriers to pregnancy and childbirth, including cisnormative bias, stigma, and discrimination in health care settings in particular and in society in general, which limit their access to the full spectrum of reproductive health services (Besse, Lampe, and Mann 2020; Ellis, Wojnar, and Pettinato 2015; Hoffkling, Obedin-Maliver, and Sevelius 2017; James et al. 2016; MacDonald et al. 2016; Nixon 2013). Even in the absence of overt discrimination, transmasculine patients frequently report instances of erasure in reproductive health settings due to cisnormative assumptions about who can and will experience pregnancy. These include misgendering by clinical staff, gender-exclusive language on signage and educational materials, or electronic medical records that limit available data fields and billing codes based on a patient's registered gender (Besse, Lampe, and Mann 2020; Moseson et al. 2020). Alongside these barriers, the reproductive choices of transgender individuals are often further restricted by legislation that makes permanent sterilization a requirement for legal recognition of one's gender in some states, potentially forcing individuals to make difficult decisions about their fertility that do not reflect their underlying pregnancy goals (Nixon 2013).

Despite these well-documented barriers, research on pregnancy and fertility decision-making among this population remains limited. Moreover, much of the literature to date has focused on individuals who have already carried a pregnancy to term and thus does not account for the perspectives and experiences of those who are still deciding whether or not to pursue pregnancy within their lifetime (Ellis, Wojnar, Pettinato 2015; Hoffkling, Obedin-Maliver, and Sevelius 2017; Light et al. 2014; MacDonald et al. 2016). Compared to their older counterparts, young adults are both less likely to have undergone gender-affirming surgeries that impact their fertility and more likely to experience an unintended pregnancy while their fertility is preserved, placing them at an important crossroads of reproductive health decision-making (Beckwith et al. 2017; CDC 2016). In order to address this gap in the literature, we conducted a qualitative study to explore the fertility intentions and desires of transmasculine U.S. young adults, as well as the unique multilevel factors that may influence their decision-making around fertility and pregnancy.

Our findings contribute to the limited research on this topic and inform future studies and interventions that enable transmasculine young adults to make informed decisions about their fertility and facilitate access to high-quality, person-centered pregnancy-related services that address the unique reproductive health needs and concerns of this marginalized population.

MATERIALS AND METHODS

Participant sampling and recruitment

We used a purposive sampling strategy (Marshall 1996; Patton 2002) to select participants according to the following eligibility criteria: a gender identity along the transmasculine spectrum (e.g., man, transgender man, transmasculine, or nonbinary); assigned a female sex at birth; aged 18–29 years; had an assigned male at birth (AMAB) sexual partner in the last five years; and resides in the greater Boston area. All participants self-identified as transmasculine, alone or in combination with other gender identities, at screening, though participants were surveyed both at screening and at the end of the interview on preferred terms for their gender identity and gender expression to better capture the full diversity of gender identities and expressions in the transmasculine population. Participants were selected as part of a larger study exploring the reproductive health care needs and experiences of transmasculine young adults and were therefore not screened on the basis of their fertility intentions and desires or their pregnancy history. Participants were recruited through community-based, health care, and student organizations, email listservs, and Facebook groups that served transmasculine young adults (Patton 2002), as well as through recruitment ads posted on Craigslist. Additional participants were recruited via a snowball sampling strategy in which participants were asked to inform potentially eligible individuals in their social networks about the study (Arcury and Quandt 1999; King and Horrocks 2010; Marshall 1996; Patton 2002).

Data collection

We conducted in-depth interviews with 21 transmasculine young adults on topics pertaining to their pregnancy, contraception, and abortion beliefs, attitudes, and experiences. In-depth interviews were conducted in Boston, MA between February and July 2018 using a semi-structured interview guide developed based on the scientific literature (King and Horrocks 2010). The interview guide, which was reviewed by members of the study population and experts in transgender health, consisted of open-ended questions and probes pertaining to the following topics: pregnancy intentions and attitudes, perceptions of and attitudes toward contraceptive and abortion care, contraceptive method preferences and experiences, differential treatment by health care providers in reproductive health care settings, patient-provider communication in the context of contraception, abortion care, and fertility preservation, and health systems barriers to and facilitators of reproductive health care. Interviews were conducted by two members of the study team, a biracial, young adult cisgender woman and a white, young adult transgender man. All interviews were conducted in person in a private room in a university office building or health care facility and lasted between 36 and 66 minutes ($M = 51$). Interviews were conducted in English and audio-recorded upon

obtaining written informed consent from participants. Participants received a $25 gift card for their time. All research activities were approved by the Office of Human Research Administration at Harvard Longwood Medical Area.

Data analysis

Interview audio recordings were transcribed verbatim and entered into Dedoose (version 8.1.8) for analysis. Interview transcripts were analyzed using a template style thematic analysis approach (Crabtree and Miller 1999; Fereday and Muir-Cochrane 2006; King 2004). Data analysis began with immersion in the data and team-based codebook development and refinement (Crabtree and Miller 1999; MacQueen et al. 1998). The initial hierarchical codebook was developed collaboratively among research team members and included both deductive codes based on the scientific literature and in-depth interview guide and inductive codes based on four interview transcripts. Two independent coders each applied the codebook to these four transcripts to test its fit to the data and ensure consistency in its application. Codes were merged, refined, and discarded, and coding discrepancies were discussed and resolved by consensus between the two coders and Principal Investigator. The codebook was then applied to the entire sample and periodically refined based on emerging patterns and discussions among research team members. Approximately 20% of transcripts were double-coded by two independent coders to further ensure consistent application of the codebook throughout the coding process (Fereday and Muir-Cochrane 2006; King and Horrocks 2010; MacQueen et al. 1998). For the present manuscript, coded text fragments pertaining to fertility intentions and desires were further organized into themes and sub-themes (Crabtree and Miller 1999; Fereday and Muir-Cochrane 2006; King 2004) and a matrix was used to systematically identify and delineate similarities and differences among study participants (Miles, Huberman, and Saldana 2014). Memo writing, searching for disconfirming evidence, and regular research team discussions were also used to facilitate the identification and refinement of themes and sub-themes (Miles, Huberman, and Saldana 2014).

RESULTS

Participant characteristics

Participants ($N = 21$) ranged in age from 18 to 29 years, with a mean age of 25 years ($SD = 3.1$). The majority identified as transgender men ($n = 9$, 42.9%), nonbinary ($n = 8$, 38.1%), or transmasculine ($n = 5$, 23.8%), though these categories were not mutually exclusive, and the majority reported current testosterone use ($n = 13$, 61.9%). Most participants identified as white ($n = 16$, 80.0%), were born in the United States ($n = 20$, 95.2%), and had a bachelor's degree or more ($n = 17$, 81.0%). The majority identified as queer ($n = 14$, 66.7%) and reported having sex with a cisgender man in the past year ($n = 14$, 73.7%). Only one participant had ever been pregnant or received abortion care ($n = 1$, 4.8%), and none had ever given birth. When asked about their lifetime fertility desires, the majority of participants ($n = 14$, 66.7%) reported that they did not want to become pregnant during their lives; however, a substantial minority expressed either uncertainty ($n = 5$, 23.8%) or an unequivocal desire ($n = 2$, 9.5%) to become pregnant in the long term.

Table 1. Social, Economic, and Health Care Characteristics of Transmasculine Individuals Aged 18–29 Years (*N* = 21)

Variable	*n*	%
Gender identity*		
Man or male	5	24
Transgender or trans man or male	9	43
Transmasculine	5	24
Genderqueer	4	19
Gender non-conforming	4	19
Non-binary	8	38
Gender fluid	3	14
Agender	3	14
Bigender	1	5
Another gender identity	2	10
Lifetime desire for pregnancy		
Yes	2	10
No	14	67
Unsure	5	24
Currently taking testosterone		
Yes	13	62
No	8	38
Changed gender markers on any legal document		
Yes	10	48
No	11	52
Race/ethnicity* (*n* = 20)		
White	16	80
Black or African American	2	10
Latinx or Hispanic	2	10
Asian/Asian American or Pacific Islander	1	5
Native or Indigenous	1	5
Bi/multiracial	2	10
Another race/ethnicity	2	10
U.S. born		
Yes	20	95
No	1	5
Relationship status*		
Not dating anyone	4	19
Dating one person	11	52
Dating multiple people	4	19
Living with a partner	5	24
Married	0	0
Divorced, separated, widowed	0	0

Another relationship status	1	5
Sexual orientation identity*		
Heterosexual	0	0
Queer	14	67
Lesbian	1	5
Bisexual	7	33
Gay	6	29
Asexual	1	5
Not sure	1	5
Another sexual orientation identity	2	10
Sexual attraction*		
Cisgender women	17	81
Transgender women	17	81
Cisgender men	19	90
Transgender men	18	86
Non-binary AFAB individuals	18	86
Non-binary AMAB individuals	20	95
No one	0	0
Gender of lifetime sexual partners* ($n = 19$)		
Cisgender women	18	95
Transgender women	10	53
Cisgender men	18	95
Transgender men	11	58
Non-binary AFAB individuals	9	47
Non-binary AMAB individuals	5	26
No one	0	0
Past-year sexual partners* ($n = 19$)		
Cisgender women	8	42
Transgender women	3	16
Cisgender men	14	74
Transgender men	4	21
Non-binary AFAB individuals	5	26
Non-binary AMAB individuals	0	0
No one	1	5
Gender expression*		
Masculine	12	57
Androgynous	12	57
Genderqueer	1	5
Gender fluid	1	5
Another gender expression	1	5
Usual health care provider*		
Physician	13	62
Nurse (RN or NP)	9	43

Physician assistant	2	10
Not sure	1	5
Another provider	1	5
Usual site of sexual and reproductive health care*		
Private doctor's office	3	14
Community health center	15	71
Hospital clinic	3	14
Planned Parenthood clinic	3	14
Another site	2	10

Note. Percentages may not add to 100% due to rounding error and/or non-mutually exclusive categories. Asterisks (*) indicate that categories are not mutually exclusive. AFAB = assigned female at birth; AMAB = assigned male at birth.

Theme 1: Fertility and pregnancy were often considered in the context of plans for gender-affirming health services

Participants reported a wide range of attitudes towards fertility and pregnancy. Many felt strongly that they did not want to become pregnant. A 29-year-old white, male-identified participant summarized his feelings in this way:

> That's definitely one of those things that has always been a pretty hard no for me, and so I've, since becoming sexually active, been pretty diligent about making sure that was never […] going to come up.

Among those who did not want to become pregnant, some specifically regarded the loss of fertility as a positive potential consequence of pursuing gender-affirming medical services, such as hormone-replacement therapy or surgery. Referring to the experience of signing an informed consent document explaining that testosterone may decrease individuals' ability to conceive, another participant, a 27-year-old transgender man, described:

> I also kind of laughed because, you know, even before I knew that I was trans, I knew that I did not want to be a pregnant person. So that was honestly probably the easiest thing I did that day.

In contrast, several participants expressed a desire to keep their options open, and to consider the possibility of a future pregnancy when structuring their plans for gender-affirming medical services and other health goals. One participant, a 27-year-old white, nonbinary participant who reported wanting to start testosterone use but had not yet done so, stated:

> There's a lot of people who say that there isn't actually a risk of becoming infertile, but there is a chance […] and so I have to decide how attached to that future I feel.

Another 21-year-old multiracial, nonbinary participant echoed this sentiment when discussing considerations around the timing and sequencing of testosterone use and gender-affirming surgery:

> When thinking about whether I should start taking T [testosterone] or […] if I ever decide to get top [chest] surgery, whether I want to be pregnant and have a baby would definitely be on that list.

While many participants reported uncertainty about their pregnancy-related goals,

some cited a strong intention to have biological children and expressed confidence in their ability to navigate any emotional or medical barriers that might arise. As stated by one 26-year-old white transgender man:

> I really want to be a parent. I want to grow a baby. […] I don't really know what sort of gender feelings might show up, but I also know that I'm just going to be really excited to be a parent, and I think that will end up overshadowing any distressing stuff.

Among participants who desired pregnancy, nearly all felt that their gender identity and perceived gender expression would alter the experience of preserving their fertility or carrying a pregnancy to term, and many felt that the process would be more difficult as a result. Anticipated barriers fell into three broad categories: (1) dysphoria and gendered stigma associated with being visibly pregnant as a masculine-identified person, (2) difficulty accessing fertility- and pregnancy-related services due to gendered stigma in health care settings, and (3) lack of trust in health care providers to offer pre-, peri-, and postnatal care that meets the needs of transmasculine patients. These concerns were shared by participants across a wide range of fertility desires and intentions, though participants differed on how surmountable they perceived these barriers to be and how heavily each factored into their decision-making around pregnancy.

Theme 2: Perceptions of pregnancy as a gendered experience complicated decision-making around fertility and pregnancy

Pregnancy as a source of gender dysphoria

Many participants believed that pregnancy and childbirth would be a source of gender dysphoria for them, due to the hormonal and bodily changes inherent in the process. Several participants commented on the need to halt testosterone during and prior to the pregnancy, due to its potential impact on fertility and fetal development (WPATH 2011). As stated by a 26-year-old white, nonbinary participant:

> I think it [pregnancy] would be hard and weird. […] I think the biggest thing in my understanding is that you have to be off T for at least a little while before getting pregnant and then for the duration of the pregnancy.

Some participants cited dysphoria as their primary reason for choosing not to pursue pregnancy. One participant, a 27-year-old transgender man, emphasized:

> It's just a whole other animal that if I woke up tomorrow with this crazy urge to be pregnant, I think that would just tear me apart.

For others, the need to halt or delay gender-affirming services was one factor to weigh among many, albeit one about which they expressed some concern. As stated by another participant, a 26-year-old white transgender man:

> I mean, I would [stop testosterone] because that's what I would need to do to have children, but menstruating again, I haven't done that in a couple of years, so I'm not looking forward to that.

Pregnancy as a driver of cisnormative stigma

For many participants, concerns about the physical symptoms of pregnancy were compounded by cisnormative stigma expressed as fears of ostracization and discrimina-

tion that might result if they were to be perceived as pregnant in an androgynous or masculine body. A 28-year-old white transgender man described this as his primary reason for choosing not to preserve his fertility or attempt a planned pregnancy in his lifetime:

> I would have loved to have been able to, but I just don't think I could. Not for the physical piece of it, which I actually would have enjoyed, but for the social aspect of it. […] There are visible changes that happen to your body, and people questioning, and people looking. I just couldn't have done that.

A 27-year-old transgender man shared a similar concern:

> The idea of being a pregnant man is terrifying, you know. I have a lot of anxiety about getting clocked as trans all the time. You know, I'll butch up, like in an Uber, like talking to some dude, you know. I'm constantly afraid of getting clocked as trans or even gay.

Pregnancy as a gender-neutral state

Among participants who reported some lifetime desire to become pregnant, many coped with the potential for gender dysphoria and cisnormative stigma by reframing pregnancy as a gender-neutral and strictly biological state. A 28-year-old white transgender man stated:

> It's something that my body can do. My body is uniquely my own and I don't think of it as a female body in any way. It's just like, these are my parts, and this is what they can do.

A 20-year-old Latinx, agender participant echoed this sentiment:

> It's weird because I want to be a mom and I want to be a dad at the same time. […] I feel like my reproductive organs don't make me necessarily feminine because I feel like gender is just so mental.

Theme 3: Open patient–provider communication was hindered by health care providers' gendered assumptions about patients' pregnancy goals

Although many participants reported that they had not discussed their fertility intentions with a health care provider, those who had done so expressed difficulty communicating their needs due to the gendered assumptions they encountered in health care settings. Participants often found themselves caught between two competing stereotypes: (1) that all individuals with a uterus will want to become pregnant in their lifetime and (2) that all transmasculine individuals will want to avoid pregnancy and eventually seek to end their fertility. While the latter stereotype was more salient for participants seeking to plan for pregnancy or preserve their fertility, the former was raised by participants who wished to end their fertility, emphasizing that gendered stereotypes can be a double-edged sword that does not appropriately serve either group.

Provider bias against treatments that may compromise fertility potential

Participants who reported that their providers were not aware, or not fully supportive, of their gender identity expressed frustration that their fertility was often prioritized over their other health care needs, regardless of their stated pregnancy intentions. A 29-year-old white, nonbinary and agender participant who reported no lifetime preg-

nancy desire shared the experience of seeking care for an unrelated ophthalmological condition:

> I don't know what the medication would have been, but my ophthalmologist was like, 'Well, I could prescribe you this medication, a particular medication that we don't prescribe to women who are pregnant or might become pregnant, and I'd be hesitant to prescribe it to you.' […] That was a weird interaction, because I was like, 'Oh, I could be denied a medication.'

Interactions in which fertility was prioritized over other health care needs were common for participants pursuing a total hysterectomy, a common gender-affirming surgery that results in permanent loss of fertility. This was especially true for participants whose providers were unaware of their gender identity or who wanted the surgery primarily to address other health care needs, such as pregnancy prevention. As stated by one 22-year-old white transgender man:

> I brought it up to my doctor, and I was like, 'Hey, I would like to be sterile indefinitely because I've known I don't want kids forever,' and she's like, 'You're 20. Good luck.'

Similarly, some participants felt pressured to disclose their gender identity to health care providers sooner than they would have liked in order to overcome providers' insistence on preserving the fertility of patients they perceive as women. A 27-year-old white, nonbinary participant described the experience of seeking a hysterectomy to control the symptoms of endometriosis:

> I'd love to get a hysterectomy, and that's where it almost came up on the phone. […] I was like, 'And you know, if I have to get a hysterectomy, that won't be the end of the world,' And she's like, 'Oh, but you'll want to have kids.' […] So that kind of thing. I'll probably have to mention [my gender identity].

Provider reluctance to address fertility and pregnancy with transmasculine patients

On the other hand, participants who felt that their providers viewed them primarily as transgender men expressed frustration that fertility and pregnancy were no longer considered a relevant part of their health care. As stated by one 27-year-old white, nonbinary participant:

> I think the fact that I present more masculinely does affect things. I think people assume that I'm not interested in physically reproducing. I don't think any providers ask me about […] what I want.

Several participants felt that their providers adopted a one-size-fits-all approach, in which they expected all transmasculine patients to pursue the same set of gender-affirming medical services, without regard for fertility preservation or pregnancy planning. A 24-year-old white, nonbinary participant described their experience this way:

> I think that because providers see me, and it's very clear that they're checking the box 'transman' in their head […] I see an attitude of reduced flexibility around what my needs might be. So it's like, 'Got it. You're a man. You want this, this, and this.' And I'm like, 'Do I, though? Is that what I need?'

Another participant, a 22-year-old white transgender man, expressed a similar sentiment:

> A lot of people are concerned about how the narrative around transition often includes sterilization, and there's sort of this idea that you have to go through all of these steps.

This approach was particularly alienating for participants whose decision-making around fertility preservation and fertility loss had been painful or complex. A 28-year-old white transgender man, who ultimately chose to pursue a hysterectomy, described his provider's behavior in the weeks leading up to the procedure:

> I think she was erring so much on the side of being supportive and like, 'This is great. This is the next step in your [...] transition process,' that when I tried to bring up that real sadness it was like, 'Oh, no, no. This is what you need to do.'

Finally, some participants felt pressured to hide the complexity of their emotions around fertility loss during the hysterectomy process, lest their providers question their preparedness for the procedure or deny them access to other gender-affirming medical services in the future. As stated by one 21-year-old multiracial, nonbinary participant:

> I think if I'm going to the doctor and saying something, I know that anything I say could end up in my record and be passed from doctor to doctor, and so I only want to say things that I'm comfortable with that happening with.

Similarly, another participant, a 28-year-old white transgender man, explained:

> I'm afraid that if I voice any [...] sadness around it, then they would start questioning, and then the barriers would go into place around being able to access that. So, I feel like in some situations, I've had to say what I know they want to hear, but not necessarily honoring the true feeling behind it.

Theme 4: Health care providers often lacked knowledge and fluency in transmasculine fertility and pregnancy needs

Lack of guidance from providers around potential fertility loss

Many participants felt that they were forced to make decisions about their fertility sooner and with less information than they would have preferred in order to progress toward their gender-affirmation goals. For example, nearly all participants believed that testosterone would decrease their fertility, but most were unsure how immediate or permanent this effect would be. As stated by one 22-year-old white, nonbinary, and genderqueer participant:

> The informed consent that I signed to start [testosterone] was ten pages of, 'You may or may not be able to become pregnant. You may or may not. You may or may not.' [...] And to sign that at 21 was kind of like, 'Oh, I wish I knew more.'

Another 21-year-old multiracial, nonbinary participant shared their stress at having to navigate fertility preservation at such a young age:

> [It] feels really stressful and overwhelming, and like a whole bunch of things that I wish I didn't have to think about because I know that I don't

> want to have a baby for a while, but because I need to make peace with my body in the meantime I have to deal with it now.

Lack of guidance from providers on fertility preservation and pregnancy planning

For many participants, this stress was amplified by a sense that they could not rely on their health care providers to offer meaningful guidance on fertility preservation options, due to lack of provider knowledge, experience, or comfort discussing pregnancy with transgender patients. A 26-year-old white transgender man reported the following interaction with his surgeon:

> I got chest surgery two years ago and I saw a surgeon who does a lot of chest surgery, and I was like, 'Oh, I'm thinking about having children at some point. Do you know if I can lactate or what would happen?' […] She's like, 'I don't know.' She's like, 'I perform this surgery on women who have a breast reduction […] but yours is obviously a lot more than a reduction, so I don't know.'

Further, several participants expressed frustration that they were warned of the impact testosterone might have on their fertility but given little guidance on how to navigate the potentially complex and expensive process of extracting and preserving their eggs. As stated by one 26-year-old white transgender man:

> They're like, 'Oh, we recommend that you save your eggs,' but […] it's very expensive and that's all they said, so I was just like, 'Okay, we'll see.'

Another participant, a 28-year-old white transgender man, shared a similar experience:

> I was trying to ask around banking of eggs, or what are some options to maintain future fertility, and it was just kind of brushed under the rug like, 'Oh, that's just really expensive. You're not going to be able to do that.'

Perceived lack of providers with experience in caring for transmasculine patients during pregnancy

Likewise, several participants expressed concerns about the lack of health care providers with the knowledge, training, and experience to provide transmasculine individuals with high-quality pre-, peri-, and postnatal care. As stated by one 26-year-old white transgender man:

> There's not a lot of trans men who become pregnant and give birth, not that anyone has information about anyway, so I don't […] know where I would go.

Another participant, a 27-year-old transgender man, elaborated on this fear:

> I don't know even if a doctor would understand the full impact of, you know, half a decade on hormones and stuff. […] Even if I could find the most trans pregnancy experienced doctor, how many of those has he or she actually experienced providing care to, you know, maybe two?

Many participants endorsed a general strategy of doing their own research ahead of health care encounters, as well as crowdsourcing advice and information from their communities. As stated by one 26-year-old white nonbinary participant:

> My method is 100% to walk in informed. And so, like, I will crowdsource

> information from people that I know that would be experts. So, like, I will ask my friends who are doctors and nurses […] and then walk in demanding the things that I need, as opposed to walking in and asking for recommendations, because historically doctors' recommendations are […] poorly informed on the way my life works.

However, pregnancy was viewed as more complex than the typical health care encounter, and at least one participant, a 26-year-old white transgender man, felt that lack of confidence in provider expertise was enough to make him question the feasibility of having biological children:

> I will think a lot about […] where I would get medical care and who would be qualified to help me with that, if there were complications or anything like that. Like the one or two people in Boston who have helped trans men have children may or may not be equipped to deal with things that come up. So, I don't know if I'll do it.

Importance of open patient–provider dialog

Among participants who felt confident in their ability to navigate a future pregnancy, several emphasized the importance of finding a provider with whom they had a respectful and trustworthy rapport. Some felt that their history of negative health care experiences could be leveraged to better establish these relationships in the future. As stated by one 24-year-old white, nonbinary participant:

> I think, in general, my experience with […] my current PCP. Again, it's incredibly communicative. I understand that has a great deal to do with her, and also it does have something to do with me walking into the room and being, you know, my capacity to medically advocate for myself unfortunately comes from a lot of poor experience.

Others stressed the need for better representation of transmasculine individuals among health care providers, as well as clinical staff, patient navigators, and peer educators, and expressed a desire to serve as a resource for other patients themselves. As stated by one 29-year-old white, nonbinary participant:

> That's the kind of stuff that I just didn't even realize was missing until recently, where I'm like, you know, it would be really, really nice to take a workshop on my own health led by somebody who's lived it. It would also be nice to feel invited into that process, you know? […] I would love to be available to people.

When asked what approaches they would like to see from health care providers in the future, nearly all participants emphasized the need for open communication between providers and their transmasculine patients around fertility and pregnancy. As stated by one 28-year-old white transgender man:

> I do know some patients don't want to have that conversation, and that's fine, but some definitely do. So being open to having that conversation and knowing what the potential options are around adoption or banking of eggs and those kind of different options. That would've been super helpful to me when I started to transition.

A 24-year-old white, nonbinary participant echoed this sentiment:

> I see a lot of value in providers asking more questions about patients'

> […] hopes, thoughts, and feelings around their reproductive health and those organ systems or anatomical systems.

Further, participants urged providers to be aware of the diversity of fertility needs, intentions, and desires that exist among transmasculine individuals. A 28-year-old white transgender man shared the following:

> I feel like people get one narrative in their heads and that's that. […] So that's one of my big things with providers is everybody's experience is individual, and so you can't assume one person's individual experience based on collective experience with the community.

DISCUSSION

Prior research on fertility and pregnancy among transgender men, and transmasculine people more broadly, has chiefly focused on the perspectives of individuals who have already carried a pregnancy to term (Ellis, Wojnar, and Pettinato 2015; Hoffkling, Obedin-Maliver, and Sevelius 2017; Light et al. 2014; MacDonald et al. 2016). Our findings expand upon this literature by exploring the perspectives of transmasculine young adults, many of whom were still grappling with the decision of whether or not to incorporate pregnancy or fertility planning into their life goals. Consistent with prior work (Besse, Lampe, and Mann 2020; Hoffkling, Obedin-Maliver, and Sevelius 2017; Moseson et al. 2021; Wierckx et al. 2012), participants expressed a wide range of attitudes towards pregnancy. A majority felt certain that they did not desire pregnancy in their lifetime, while a small minority had already chosen to structure their plans for gender-affirming medical services and other major life events around an intended future pregnancy. However, by focusing on a younger, childless cohort, our findings offer additional insight into the perspectives of a third group who, though they may have some lifetime desire for pregnancy, feel ambivalent or undecided due to the perceived difficulty of carrying a pregnancy as a transmasculine individual. These perspectives are unlikely to be included in research that singles out individuals who have already given birth, but they offer a valuable outlook on the barriers that may prevent transmasculine individuals from accessing the full spectrum of options for their fertility and reproductive health.

Despite recent strides in visibility and societal acceptance, transgender people still face considerable cisnormative bias, stigma, and discrimination in health care settings (Poteat, German, and Kerrigan 2013). As many as 33% of transgender respondents on the 2015 U.S. Transgender Survey reported at least one negative health care experience related to their gender identity in the past year, such as being asked unnecessary or invasive questions by a health care provider, being verbally harassed in a health care setting, or being denied access to health care services (James et al. 2016). Furthermore, as many as 23% reported choosing not to seek a health service when they needed it at least once in the past year for fear of mistreatment related to their gender identity, and 24% reported at least one experience in the past year in which they were required to educate their provider about their needs as a transgender patient (James et al. 2016). These results are not surprising, given the lack of training providers receive that is geared towards transgender patient populations. As of 2020, only 16% of medical schools accredited by the Liaison Committee on Medical Education reported

offering a comprehensive LGBTQI+ competency training program, and only 48% reported offering any training on LGBTQI+ patients in their curriculum (Moseson et al. 2020). A 2015 survey of OB-GYNs in the United States found that fewer than half had received education on LGBTQI+ health during their residencies and fewer than 20% had received training on transgender patients (Unger 2015). In this context, pregnancy and childbirth represent a difficult choice for many pregnancy-capable transmasculine and nonbinary individuals, who are routinely forced to navigate a complex set of medical, structural, and psychosocial obstacles with incomplete information and inadequate support from their health care providers.

The present findings document several key barriers faced by transmasculine individuals who are considering pregnancy and highlight concerns about the impact of cisnormative stigma and discrimination in reproductive health care settings. These concerns are in line with the narratives of transgender men, and transmasculine people more broadly, who have experienced pregnancy and childbirth, many of whom report instances of discrimination and stigmatizing behavior from their health care providers, including rudeness, invasive questioning, incorrect name and pronoun use, and denial of key services such as lactation coaching (Light et al. 2014; MacDonald et al. 2016). The exclusion of pregnancy-capable transmasculine people from clinical narratives of pregnancy and childbirth has its roots in repronormativity, the pervasive assumption that childbearing is essential to, and indivisible from, femininity and womanhood (Karaian 2013; Radi 2020). As mainstream visibility of the transgender community has increased, these pressures have been compounded by the evolution of transnormativity, a normative framework that selectively legitimizes transgender narratives and experiences that conform to certain social and medical standards, such as identification with a binary gender, pursuit of gender-affirming medical services in line with that gender, and rejection of the social norms and physical characteristics associated with one's assigned sex (Johnson 2016). In the context of reproductive health care, these biases may serve to portray pregnancy and masculinity as fundamentally incompatible, making it difficult for nonbinary and transgender patients to receive support for their gender identity and their fertility goals without undermining one or the other (Karaian 2013; Johnson 2016).

In the present work, participants cited gendered assumptions held by providers about their pregnancy goals, as well as the lack of provider fluency with transmasculine reproductive health needs, as two of the most significant barriers to establishing an open dialog with their providers about their options for fertility and pregnancy. On the one hand, participants whose providers did not know of, or did not fully support, their gender identity often described feeling pressure to prioritize fertility preservation over a variety of other health needs, and, in some cases, to disclose their gender identity sooner than they would have liked in order to justify pursuing medical services that would put their future fertility at risk. On the other hand, participants whose providers were nominally supportive of their gender identity often reported feeling that their providers no longer considered fertility and pregnancy a relevant part of their health care, and, in some cases, reported feeling pressure to hide their fertility desires lest their providers retract their support or question their readiness for gender-affirming medical care. The tension between the repronormative pressure to preserve fertility in some cases and the transnormative pressure to opt out of it in others pro-

duces a system in which individuals may feel that they are effectively forced to choose between gaining full recognition of their gender identity in reproductive health care settings and engaging with the reproductive capabilities of their body (Johnson 2016).

Prior research has suggested that access to respectful and non-stigmatizing preconception counseling can significantly reduce feelings of loneliness and isolation among transmasculine patients preparing for pregnancy (Besse, Lampe, and Mann 2020). These findings were echoed by participants in the present work, who emphasized the importance of an open and respectful rapport with a trustworthy provider in their assessment of pregnancy as a feasible goal. Consistent with prior work, participants endorsed care navigation strategies geared towards seeking out more positive patient-provider relationships, such as leveraging negative past experiences for self-advocacy in clinical encounters, relying on peer advocates and social supports to better prepare for difficult conversations, and seeking out transmasculine providers who might better understand their health care needs (Seelman and Poteat 2020). As such, our findings highlight a pressing need to equip health care providers with the training and experience required to offer pre-, peri-, and post-natal care that meets the needs of this population, as well as increase representation of transmasculine individuals in health care roles. Further, our findings emphasize the need for providers to offer flexible care that avoids making assumptions about the fertility intentions and desires of transmasculine patients.

These recommendations would be further bolstered by systems-level interventions that target the wider policy landscape in which reproductive health services are delivered. The World Professional Association for Transgender Health (WPATH), as well as the American Society for Reproductive Medicine (ASRM) and the American College of Obstetricians and Gynecologists (ACOG), have all issued guidance recommending that transgender patients receive counseling on potential fertility loss and fertility preservation options prior to the start of gender-affirming hormone therapy (ACOG 2021; ASRM 2015; WPATH 2011). Despite this, fertility preservation techniques such as oocyte retrieval and cryopreservation remain prohibitively expensive for many patients, with out-of-pocket costs as high as $9,253 per procedure, in addition to the costs of long-term storage (Lyttle Schumacher et al. 2017). While a number of U.S. states have enacted fertility insurance laws mandating health insurance coverage for fertility-related diagnostic services and infertility treatments, only eleven (i.e., California, Colorado, Connecticut, Delaware, Illinois, Maryland, New Hampshire, New Jersey, New York, Rhode Island, and Utah) have enacted mandates requiring some insurers to extend coverage to fertility preservation services in cases of medically-induced infertility (Kyweluk, Reinecke, and Chen 2019; RESOLVE 2022). Application of these mandates is often restricted to cases where fertility-compromising treatments are deemed "medically necessary," criteria which were developed in the context of cisgender women undergoing cancer treatments and which may not be understood to apply equally to transmasculine patients in all states (Kyweluk, Reinecke, and Chen 2019). Additional legislation to ensure that existing mandates may be applied in the context of gender-affirming medical care, as well as the development of similar mandates in other states, would represent a crucial step towards making fertility preservation accessible to all who desire it. At the same time, not all transmasculine individuals will choose to pursue gender-affirming medical services that impact their fertility,

and existing legislation that makes fertility-compromising treatments, such as certain gender-affirming surgeries, a prerequisite for individuals to gain access to identification that matches their gender identity are discriminatory and should be repealed wherever possible (Nixon 2013).

Limitations

These results have several limitations. First, although participants reported a diversity of attitudes, intentions, and desires around pregnancy, only one individual in our sample had ever been pregnant and none had given birth. Thus, we were unable to identify or explore any systematic differences between individuals who are willing and able to pursue pregnancy and those who desire pregnancy but do not ultimately pursue it. Second, because these data were gathered as part of a broader study that also examined experiences with contraception, unintended pregnancy, and abortion, participants were only eligible if they reported an assigned male at birth (AMAB) sexual partner within the past five years, a requirement that does not reflect the full range of transmasculine individuals' sexual and romantic relationships or family configurations. Further, because our goal was, in part, to explore transmasculine young adults' experiences navigating reproductive health services, we did not recruit for or include gender diverse AFAB individuals who did not view themselves as transmasculine, alone or in combination with other gender identities, in the present study. Thus, our results may not be applicable to gender diverse people who do not identify as transmasculine and whose experiences may differ from those described here. Finally, a majority of participants in our study sample were white, college-educated individuals enrolled in a private health plan. Nearly all were U.S. born, and all were fluent English speakers. Further all participants resided in or around the greater Boston area. As a result, our findings may not reflect the experiences of transmasculine people of color, individuals with less than a college-level education, or those enrolled in a public health plan or who lack health insurance. Likewise, they may not reflect the experiences of transmasculine individuals who face linguistic or cultural barriers or who reside in regions with different social and political climates and different levels of access to health insurance and health care. Nonetheless, these findings offer insights into the factors that influence decision-making around fertility and pregnancy among transmasculine U.S. young adults, with a particular focus on the decision-making of individuals who have not yet gone through the process of becoming pregnant or giving birth and who are, in many cases, still grappling with the decisions and the barriers described throughout.

CONCLUSION

Transmasculine individuals seeking to become pregnant must navigate a complex set of structural, institutional, interpersonal, and psychosocial barriers—both inside and outside of the health care system. Health care providers are well-positioned to reduce the impact of these barriers by offering high-quality, non-stigmatizing pre-, peri-, and post-natal care to all patients regardless of gender identity or expression. Moreover, health care providers should strive to maintain open communication with transmasculine patients about their fertility desires and intentions in the context of other health care needs, such as efforts to minimize gender dysphoria and any plans for tes-

tosterone use or gender-affirming surgeries. Likewise, health care institutions should ensure that providers and staff are trained in best practices for supporting transmasculine patients, including the use of gender-inclusive language in patient-provider communication and educational materials, correct name and pronoun use, and reliance on person-centered patient-provider communication that avoids making gendered assumptions about patients' sexual and reproductive health needs, preferences, and experiences.

Providers and institutions alike should be aware of and prepared to address the wider structural- and institutional-level barriers faced by transmasculine patients accessing and navigating reproductive health care, such as difficulty obtaining health insurance coverage for oocyte cryopreservation and other key fertility services. Further, health care institutions should make additional efforts to incorporate transmasculine perspectives into health information and services delivery, including in the form of peer-to-peer sexuality education, peer-led health care navigation programs, collaboration with transmasculine communities in developing patient educational materials, and improved representation and retention of transmasculine health care providers. Systems-level interventions that mandate or incentivize insurance coverage for fertility services, ensure that transmasculine patients are not excluded from such coverage on the basis of gender identity, and discourage the use of proof-of-surgery requirements in applications for updated identification documents should also be considered. Finally, efforts to address institutional cissexism in health care settings by incorporating comprehensive training on the health needs of transmasculine patients, and gender diverse patients overall, into medical and nursing school curricula, continuing education for health professionals, and institutional staff trainings should be used to bolster these strategies, as should efforts at wider advocacy to address structural cissexism in society as a whole.

Despite significant barriers, many transmasculine individuals desire parenthood, and many choose to become pregnant and give birth. A greater understanding of the fertility-related needs, intentions, desires, and experiences of this population, as well as multilevel interventions that advance access to high-quality reproductive health care and address cissexism and other forms of discrimination in health care and other settings, will enable health care providers and organizations to better support the reproductive health, autonomy, and dignity of all people across the full spectrum of gender identities and expressions.

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ORIGINAL ARTICLE

Moving from Gender Dysphoria to Gender Euphoria: Trans Experiences of Positive Gender-Related Emotions

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While trans identities are typically understood through the distress-based concept of *gender dysphoria*, some trans people use the term *gender euphoria* to describe their experiences. Broadly defined as positive gender-related emotions, the concept has become more common in trans communities in recent years but has received little academic attention. To fill this gap, we conducted qualitative interviews with five trans individuals. We found that gender euphoria refers to positive emotions resulting from affirmation of one's gender identity or expression and can include a wide variety of emotions and experiences. Gender euphoria can range from feelings of intense joy accompanying the attainment of milestones in gender transition through to a more consistent sense of calmness and relief occurring later in transition. We contextualize these findings within the gender minority stress model to explore the link between gender euphoria, dysphoria, and health and well-being generally. Our findings emphasize the value of prioritizing euphoria, happiness, and safety in gender-affirming care.

KEYWORDS gender euphoria; gender dysphoria; gender affirmation; gender minority stress model; transnormativity
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In both medical and mainstream discussions, gender dysphoria is nearly synonymous with transness itself. Transgender people are born in the wrong body, so they experience great distress over their sex characteristics and use hormones and surgery to change their bodies and eliminate their distress—or so the story goes. But increasing-

ly, trans communities and scholars are pushing back against this focus on dysphoria to make space for discussions of more positive aspects of trans experiences. Ashley (2019) has argued that demanding that trans patients present with gender dysphoria is dehumanizing, and that there are other valid reasons a trans person might pursue medical transition, such as gender euphoria or creative transfiguration. Similarly, Bradford, Rider, and Spencer (2019) have called for future research to go beyond deficit and distress-based models of trans identities. Both Ashley and Bradford, Rider, and Spencer use the term *gender euphoria* to describe positive gender-related emotions that might emerge from transitioning, a term that has become more common in trans communities in recent years. However, very little academic research has been done on the topic.

This research sought to fill this gap, and asked: How do trans individuals describe their experiences of euphoria, joy, affirmation, or positive affect in relation to their gender? To answer this question, we conducted an exploratory study using qualitative interviews with a small sample of young trans people living in British Columbia, Canada, about their experiences of gender euphoria. We found that gender euphoria refers to positive emotions resulting from affirmation of one's gender identity or expression and can include a wide variety of emotions and experiences. Given these findings, we challenge pathologizing narratives of transness by illuminating the joys and positive reverberations that can come with being trans. We also interpret our findings in the context of the gender minority stress model. While our small sample was fairly homogenous in terms of age, race/ethnicity, geography, and social context, our findings indicate the need to create space for gender euphoria within gender-affirming medical systems and to conduct further research.

DYSPHORIA AND TRANSNORMATIVITY

Most research on trans experiences centers around the concept of gender dysphoria, which the 5th edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; 2013, s. 302.6) defines as "a marked incongruence between one's experienced/expressed gender and assigned gender" that is associated with "clinically significant distress or impairment." Similarly, the 7th edition of the World Professional Association for Transgender Health's *Standards of Care* (2012, 2) defines gender dysphoria as "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)." Accompanying gender dysphoria is a larger hegemonic narrative that dominates medical and mainstream cultural representations of trans identities. This narrative includes a sense of being "born in the wrong body," displaying gender non-conformity since childhood, and seeking medical transition to express an authentic inner self. Several scholars have referred to this narrative as *transnormativity.* Matte (2014) traces how interplay between trans activists and American medical and legal systems from 1960 to 1990 produced these narratives as a way to gain legitimacy and recognition of trans identities in the public eye. Johnson (2016) further defines transnormativity by focusing on how trans people are held accountable to these narratives. Both scholars argue that while transnormativity has been used successfully to gain some trans people rights and legitimacy in the public eye, it has also constrained the narratives available to trans people.

Both historically and in the present day, trans people seeking gender-affirming medical care have often felt the need to selectively narrate their experiences in a way that is legible to care providers operating in a medial model. This has often meant emphasizing dysphoria and distress over other aspects of experiences of gender (Bolin 1988; Davy 2015; Johnson 2015; shuster 2021). This pervasive focus on distress has detrimental impacts on the lives of trans people. Budge, Orovecz, and Thai (2015, 422) argue that the overwhelming emphasis on dysphoria and distress in trans narratives "fuels anxiety and anticipatory negative emotional processes" for trans people and limits their ability to experience and express positive emotions. Relatedly, Westbrook (2021) describes how activists working to raise awareness about violence against trans people through campaigns such as Transgender Day of Remembrance have argued for the protection of trans lives primarily by focusing on the unjust violence they face, and in the process have constructed trans lives as inherently vulnerable and victimized. An unintended consequence of this strategy is an increase in feelings of fear and hopelessness among trans people, who see themselves as in constant threat of violence. To position trans lives as worth living, Westbrook (2021, 175) argues that we must not only focus on the violence trans people face, but also the joyful lives they live: "narratives about transgender lives should highlight gender euphoria, not just dysphoria, as well as transgender joy, not just risk for violence." Westbrook and Budge, Orovecz, and Thai's research demonstrate how transnormativity—and in particular, the overemphasis on trans distress and dysphoria—restricts the emotional expression of trans people.

GENDER MINORITY STRESS MODEL

The sexual minority stress model, first developed by Brooks in her work with lesbian women in 1981 and popularized by Meyer in 1995, describes how homophobia and oppression impact sexual minority people's health and well-being. In recent years, Testa and colleagues (Hendricks and Testa 2012; Testa et al. 2015) have applied this model to trans people using the gender minority stress model. This model distinguishes between distal or external stressors, such as direct experiences of discrimination and violence, and proximal or internal stressors, such as internalized transphobia (Hendricks and Testa 2012; Testa et al. 2015). The impact of these stressors is mediated by resilience factors, including community connectedness and pride (Testa et al. 2015). Recently, some scholars have proposed gender dysphoria as an additional proximal stressor that may be worsened or alleviated by distal stressors and other social experiences (Cooper et al. 2020; Galupo, Pulice-Farrow, and Lindley 2020; Lindley and Galupo 2020).

Related work has also considered the importance of gender affirmation to trans people's health and well-being. For example, Sevelius (2013) uses gender affirmation as a framework for understanding risky behavior among trans women of colour. Sevelius posits that transphobic stigma leads to both psychological distress, which increases the need for gender affirmation, and social oppression, which decreases opportunities to access gender affirmation. This combines to create a state of identity threat, in which the need for gender affirmation exceeds the opportunities to access it. With few avenues to affirm their gender, the highly marginalized trans women of colour

in Sevelius' research turned to activities such as sex work, substance use, and street hormone and injection silicone use, which meet their need for gender affirmation, but also increase their risk of HIV exposure. Other literature emphasizes the role of transition-related hormones and surgeries, gender-concordant identification, trans-affirming social support, and other gender-affirming experiences in improving the health and well-being of trans people (Baker et al. 2021; Bauer et al. 2015; Bradford, Rider, and Spencer 2019; Glynn et al. 2016; Hughto et al. 2020; Lelutiu-Weinberger, English, and Sandanapitchai 2020; Matsuno and Israel 2018; Scheim, Perez-Brumer, and Bauer 2020). Finally, Budge and colleagues' (Budge et al. 2013; Budge, Chin, and Minero 2017; Budge, Orovecz, and Thai 2015) qualitative research on trans people's emotions and coping strategies highlight how positive emotions and experiences can help trans people cope with dysphoria, distress, and discrimination.

Thus, while existing literature demonstrates that gender affirmation plays an important role in trans people's health and well-being, further research is needed to understand these processes in more detail. One phenomenon that may play an important role is gender euphoria.

GENDER EUPHORIA

The term gender euphoria has been used in trans communities since at least 1976, when it was used to describe people who "[felt] content expressing a dual gender role," in contrast to "transsexuals" who experienced dysphoria and sought medical transition (Kane 1976, 5–6). A decade later, the term appeared in the title of the newsletter of the Boulton and Park Society, a transgender peer support group based in San Antonio, Texas that was active from 1986 to 1999 (Digital Transgender Archive n.d.). The term is also mentioned in Devor's (2004, 63) model of trans identity development, where he explains that as trans people transition into their affirmed gender, "many people find that their feelings of gender dysphoria are supplanted by feelings of gender euphoria." In recent years, the term has become increasingly popular among trans communities to describe positive gender-related feelings, in contrast with gender dysphoria.

Beischel, Gauvin, and van Anders (2021) provide the first research-based effort to define and explain gender euphoria through an online survey in which they recruited 47 participants who were familiar with the term gender euphoria. Most participants identified as trans or nonbinary, but a substantial minority were cisgender. Based on their findings, Beischel, Gauvin, and van Anders (2021, 13) define euphoria as a "joyful feeling of rightness" related to gender. Austin, Papciak, and Lovins' (2022) research using photo elicitation interviews confirmed and extended Beischel, Gauvin, and van Anders' findings. They found that euphoria describes "a constellation of emotional reactions" that can vary greatly in terms of intensity, duration, and specific emotions (Austin, Papciak, and Lovins 2022, 16).

Aside from the articles mentioned above, gender euphoria is mentioned in a handful of academic articles. Ashley and Ells (2018, 24) define gender euphoria as "the positive homologue of gender dysphoria," referring to "a distinct enjoyment or satisfaction caused by the correspondence between the person's gender identity and gendered features associated with a gender other than the one assigned at birth." Bradford, Rider, and Spencer (2019, 6) have proposed that "gender euphoria can be un-

derstood in terms of increased subjective well-being, including greater positive affect and decreased negative affect, in relation to gender transition and gender-affirmative interventions." While broad in scope, both definitions emphasize that euphoria refers to positive gender-related emotions.

While academic literature on the topic is scant, several trans community members have written on the topic in non-academic books, blogs, and other formats. This includes Kane's work in the *Provincetown Symposium*, quoted above. Additionally, Iantaffi and Barker (2017, 128) describe euphoria in their book *How to Understand Your Gender* as "moments of pure joy, when you feel good about your body, how you feel in it, what you're wearing, and how you're perceived by others". In *The A–Z of Gender and Sexuality*, Holleb (2019, 132) defines gender euphoria as "the trans joy of experiencing your gender. Gender euphoria is a sense of joy, exhilaration, and excitement experienced when you feel happy with your gender or gender expression." Hawley (2019, paras. 5–6), author of the blog "Trans Autistic Feminist," describes her experience of euphoria as "a deep feeling of happiness that overcomes me" and as "an affirmation that transitioning was the right thing for me." These three definitions encapsulate a range of experiences that may be understood as gender euphoria, and all revolve around a sense of joy, happiness, and affirmation.

As Iantaffi and Barker's definition suggests, euphoria can be derived from a variety of experiences, including an internal feeling of contentment with one's body or from external social interactions. Beischel, Gauvin, and van Anders (2021) found that their participants described euphoria as arising from both internal and external triggers related to their physical body, social experiences, and/or self-concept and identity. Similarly, Austin, Papciak, and Lovins (2022) highlighted the importance of "gender-affirming antecedents" in preceding feelings of euphoria. These antecedents included medical transition as well as non-medical aspects of gender expression and transition. Notably, the authors found that specific thoughts and self-talk often contributed to experiences of euphoria, highlighting that "it is not simply the gender affirming interventions and experiences, but also meanings ascribed to them by the individuals that leads to feelings of gender euphoria" (Austin, Papciak, and Lovins 2022, 12).

In sum, the literature suggests that gender euphoria is an important aspect of trans identity and experiences for some individuals, but little is understood about the different manifestations euphoria may take, who experiences it, and how it may change over time or in different contexts. This research sought to fill this gap by using in-depth qualitative interviews with trans individuals to understand their experiences of euphoria and contribute to developing a theoretical definition and conceptualization of the term.

METHODS

This research used qualitative interviews and a grounded theory approach to understand how some trans individuals describe, articulate, and label their experiences of gender euphoria. Grounded theory is an inductive approach to research that seeks to make meaning out of the data and then abstract to the level of theory, rather than imposing a pre-existing framework or hypothesis. The research protocol was approved by

the University of Victoria's human research ethics board.

Participant selection was guided by a combination of theoretical and convenience sampling. To be eligible, all participants had to identify as trans; have taken some steps towards transitioning, whatever that meant to them; and be between the ages of 19 and 29. These criteria were chosen for several reasons. As this study focused specifically on defining trans experiences, it would be unethical and counter to the aims of this research to impose the term on individuals who may not identify with the term. However, we understand trans in an expansive and inclusive manner, recognizing that individuals with specific identities of transgender, transsexual, nonbinary, Two-Spirit, genderqueer, agender, and other identities may identify as trans. Given the varied and contested meanings of trans, we chose to allow participants to interpret the term themselves when deciding to participate.

The existing literature suggests that people tend to experience gender euphoria more after beginning to transition than before (see Austin, Papciak, and Lovins 2022; Beischel, Gauvin, and Anders 2021; Bradford, Rider, and Spencer 2019; Glynn et al. 2016), and as such, it is useful for participants to have had experiences that are likely to result in gender euphoria, rather than anticipating transition while being unable to access it. We understand transition as a non-linear journey that may include—but is not limited to—changes in gender expression, name and pronoun usage, gender roles, and gender-affirming medical interventions. Participants were accepted into the study based on their own assertion that they had taken some steps towards transition—whatever that meant for them.

Finally, the third criterion related to age was chosen for convenience. Given that the primary researcher is a trans and nonbinary person in their early 20s and many of their trans networks are in a similar age range, they are best positioned as a peer to other young trans individuals. As trans communities have historically been researched by cisgender individuals who do not share the participants' experiences of gender, the researcher's insider positionality in terms of trans identity and age was important to building trust and rapport with participants and collecting rich data. The age criteria for participants was therefore established as 19–29, with the lower limit chosen to reflect the age of majority where the research was conducted.

In addition, race and gender identity were expected to be salient characteristics, and as such we sought to reflect the diversity of identities and individuals within the trans community to the extent possible given the small sample size. Therefore, we planned to interview a minimum of one transmasculine-identified individual, one transfeminine-identified individual, and one person of colour. Due to time limitations and capacity constraints for this exploratory study, the maximum number of participants was set at six individuals before recruitment began. To be considered as a potential participant, individuals were asked to provide their name, age, the words they use to describe their gender, and whether they identified as BIPOC/a person of colour/a racialized person. This information was used to determine eligibility. As more than 30 individuals responded to the call for participants, participants were selected largely according to the order in which emails were received, with some flexibility to ensure sampling quotas related to gender and race were reached. Specifically, a few white potential participants were placed on a waitlist to prioritize racialized participants. Overall, interviews with six individuals were scheduled, but the sixth participant did

Table 1. Participant Information

Pseudonym	Age	Gender Identity	Racial Identity	Pronouns
Higgs	27	genderfluid, woman, nonbinary	white	she/her, they/them
Jake	25	nonbinary trans man	biracial, mixed	he/him
Pike	23	butch and trans	white	they/them
Curtis	21	trans man	white	he/him
Loaf	26	nonbinary	biracial	they/them

not show up, resulting in a final sample of five individuals. Demographic information of the final sample of five participants along with the pseudonym chosen by each participant is found in Table 1.

All recruitment was conducted online through LGBTQI+ Facebook groups based in British Columbia (BC), Canada. While living in BC was not a requirement, all participants lived in BC at the time of their interview. The study was advertised as a "Gender Euphoria Research Study" and described as "a trans-led research project on trans people's experiences of euphoria, joy, happiness and affirmation related to their gender." Data collection took the form of semi-structured qualitative interviews conducted and recorded over Zoom in January 2020. Interviews ranged in length from 40 to 60 minutes. The first author conducted all interviews, and established rapport and trust with participants before recording began by describing the research project and its goals; sharing relevant aspects of their identity as a young, white, neurodivergent, trans, nonbinary, and queer person; and reviewing the informed consent document that had previously been shared with the participant. After the participant confirmed their consent, the first author followed a semi-structured interview guide which began by asking participants to recall times they had experienced happiness, joy, affirmation, pleasure, contentment, or euphoria in relation to their gender. The interviewer probed for details about what prompted the emotions, what they felt like, and other details about the experience. Participants were also asked broader questions about the language they used to describe these feelings, whether and how these experiences were important to their identity and transition journey, how they felt euphoria related to dysphoria, and what they would like other people to know about their experiences with euphoria.

Guided by a grounded theory approach (Charmaz 2006), the first author conducted inductive emergent coding of the interview transcripts using NVIVO 12. Using the codes generated by this process, they collapsed and clarified categories to create a preliminary codebook. This codebook was then used for repeated rounds of coding until all interviews had been coded multiple times using a consistent codebook. Based on this codebook, the first author then created a list of key themes and collected key quotes and insights related to each theme, which formed the basis of the findings section. When a first draft of the manuscript was complete, the first author provided a copy of the manuscript to all participants for their feedback and to confirm quotes

used. Four of the five participants responded, all with positive feedback, and one with a minor correction. The second author provided feedback and input throughout all stages of the research process.

At the time of research design and data collection, there were no published studies on gender euphoria. As such, this research was designed as a small, exploratory pilot study. The results provide a case study in the experiences of gender euphoria for five young, mostly white, trans people in BC, Canada, and do not represent all experiences of gender euphoria. Rather, the study results provide a preliminary description of gender euphoria and indicate some directions for future research.

FINDINGS

Defining euphoria

Participants defined euphoria in a variety of terms. Pike defined it as simply "acceptance" and Loaf described it as "confidence [and] self-happiness about your body." Higgs described euphoria as "a wonderful explosion," while Jake explained it as a "feeling of joy that radiates throughout my entire body, that either confirms how I might be feeling or validates who I am." Finally, Curtis defined euphoria as "positivity … [that] makes the brain stop in the best way possible." Given this range of experiences, emotions, and sensations held by participants under the umbrella of gender euphoria, we confirm previous definitions of euphoria as positive emotions resulting from affirmation of one's gender identity or expression.

Intensity and frequency

Participants described euphoria as a complex, multi-faceted emotion that could take many different forms. In particular, they all distinguished between two types of euphoria: firstly, an ecstatic joy which at times felt explosive or overwhelming, and often occurred at milestones in their gender journey, and secondly, a quiet sense of calmness and relief that tended to occur once participants were being gendered correctly more frequently. This first feeling was described as energy, "joy," "a surge of happiness," and "confidence" that at times felt "powerful," "explosive," or "overwhelming." Participants likened the feeling to that of fizziness, a "spark," or "fireworks," and often identified the emotion as beginning in their chest and spreading to other parts of their body. In contrast, the second feeling was a quieter, less noticeable feeling that felt like "relief," calmness, peace, "soundness," wholeness, "resonance," "acceptance," and authenticity. Jake, Curtis, Higgs, and Pike, who had all been transitioning for at least five years, noted that the explosive joy moments were more common early on in their transition, while the quieter feelings were more common after they had been out for several years. Experiences that might have brought them euphoria earlier on, such as being gendered correctly, were now much more commonplace and did not elicit the same intensity of emotions. Jake, who had been medically transitioning for 6 years and socially transitioning for longer, explained:

> I think in the beginning there would have been a lot of new moments—or even before coming out, exploring my gender, all of that would have been new, so then I probably would have experienced euphoria a lot more frequently. And now it's a little bit more calm and peaceful.

Two participants, Curtis and Jake, referred to this second, quieter type of euphoria as *affirmation*, and reserved the term *euphoria* for more explosive and significant moments of joy. Another participant, Higgs, associated affirmation with clinical settings and language, as in "gender-affirmation surgery," and preferred to use euphoria to refer to both types of feelings. While participants varied in their use of terminology, all five distinguished between these two types of euphoria based on their intensity and frequency.

Prompting events

Participants described euphoria as arising from many different prompting events and experiences. Those who had embarked on medical transition by way of hormone replacement therapy or gender-affirming surgeries—Higgs, Curtis, Jake, and Pike—described the resulting physical and emotional changes as euphoric. The physical changes brought their gender expression and others' perceptions of their gender more in line with their internal gender identity, resulting in euphoria. Even before any visible changes had occurred, however, participants identified the knowledge that changes would soon occur as empowering. Curtis explained: "Just being able to say that I'm on T [testosterone] made me feel like I'm in progress. It's like a little loading bar and it's finally moving." Both Curtis and Jake described the day of their first testosterone injection as ecstatic and energetic, sometimes to the point of being overwhelming. This explosion of energy and emotion was the ultimate peak of euphoria for them. For Higgs, the increased range and intensity of emotions that taking estrogen brought about was euphoric. They explained it affirmed their sense of themselves as a woman and "an estrogen-powered individual": "It feels like my brain is working how it's always supposed to be working, or how I've always wanted to be." These internal changes affirmed her gender identity, even when they weren't visible to others.

All participants also identified non-medical practices that resulted in physical changes to their appearance as affirming and euphoric, such as exercising, buying new clothing, and wearing a binder to flatten their chest. Pike and Higgs particularly enjoyed the self-determination in choosing how to express their gender and modify their body. For example, Higgs explained why she liked working out: "Especially pre-HRT … working out was a way I could modify my body in ways that are more traditionally feminine and stuff like that, and it was a way of gaining control." Higgs identified both the physical changes resulting from working out and the practice of exercising itself as euphoric, as they expressed their gender in ways that reflected and affirmed their internal sense of themselves. Similarly, Pike remembered the sense of freedom and euphoria they felt when they tried on a binder for the first time:

> I remember just going in the mirror and just staring for a second, and turning to the side and just seeing that flatness and just being like, I can do whatever I want! Gender is fake! The world is my oyster! I can do what I want! [laughing]

Both Higgs and Pike identified feeling empowered to express their gender in the ways that they wanted as euphoric.

In addition to the experience of internal empowerment, Curtis and Pike reported that they were gendered correctly more of the time once they began transitioning, which resulted in more moments of gender euphoria. Curtis explained: "once I got

facial hair, nobody misgendered me, like it was just this immediate camouflage mask of like alright, you're a dude, fine, we can't fight you on it anymore." Loaf contrasted the dysphoria of being misgendered with the affirmation of being gendered correctly: "when someone uses she/her, it just [shudders], it feels like sandpaper against the skin, it feels like a whip against the back. But when someone uses they/them, it just feels right." All participants identified being gendered correctly by others as affirming and/or euphoric, whether through the use of pronouns, compliments, honorifics and titles, or their chosen name.

For participants who identified as nonbinary or genderfluid, expressing the contradictions and instabilities within their gender sometimes elicited euphoria. Pike described their most significant moment of euphoria that occurred at a pride parade, where they were wearing a lacy bra and feminine shorts alongside a full beard and thick body hair: "It was very affirming for me and it was very much like, I can be in this strange in-between space and still feel safe with myself." Similarly, Higgs enjoyed combining different gender norms and expressions, such as their long hair and acrylic nails with their deep voice. She described this as "thumbing your nose at gender," explaining that having the freedom to express her gender outside of the binary was key to developing the sense of authenticity and self-determination that led to euphoria.

Four participants also identified sexuality as a site of gender euphoria for them. Exploring and expressing their gender identity paralleled an increasing sense of freedom from heteronormative sexual scripts. Higgs explained:

> So I think what's also great about queer sex is the lack of script. You can make up anything and it's wholly focused on pleasure and communication … and being like "I like this, I do not like this. Call me this, do not call me this. I have these parts that I like to use in these ways, and other parts I like to pretend do not exist at all."

Higgs expressed her gender by re-defining what sex looked like for her and by choosing the words she used to describe her genitalia and body parts. She noted that she experienced this affirmation and euphoria when dating both cis and trans women, but that it came more naturally when with other trans people. She explained that she would sometimes feel burdened by the need to explain her body and gender in detail to cis women who lacked a shared experience, whereas with other trans people, there was "such a degree of understanding and acceptance and patience." Similarly, Jake found hooking up with other trans people euphoric, as he was able see parts of himself in the trans men he dated and experienced increased acceptance and love for both their bodies and his own. He described one particular moment:

> I remember after top surgery, my scars were really prominent, and I was feeling really unsure about the way that my nipples looked as well. And then I hooked up with this trans guy, and just seeing his scars and seeing the way he looked, I was like, "Oh, I don't have to feel bad about my body because I know that they [the scars] look as beautiful as his do."

By finding other trans men's bodies attractive, Jake was able to learn to find himself attractive as well.

Higgs found that dating trans people with different bodies and genders also elicited euphoria, as they could play with gender roles and expectations in a way that was mutually affirming and satisfying. She described using roleplay and sex toys to play

with gendered sexual scripts and giving gendered compliments like "my big strong man" and "you're so small and feminine" to affirm her partner's gender, even when the compliments defied the reality of their bodies. Loaf found similar euphoria in their relationship with a cis man, explaining that their partner supported them in "finding a new way to enjoy [their] body" during sex such as by "using … a clitoris stroker instead of using an insertable toy."

Curtis, Pike, Loaf and Higgs also described finding gender euphoria through the internet and media representations, such as by choosing their character's gender in video games or seeing trans characters in books and television shows. For example, Higgs found euphoria in playing the character Samus in Super Smash Bros., an extremely muscular and tall woman: "She's badass, she's strong, her moves fucking hit like a tank, she's awesome. She's what I want to be." As video games had been a place where Higgs dissociated from her reality before she transitioned, by playing as woman and seeing her gender represented in the fantasy world into which she escaped, Higgs was able to bridge the divide between her real life and physical body and the video games she used as an escape.

Curtis and Pike described interacting anonymously on the internet while growing up as an early way to explore their gender identities and experience euphoria. Curtis explained: "I could just identify as male, and nobody questioned it, nobody asked. I didn't have a chest, I didn't have a voice, I was just a person behind a screen. And I could just be Curtis." Pike explained that they found acceptance in the furry community online, a subculture where individuals represent themselves as anthropomorphic animal characters, often associated with the queer community and sometimes including sexual imagery. They explained:

> Your fursona could look like whatever you wanted … And so it was this really good sense of freedom and having that ability to completely be like, do I feel comfortable like this? Is this aesthetically pleasing for me? Is this the kind of validation that I want? That was very euphoric for me and very validating for me.

By interacting behind the safety of a screen, Curtis and Pike were able to express their gender at times when they couldn't do so in their offline lives.

Loaf found that seeing other trans characters in the media who used they/them pronouns affirmed their gender, helping them feel "that I'm not weird, that I'm not a freak." Pike also identified media representations of other trans people as key to their euphoria. In particular, they resonated with the character Jess from *Stone Butch Blues* by Leslie Feinberg (1993). Pike explained:

> It was this literal written document of, here you are, of this is everything you've ever lived in this book that was written by someone thousands of miles away feeling the same things that you are. And it was just huge for me.

Whether through using video games and fursonas to express and explore their gender or by seeing themselves represented in another trans character, Higgs, Pike, Loaf, and Curtis all identified the internet and media representations as sites of euphoria, particularly when they couldn't experience euphoria in offline settings.

Curtis, Higgs, and Pike described their euphoria as reliant on experiencing affirmations from other people and being recognized as their true gender. For example,

Higgs found euphoria in being treated as just another girl when hanging out with other women: "women accepting me and talking to me like they talk to other women … stuff they wouldn't normally or typically tell their guy friends." Similarly, Pike found validation in being treated by cisgender men as a fellow man, especially after they disclosed their trans identity. They described one moment after coming out to a co-worker as trans:

> He was able to give me—like as a cis guy—that same level of acceptance I felt going to my trans spaces. And that acceptance… it was euphoric in a way of just like, number one, there's still good dudes out there that I can trust. Number two, guys like that see me as part of their circle too.

Pike had grown up in a rural area with few role models of positive masculinity, and so claiming their own masculinity and membership as a man through interactions with other men was an important and euphoric experience for them.

Changes in euphoria and dysphoria over time

In general, participants described their euphoria as increasing over time, as they were able to transition, access gender-affirming medical care, and express their gender in the ways that they wanted. They were affirmed in their gender by others more of the time, and therefore experienced more euphoria. But as the frequency of these euphoric experiences increased, the accompanying emotions also changed. Jake explained that in the early stages of his transition, he was experiencing many moments for the first time accompanied by intense euphoria. Now that he had been out as trans for five years, he experienced more feelings of calmness and peace—what he called affirmation—and less excitement and euphoria. When asked to describe times they had experienced euphoria, all five participants mentioned important "firsts" in their transitions, such as their first day on hormones, first time going out shirtless after top surgery, or first time introducing themselves with their chosen name and pronouns. As these experiences became more frequent and a regular part of their lives, Curtis, Higgs, Jake, and Pike explained that affirming moments become more commonplace and less exciting. This allowed them to experience an increased sense of safety, comfort, and security in their daily lives, which participants described as being foundational to their mental health and well-being. For example, Curtis noted that his mood was more stable and less affected by others' perceptions of him as he progressed in his transition. Higgs also found that as they felt more confident and secure in their gender, they didn't feel the need to put as much work into "performing the rituals of femininity" in order to be gendered correctly and were able to choose to present more androgynously or masculinely without threatening their emotional or physical safety. But these changes in the intensity and arousal level of gender-related emotions also came with drawbacks—what Pike called "the gentle curse of having it become normal." Curtis, Higgs, and Jake expressed similar sentiments, explaining that as they now took affirming experiences like being gendered correctly for granted, they had to actively seek out new experiences to feel intense euphoria again.

Curtis, Loaf, and Pike defined euphoria by relating it to dysphoria. For example, Curtis defined euphoria as the opposite of dysphoria, and added that most of the time for him, his euphoria was simply the lack of dysphoria. Loaf agreed that euphoria and dysphoria were opposites, but added that both could be experienced simultaneously,

explaining that "gender euphoria and dysphoria is kind of like a binary, like a 1 or a 0 and then there's values in between." Pike also conceptualized euphoria and dysphoria as two distinct but related phenomena that could be experienced at the same time:

> I see life as this subject of graphs. So you can have a lot of dysphoria and euphoria at the same time, depending on your environmental outputs and inputs for yourself.

Pike illustrated this by explaining that while they had a close circle of queer friends that affirmed their gender and brought them euphoria, they also experienced isolation, ostracization, and dysphoria in their workplace. Pike's experience demonstrates that while levels of euphoria and dysphoria may change over time, it is important not to assume this means a linear progression away from dysphoria and towards euphoria.

The importance of euphoria

While dysphoria is typically seen as the defining feature of trans experiences, three participants identified euphoria as more important than dysphoria to their gender journeys. While dysphoria was distressing and confusing, euphoria elicited clarity and understanding. Loaf succinctly summed it up: "Dysphoria really doesn't help; it just causes confusion and anguish. Euphoria guides and points to where you want to go on your journey." Jake concurred and elaborated, noting that:

> I know that trans identity is so defined by this feeling of dysphoria, but you know, I don't think we would put ourselves through so much difficulty to come out and to change the way we look and change the way we interact with other people if there wasn't something pleasurable about that.

Higgs expressed a similar sentiment, noting that:

> Euphoria tends to be the rule instead of the exception. Like the exception is the bad hard things that are part of transness, and most of the time, 99% of the time, I am so elated and happy to be trans and nonbinary. And I think that's the rule for most trans people I talk to, at any stage. Like the early stages are pretty rough because self-discovery is rough, but there's always this undercurrent of joy and love and self-love and love of others that is fundamental to what being trans is for me and for a lot of people that I talk to. And I don't think people get that.

Both Higgs and Jake were careful not to minimize the negative impact that dysphoria can have on trans people's mental health and well-being. However, Higgs, Jake, and Loaf felt that it was more important to recognize euphoria, as this challenged normative ideas of transness and better reflected their own experiences.

Euphoria and mental health

Each participant described their experiences of euphoria and dysphoria as inextricably linked to their general mental health and well-being. Lessening dysphoria tended to improve the rest of their mental health, just as taking care of their mental health helped lessen their dysphoria, but their mental health also impacted their ability to experience euphoria in the first place. For example, Pike explained that when they were depressed, they tended to isolate themselves, spending less time with supportive individuals who might affirm their gender, and therefore experienced euphoria less often.

They also struggled with social anxiety and noted that this was compounded by hypervigilance of other people's perceptions of their gender and feeling that their gender was a burden or disappointment for other people. They explained:

> I have a feeling that's why I withdraw from people a lot, is because there's no mask to put on [when alone]. That's where my euphoria is, and then being in social situations … is really stressful for me.

Pike would cope with this anxiety by retreating from other people and spending time alone, but this had the negative effect of limiting their opportunities to experience social affirmation and therefore euphoria.

Curtis also struggled with depression and explained that he found it difficult to take care of himself before he started testosterone due to the overwhelming dysphoria he was experiencing:

> If I feel like garbage and I feel like my body is going the other way or I'm just not loving myself, my brain—and it's definitely not intentional—but my brain almost punishes my body. I shower less, I eat worse, I don't get out.

But as his body changed and he experienced less physical dysphoria, Curtis was able to show himself more kindness and care, practices that helped elicit euphoria.

Loaf explained that the intensity and frequency of moments of euphoria also depended on their mental health at that time: "If my mental health is good, it lasts longer. It can last the entire day. But if my mental health is not good, it could be very fleeting, or I could even possibly interpret it as patronizing." Participants' other experiences with mental illness and neurodivergence informed their perceptions of euphoria and dysphoria. For example, Higgs and Jake identified as substance users and used the intoxicating and energetic effects of some drugs as an analogy for euphoria. Higgs explained

> It's like the chasing the dragon kind of high, where at the beginning, you just need a tiny little hit of weed, and you're high … and now painting my nails is such a base thing where I feel weird without it.

Here, Higgs compares the idea of tolerance to a drug's effects to a baseline level of euphoria, where small acts like painting her nails that once brought her intense euphoria were now part of her every day and less significant. For both Higgs and Jake, their experiences with substance use affected the way they framed and talked about their experiences of euphoria.

Curtis, who is on the autism spectrum, explained that his autism affected how he expressed and reacted to moments of euphoria. He described the day he started testosterone: "Oh, I was ticcing … the hands just, you know, started going, shaking [gestures flapping hands]. My back teeth are grinding in the best way possible. I'm ready to lift off the ground." His neurodivergence interacted with his experiences of euphoria such that he expressed his feelings with full-body movements, described as stimming or ticcing within the autistic community.

Loaf, who had experienced past relationship abuse and grooming, found that their journey to accepting their gender paralleled their process of healing from abuse. The first few times they experienced gender euphoria, they found themselves trying to suppress their feelings, as they had become used to prioritizing other's needs and wants above their own. But they explained that "The more that I got away from my

abusive ex-partner, the more I became comfortable with it [gender euphoria] … so in the process of cutting off this person, I became more and more accepting of my actual identity." As they distanced themselves from their abuser and healed from their trauma, Loaf was able to experience euphoria and self-acceptance more frequently.

Jake, who had experienced body dysmorphia and disordered eating since the age of 13, explained that his body dysmorphia lessened along with his dysphoria: "It's definitely gotten easier to manage now that I'm happier with more aspects of my body and the way that I'm perceived in the world." But transitioning did not completely solve his dysmorphia, as he noted that

> after top surgery, my stomach has, you know, when I look down, I can see it more prominently, and when I wear clothing that's what the bump is instead of my chest. So I still struggle with some fatphobia and I think dysmorphia is there as well.

Every participant also identified euphoria as a resource and coping strategy they could draw upon to help get through dysphoric and difficult periods. For example, Loaf explained that wearing a binder to flatten their chest lessened their dysphoria and improved their mood. Curtis described testosterone as his "magic juice," explaining that "I could handle anything as soon as I was on T. Someone could misgender me, because then my mind goes, 'not for long.'" Similarly, Higgs described drawing on her own internal resilience and sense of self-determination to cope with being misgendered and other microaggressions. These experiences suggest that experiencing euphoria can improve an individual's self-esteem, self-acceptance, and confidence in their gender, along with fostering resilience and providing a resource to draw on to cope with the inevitable moments of dysphoria and transphobia. Participant's description of the relationship between euphoria, dysphoria, and other aspects of their mental health demonstrates that gender-related emotions can be embedded in the individual's larger psychosocial contexts and affected by other aspects of their life and well-being.

Importance of trans community

Each of the five participants identified spending time with other trans people and in LGBTQI+ community spaces as a key aspect of what brought them euphoria. When with other trans people, participants didn't have to explain themselves as much, and experienced the euphoria of connection and recognition of oneself in others. Jake explained: "Finally talking to people who saw me the way that I wanted to be seen and validated, that feels good." When so much of participant's lives were spent around people who did not affirm their gender, spending time around people who not only affirmed but could relate to their experiences was euphoric. For example, Jake recalled getting his first binder with the help of a trans youth worker:

> I remember chatting with the guy, who was another trans guy. He was helping me find the right one, and just being seen and validated and like someone who saw me and wanted to help me get to the place where I wanted to be. Being cared for in that way made me really happy.

Similarly, Pike identified meeting someone who shared their gender identity for the first time as a deeply euphoric experience:

> Hearing from somebody who has the same gender identity as you, and you have the same sexuality kind of idea, it was like two leaves in the

> wind of the same very rare tree just happening to meet for a moment, and then going off in two different directions. And me and this person, I know we're going to be friends. We're going to keep in touch for a very long time, which I'm really grateful for. And it was this very validating experience of just not being alone.

Pike had struggled to find community around their butch identity, and so finding someone who shared their gender identity was very validating and affirming and created a connection that they identified as immediately bonding and emotionally intimate.

A few participants also noted that supporting and standing up for other trans people in their lives also validated themselves. Curtis explained: "Validating other people also kind of validates myself. It's like a two-way street. So being able to fight for them, makes me feel like I'm fighting for me." Similarly, Loaf explained that they supported their trans friends by validating their emotions and helping them identify what brought them euphoria. They found that doing so helped them experience euphoria themselves:

> I get gender euphoria helping other people out with their impostor syndrome and gender dysphoria. Because, it's funny, you can tell other trans and nonbinary people that what they're feeling is valid, and mean it, and say that their gender is valid, but when it comes to you, God forbid!

Even when Loaf was having a hard time showing kindness and compassion to themselves, by extending care to others they were able to begin to allow themselves to also accept that care and love.

Impact of transnormativity and medicalization

While the interviews focused on positive emotions and experiences, every participant also brought up the impact of transphobic and transnormative narratives on their experiences of euphoria. For example, several participants identified as harmful the idea that a person must experience dysphoria to be trans. Loaf explained:

> There's a lot of internalized hatred and certain standards that you should meet if you're going to be considered nonbinary or trans. And even within the trans community, there's a lot of nonbinary hatred, because "You can only be one or the other! If you don't fit in, you're making the rest community look bad!" kind of thing.

Loaf and other participants found that these ideas contributed to self-doubt and had a negative impact on their mental health and self-esteem, including limiting their ability to experience euphoria. In particular, Loaf and Curtis discussed their experiences with impostor syndrome and questioning whether they were really trans. Loaf expressed that impostor syndrome presented itself in the form of an internal voice that questioned their identity and decision-making, hindering their efforts to seek out affirming and euphoric experiences. Similarly, Curtis felt that these normative expectations had limited his ability to experience euphoria, making it reliant on medical transition and passing as a cis man:

> So now as I've transitioned—and for me, it was mental health that has me put all of these high expectations on myself. And these like rigid bi-

> naries of when I'm allowed to feel euphoria. It's like I need to pass all these tests to like open a little box of happiness and if I don't, I don't get the box.

This demonstrates that even some binary-identifying trans people whose experiences largely resemble the "born in the wrong body" narrative may feel a negative impact of transnormativity on their euphoria.

All participants identified these harmful normative expectations as originating from both within and outside of the trans community. Curtis explained that many trans people internalize transphobic and cisnormative messages and reproduce them within the trans community— "we make it into self-expectation as well, because we're socialized in a very rigid world." He elaborated that "I think sometimes we get so caught up in our oppression Olympics and our trauma Olympics of who suffered more, who is more trans … that we don't even want to talk about the good stuff." Higgs, Jake, Loaf, and Pike also emphasized the role of medical gatekeeping and media stereotypes in creating and perpetuating harmful narratives about transness. Higgs identified the medical gatekeeping required to access gender-affirming care as perpetuating a deficit- and distress-based model of transness: "Medical model is something bad with you, therefore we'll fix it. Not something is missing in you and we're gonna help you fulfill that through an act of joy and love." They also highlighted the impact of media representations, noting that

> I have never seen a trans movie that is happy. Like not even just a little bit of happy. It's all supposed to be this terrible thing that destroys us, and I think that helps fit in the cis narrative of, "Well you're doing what they consider 'extreme measures' so there has to be extreme motivation for stuff like that." And the trope of the self-hating trans person is so persuasive and I think fundamentally wrong, because we don't do these things through an act of self-hate. Like, I didn't become a woman because I hated men and masculinity.

The media's emphasis on dysphoria, distress, and self-hatred did not reflect Higgs or her peers' experiences of being trans, and instead served to reinforce cis people's ideas of what it means to be trans. Specifically, Higgs identified that to justify medical transition—seen as "extreme" in the normative cisgender gaze—trans people needed to prove that they were experiencing "extreme" distress. But Higgs argued that this falsely associated transness with overwhelmingly negative experiences, ignoring the many joys and positive emotions she and other trans people experienced. Jake agreed, explaining that: "Being trans is a really pleasurable thing and a really enjoyable thing and that we wouldn't transition, we wouldn't come out if it wasn't pleasurable. And there is value in seeking that pleasure and expressing that pleasure." Jake felt that the overwhelming emphasis on trans people's high rates of mental illness and suicidality falsely blamed these experiences on being trans, rather than living in a transphobic society. All participants wanted the general public to better understand the possibilities of gender euphoria and other positive trans experiences, challenging the notion that being trans is an inherently negative experience.

This is not to say that participants did not experience dysphoria, mental illness, and other distressing and negative experiences. All participants experienced dysphoria to some degree, had struggled with mental illnesses, and described experiences of

transphobia, rejection, and discrimination. But these were not the only, or even the most important, aspects of their trans identities or experiences. Curtis, the participant who emphasized his dysphoria the most, felt that dysphoria was more important than euphoria in defining his trans experience. He explained that dysphoria

> is a killer, you know, it kills people constantly. Maybe not physically, but it kills the soul. And I would much rather have them [cis people] understand why I need this and have the euphoria come from me than from them.

Here, Curtis recognizes the utility of the medical model's focus on dysphoria rather than euphoria, as dysphoria has the potential for significant harm and negative impacts that are important to attend to and can be alleviated through transition. However, Curtis also notes the limits of this model, noting that it is important to include stories of trans happiness and joy, and to highlight gender euphoria as a positive experience that he feels is unique to trans people.

Higgs and Jake explicitly identified the need for changes in gender-affirming medical practice to a model that better reflected their experiences and created space to discuss gender euphoria, not just dysphoria. Comparing it to the shift to strengths-based research in other areas of social science research, Higgs felt that medical care could improve by focusing more on resiliency and positive experiences—such as gender euphoria—as part of patient-centered care. Jake identified the informed consent model of accessing gender-affirming care as one possible way of changing medical models to incorporate gender euphoria. He elaborated:

> I think in the interviews [for a readiness assessment], rather than asking what I didn't like, if they were like, "What do you want and how can we help you achieve that through these medical interventions?", that would probably be a much more positive experience.

Both Jake and Higgs emphasized the importance of asking questions specifically about what patients wanted as outcomes of their transition and what made them feel good, which could create space for patients to talk about their experiences with gender euphoria. During his interview, Jake wondered aloud:

> I wonder how—because I know the medicalization of trans identity has been incredibly harmful and is a part of this colonial system that we live in—I wonder, though, how these narratives can change while still ensuring that we have access [to gender-affirming care].

Jake touches on an enduring dilemma of trans studies and gender-affirming health care: the need to meet trans people's immediate needs within a neoliberal capitalist system while also working to radically change that system. The process of finding that balance is complex and ongoing, but incorporating the language of gender euphoria into hormone and surgical readiness assessment offers one promising practice.

DISCUSSION

This research sought to understand how trans people describe experiences of positive emotions in relation to their gender, and to contribute to a definition and conceptualization of gender euphoria. We found that gender euphoria refers to positive emotions resulting from affirmation of one's gender identity or expression and can include a

wide variety of emotions and experiences. Experiences that may elicit euphoria include medical and social transition, social affirmation of one's gender, engaging in community care and solidarity with other trans people, and viewing media with positive trans representation. In line with the findings of Beischel, Gauvin, and van Anders (2021), participants described varying relationships between euphoria and dysphoria, but generally agreed that euphoria described positive emotions and dysphoria referenced negative emotions. Our participants emphasized the importance of euphoria and positive emotions in their experience of being trans and lamented the medical model and transnormative narratives' focus on distress and dysphoria.

Participants also highlighted the interconnected nature of euphoria, dysphoria, and mental health. These findings are consistent with the gender minority stress model, which argues that the impact of transphobia-related stressors is mediated by resilience factors, including community connectedness and pride (Testa et al. 2015). Our findings suggest that gender affirmation and euphoria may serve as additional resilience factors that moderate the impact of distal and proximal stressors on individuals' well-being and thereby may reduce dysphoria. Participants described drawing on moments of affirmation and euphoria as a resource to help them cope with dysphoria and distress. Further, participants explained that their euphoria was impacted by other stressors and mediating factors. For example, it was easier to experience euphoria when other resilience factors (community connectedness and pride) were high, and more difficult when experiencing high levels of hypervigilance in social situations (a proximal stressor) and misgendering (a distal stressor). This suggests that euphoria may moderate the impact of minority stressors on trans people's mental health, a hypothesis that is consistent with previous findings that social and medical transition and gender affirmation are associated with better mental health in trans populations (Glynn et al. 2016; Hughto et al. 2020; Lelutiu-Weinberger, English, and Sandanapitchai 2020).

Additionally, participants in this research described receiving microaffirmations from loved ones—such as providing emotional support and using gender-affirming language—as eliciting euphoria. Previous research on the various kinds of microaffirmations experienced by trans people in romantic relationships parallels our participants' descriptions of microaffirmations (Galupo et al. 2019; Pulice-Farrow, Bravo, and Galupo 2019). This provides evidence of the potential role of microaffirmations as a resilience factor in the minority stress model.

This research also demonstrates some of the limitations of the medical model of trans identity and some of the inaccuracies and harms that can come from deficit- and distress-based narratives of trans experiences. Participants repeatedly emphasized the harmful impact of hegemonic narratives of trans identities that focused on dysphoria and other negative emotions and experiences. This supports Johnson's (2016) finding that transnormativity functions as a hegemonic narrative that is enforced through external accountability to medical and sociolegal institutions, as well as internalized and reinforced within trans communities. Our participants argued that the medical model needs to shift focus from pain and dysphoria towards promoting joy and euphoria. They identified multiple means of enacting this change, from informed consent models of care to asking about gender euphoria in hormone and surgical readiness assessments. In fact, many were already implementing these practices within their everyday

lives and communities. Loaf, for example, validated and empathized with their trans friends' emotions, and encouraged them to identify and seek out things that made them feel euphoric. Curtis was working on sharing more stories of positivity and hope within the trans community to counteract the emphasis on struggles and dysphoria. These examples highlight the importance of community connectedness and peer support and illuminate just some of the ways that trans people, and those who work with them, can help foster more joy and euphoria in trans lives.

Mental health professionals and peer support workers who work with trans clients can learn from these practices of care to help trans individuals experience more euphoria. Limited existing research provides examples of ways mental health professionals can support resilience and decrease distress for trans people. For example, Matsuno and Israel's (2018) transgender resilience intervention suggests that the impact of minority stressors on trans individuals can be reduced by developing resilience. This can be accomplished through group-level factors, such as social support, family acceptance, participating in trans communities and activism, and identifying positive role models, as well as individual factors, such as self-acceptance and hope. Matsuno and Israel suggest that therapists can support trans resilience by developing interventions that seek to increase these resilience factors in the lives of their clients.

Sloan, Berke, and Shipherd (2017) outline one such intervention that uses dialectical behavior therapy (DBT) skills to help trans individuals cope with dysphoria and distress. DBT posits that emotional dysregulation is the result of living in an emotionally invalidating environment. DBT then seeks to help clients develop coping and self-validation skills to reduce their emotional dysregulation. Applied to trans individuals, Sloan, Berke, and Shipherd argue that many trans people live in a constantly invalidating environment in which they may experience misgendering and microaggressions on regular basis, resulting in distress and dysphoria, as well as potentially maladaptive coping strategies. The authors outline how DBT skills can be used to cope with this dysphoria and distress and develop more adaptive coping tools. For example, using distress tolerance skills to manage dysphoria, seeking out affirming environments and experiences that reduce dysphoria using interpersonal effectiveness skills, and balancing the desire for future gender-related changes with acceptance of one's current reality using mindfulness and radical acceptance. Many of the strategies outlined by Sloan, Berke, and Shipherd could assist trans individuals in identifying what brings them euphoria and subsequently seeking it out.

Similarly, Austin, Papciak, and Lovins (2022) argue that given the importance participant's thoughts and emotions to their experiences of euphoria, therapy may be useful in helping decrease negative self-talk and thoughts about dysphoria and enhance experiences of euphoria. Finally, Withey-Rila et al. (2020) argue that social workers should prioritize pleasure in their assessments and interventions of trans people's sexualities and lives generally. Withey-Rila et al.'s call to prioritize pleasure in sexuality can be extended to prioritizing pleasure in life generally; to make transition not just about reducing dysphoria but about increasing euphoria and pursuing joy and comfort.

CONCLUSION

This research sought to understand how trans people describe experiences of positive emotions in related to their gender, and specifically, to contribute to a definition and conceptualization of gender euphoria. We found that gender euphoria refers to positive emotions resulting from affirmation of one's gender identity or expression and can include a wide variety of emotions and experiences. Our findings suggest that there may be different subtypes of gender euphoria based on the intensity and frequency of the emotions, and further research is needed to determine the best way to differentiate between these experiences.

We have also argued that gender affirmation and euphoria represent resilience factors that are consistent with the gender minority stress model. Specifically, euphoria may moderate the impact of proximal and distal stressors, such as transphobia and dysphoria, on trans people's mental health. Future research is needed to evaluate this proposal, including quantitative research to validate the concept of gender euphoria and its relationship to other concepts in the gender minority stress model. The Trans Youth CAN! Gender Positivity Scale is one validated measure that can be used to measure gender euphoria (Bauer et al. 2021)

Our findings underscore the potential for harms that can be created by the medical model's focus on dysphoria and distress in trans experiences. Instead, we emphasize the value of prioritizing supporting euphoria, happiness, and safety when asking about trans people's transition goals.

Finally, it is important to note the limitations of this research. These findings are based on a small sample of five individuals, who were relatively homogenous in terms of age, race, and geography. While we expected that race would be a salient characteristic that would impact participants' experiences of euphoria, race did not come up in any of the interviews. The interviewer positioned themselves as white at the start of interviews and did not specifically ask any participants about how their race interacted with their experience of gender. Further, as the interviewer positioned themselves as an insider to participants in terms of being a young trans person, participants may have been more likely to share experiences that they thought the interviewer would relate to, and less likely to discuss experiences for which the interviewer would have been an outsider, such as racialized experiences.

All five participants in this research had access to supportive trans communities, gender-affirming medical care, and a general level of social and economic privilege that allowed them to seek out and experience gender affirmation and euphoria. Individuals experiencing a greater burden of marginalization may not be able to access gender affirmation and euphoria to the same degree, and these experiences may look very different. As such, these findings cannot be generalized to trans and gender-diverse people generally, and future research on gender euphoria is needed with larger and more diverse samples.

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ORIGINAL ARTICLE

Autistics Never Arrive: A Mixed Methods Content Analysis of Transgender and Autistic Autobiography

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This article presents a mixed methods content analysis of autobiographies by transgender autistics (autistic-trans). It incorporates books, anthologies, poems, and prose, including self-published, grey, and professionally published texts up to June 2020. Seventy-one English-language texts in 15 separate books were identified. The first was published in 2003 and the majority have been published since 2013. The most common themes explored individuals' experience of autism diagnosis, community, coming out (as trans), and gender, with many speaking of being nonbinary, genderless, or using autism-specific genders (e.g., autigender). Notably, these themes, which exemplify those that are important to autistic-trans writers, contrast markedly with the topics of most academic work on autistic-trans lives. These experiences were explored in the context of the double empathy problem, the looping effect, gender performance, and trans healthcare access. These findings can be used to inform future research on the transgender-autistic community.

KEYWORDS transgender; autism; autistic-trans; self-advocacy; autobiography
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> "To be neuroqueer is to strive toward the becoming of being neuroqueer. Autistics never arrive." –Yergeau (2018, 93)

This mixed methods content analysis assesses the autobiographical texts of transgender autistic (autistic-trans) individuals and explores the way they form their own narratives on this experience. I borrow from Jake Pyne's (2021) term "autistic-trans"

here, as he used it to speak about the temporarily of trans-autistic autobiography. The autistic-trans community has not come to a consensus on a common descriptive identity for this experience and other terms such as neurodiverse, which also encompasses ADHD, are sometimes used (Egner 2019). Neuroqueer has also been proposed, though it is both not limited to LGBT+ identification and denotes an explicit "disident[ification] from both oppressive dominant and countercultural identities that perpetuate destructive medical model discourses of care" (Egner 2019, 123).

The medium of autobiography "offer[s] unique insights into how individuals perceive their social world and context, … views into an author's subjectivity, … and showcase[s] how one constructs culture and identity" (Mathias and Smith 2016, 205). This content analysis counters the almost complete absence of autistic-trans voices and perspectives in academic and research literature on this subjectivity (Davidson and Tamas 2016) and enables an alternative to conventional and often pathologizing researcher-mediated methods of data collection (e.g., interviews and focus groups).[1]

The existing literature on the intersection of trans identity and autism is small but rapidly expanding and tends to focus on clinical environments and the etiology of autistic-trans co-occurrence (e.g., Glidden et al. 2016; Jack 2011; Saleh 2019; Turban and van Schalkwyk 2018). By contrast, as seen in this content analysis, autistic-trans people themselves most often cite experiences of autism diagnosis, of community, of coming out (as trans) and of gender itself as meaningful in their lives. I explore these experiences in relation to Ian Hacking's (2009) looping effect, gender performance, access to transgender healthcare, and the double empathy problem.

The double empathy problem posits that "empathy is a bidirectional phenomenon… [and] that both autistic and nonautistic individuals may have difficulty understanding and feeling for one another because of their differing outlooks on with the world" (DeThorne 2020). It contrasts with the theory of mind model, which "attributes autism to 'mindblindness' [or] an inability to understand that other people know, want, feel, or believe things" (DeThorne 2020).

The current state of autistic-trans research, focusing as it does on the "pathology" of autism, dangerously undermines autistic-trans individual's bodily autonomy and allows this group to be used in socio-political debates as a cautionary tale—all without ever speaking or listening to an autistic-trans person (Gillespie-Lynch et al. 2017). Autistic-trans people's existence is also frequently deployed to undermine transgender healthcare (e.g., Hruz 2020; Suissa and Sullivan 2021). A UK clinic for trans youth recently reported that a quarter of their patients displayed autistic traits. This was subsequently weaponized to argue that all TGNB children's care should be brought under intense scrutiny, subjected to court approval, and severely restricted for autistics (Adams 2020; Hurst 2019).

The presumption in the existing literature is that autism alone may make an individual incapable of asserting their gender identity or, at the very least, be sufficient rationale for practitioners to exercise greater caution in the provision of transgender healthcare (Adams and Liang 2020; MacKinnon et al. 2020; Shumer et al. 2015; Strang et al. 2018a; Turban and van Schalkwyk 2018; Van der Miesen et al. 2016; Van der Miesen et al. 2018). Indeed, the idea of an autistic-trans person appears to be somewhat in-

1 The author of this article is both transgender and autistic.

comprehensible to the wider public, which tends to view autistic people as sufficiently lacking an interior life and goals as to render their identification as trans "ridiculous" or possibly coerced (Yergeau 2018). Regardless, the literature on autistic-trans people is equivocal on the etiology of autistic and transgender co-occurrence and has provided little evidence that their access to resources should be fundamentally different from neurotypical transgender individuals (Turban and van Schalkwyk 2018).

I assert that these presumptions could only be reached by relying on a body of literature that excludes and dismisses autistic-trans people's voices. Indeed, foundational autism researcher Bernard Rimland (1994, 3) once asserted that well known autistic autobiographers like Temple Grandon and Donna Williams must have "recovered from their autism—because how could an autistic have an inner life, much less narrate one." Other experts have suggested that autistic autobiographers are exceptional (and therefore that their experiences can be dismissed), under the logic that "what can be pointed to in their writing that deserves the label autistic?" (Yergeau 2018, 21; see also Happé 1991). These assertions assume that autistic subjectivity and interior life must orient to the neurotypical, cisgender, and clinical worlds to be comprehensible. Autistic autobiographers, on the other hand, assert that our lives and subjectivities need not make sense to neurotypicals and clinicians to have meaning and value.

METHODS

This study is a mixed-methods content analysis of autistic-trans autobiography published up to June 2020. Content analysis is "an analytic method… for the systematic reduction and interpretation of text or video data… by identifying codes and common themes… and then constructing underlying meanings (Frey 2018, 392; see also Mayring 2000). I have specifically used a conventional qualitative content analysis, which draws "codes and themes directly from the data… [when] existing knowledge around a phenomenon of interest is largely absent" (Frey 2018, 392). This approach allows me to provide an overview of current trends in the genre of autistic-trans autobiography.

I chose to conduct a comprehensive review, rather than a more in-depth analysis of a few representative texts, to provide a broad overview of this nascent genre and the concerns of its authors. As the area is rapidly growing, it is also the case that such a comprehensive analysis is currently possible, whereas it may soon become more difficult to capture all relevant texts. This content analysis was supplemented by a statistical overview of the autobiographies to provide some contextual information on the origin and trajectory of this medium.

Data collection and eligibility criteria

I searched for all autistic-trans autobiographical media up to the point where I began the analysis in June 2020. This genre is unique as it frequently takes place in the realm of grey and self-published literature. Accordingly, I included all self-published material, as well as material published by conventional publishers and using community created imprints, so long as it was "in print" (including in digital print) and named a publisher.

Blogs are a rich source of autistic-trans autobiography and, arguably, the self-publishing ethos may be an outgrowth of these texts. However, expanding the re-

view to include them would have quickly exceeded my resources and, in any case, these texts deserve to be fully explored on their own. Similarly, I could have included interviews with autistic-trans individuals (Adams and Liang 2020; Mendes and Maroney 2019) and research in collaboration with or created by them (Strang et al. 2018b). The former, however, follow questionnaires not created by the autistic-trans interviewees, while the latter do not have a strictly autobiographical goal. By contrast, the included autobiographical texts most closely follow the direction of the individual autistic-trans people reporting on their experiences as both autistic and trans. I identified a small selection of stand-alone texts that discussed an individual experience of being both transgender and autistic (e.g., Dale 2019; Lawson and Lawson 2017). However, most autistic-trans autobiography occurs in anthologies that focus on autistic, autistic-trans, or trans identity, in that order. I therefore included the individual entries in these texts (both poems and prose), as well.

Autistic-trans autobiographies were identified iteratively through the author's personal and professional networks, Google searches, from publishers that commonly produce them (e.g., Jessica Kingsley Publishers [JKP]), and by reviewing the references of identified texts. Only English language texts were assessed. Keywords used in Google searches were "transgender autobio," and "autistic autobio." In searching for material from JKP, I reviewed their online catalogues (e.g., Jessica Kingsley Publishers 2018), as well as their website (Jessica Kingsley Publishers 2022) and that of their Canadian distributor (UBC Press 2022). I also identified texts by searching through the publications of autistic-trans authors that had published several autobiographies (e.g., Wenn Lawson and Maxfield Sparrow).[2]

Candidate texts identified in this way were screened in for further review if they mentioned or otherwise indicated in their title or synopsis that they dealt with autobiographical/personal/self-narratives and either/both transgender identity and autism/Asperger's.[3] Texts were subsequently screened out if, after a closer review of the narrative, they didn't relate the author's personal experience of *both* autism and gender identity. Individual autobiographical texts that mentioned gender identity without the writer explicitly identifying as trans then, or in subsequent texts, were also screened out.

It is entirely possible to describe one's experience in a manner that could be categorized as trans without ever mentioning that one is. I am, however, mindful of the need to respect the right to self-define and to not determine, based on my reading of

2 Both Wenn Lawson and Maxfield Sparrow transitioned over the course of multiple autobiographies and have publications under more than one name. In these cases, I have included all relevant texts that described a personal experience of both autism and gender identity (Jones 2013, 2016; Lawson 2004; Lawson and Lawson 2017; Sparrow 2020).

3 Hans Asperger, the namesake of this condition, was long considered to have saved disabled children during the Nazi regime. It recently came to light that he had supported the regime in sending several disabled children, labelled genetically inferior, to their deaths (Baron-Cohen 2018). The diagnosis has since been removed from the DSM. I include it here because some autistic-trans autobiographers used the term in writing about their experiences prior to this revelation and others continue to use it in place of autism today. In the context of this article, I refer to the spectrum as autism.

another's narrative, whether they are trans. In any case, attempting to determine the point where a narrative becomes a trans one would be a highly arbitrary process. Accordingly, autobiographical texts were only included if their authors explicitly named themselves as trans in them.[4] Note also that some anthologies included author biographies at the beginning or end of the book. They were added to the electronic document of individual narratives where this occurred. I did so because authors often used this space to explicitly identify and further articulate their experiences as trans.

The resultant autistic-trans autobiographies were downloaded and converted to word format. Doing so made it possible to use identical procedures to search these texts for relevant key words ("trans," "gender," "binary," "autis," and "asperg"), identify whether they dealt with a personal narrative of autistic-trans identity, and draw out themes from them. This process also allowed single narratives to be identified in anthologies.

Data analysis

The electronic texts of the 71 English-language individual autistic-trans autobiographies were loaded into NVivo 12 (QSR International 2018). I then submerged myself in these texts in order to identify similarities between them according to the frequency with which specific keywords were used (e.g., gender, trans, etc.). These initial codes allowed me to further identify short paragraphs and excerpts that spoke to specific experiences of autistic-trans individuals. As is consistent with a conventional content analysis, codes identified in the data were developed iteratively (Frey 2019, 393). These codes were subsequently organized into the four most common themes described in these short paragraphs and excerpts.

RESULTS

Seventy-one unique autistic-trans autobiographical narratives were identified in 15 distinct books (see Table 1).[5] Thirty-three percent were stand-alone personal narratives

4 While it is possible, and even likely, that some authors may have identified as trans in other sources, it wasn't feasible to find or screen all texts written by them for this information and so I have limited myself to their identification in autobiographical texts in which they explicitly did so.

5 Publications were identified as self-published if the author paid for the services of a company created for this purpose (e.g., AuthorHouse) or published the book under the imprint of a publishing house they created and which had not published any other texts or, when publishing these texts, did so without any screening processes and/or charged for their publication. Publications were identified as grey if they came from publishers that were created by the authors for the purpose of publishing this or a prior book, had published books by other authors, and provided wrap around services (e.g., copyediting, printing, publicity) free of charge or by sharing payment through a cooperative. It was unclear, in some instances, to what extent these organizations shared payment or if they required authors to bear all costs. I identified them as grey when this was the case. This category also includes in-house publishing by organizations and community groups (e.g., DragonBee Press). Publications were identified professional if they were a company created for the publication of books, screened

Table 1. Books Containing Autistic-Trans Narratives

Year	Title	Author(s)/Editor(s)	Publisher	Publisher Type	Focus	Text Type	Number of Narratives
2003	*Women From Another Planet*	Miller	AuthorHouse	Self	Autism	Anthology	1
2004	*Sex, Sexuality, and the Autism Spectrum*	Lawson	Jessica Kingsley Publishers (JKP)	Professional	Autism	Single	1
2013	*No You Don't: Essays from an Unstrange Mind*	Jones	Unstrange Publications	Self	Autism	Single	1
2016	*The Spoon Knife Anthology*	Nicholson and Monje	NeuroQueer Books	Grey	Autism	Anthology	6
2016	*The ABCs of Autism Acceptance*	Jones	Autonomous Press	Grey	Autism	Single	1
2017	*Spoon Knife 2*	Ryskamp and Harvey	NeuroQueer Books	Grey	Autism	Anthology	7
2017	*Transitioning Together: One Couple's Journey of Gender and Identity Discovery*	Lawson and Lawson	JKP	Professional	Trans / Autism	Single	1
2017	*All the Weight of Our Dreams*	Brown et al.	DragonBee Press	Grey	Autism	Anthology	6
2018	*Spoon Knife 3*	Walker and Reichart	NeuroQueer Books	Grey	Autism	Anthology	3
2018	*Challenging Genders: Non-Binary Experiences of Those Assigned Female at Birth*	Brown and Burill	Boundless Endeavors	Self	Trans / Autism	Anthology	2
2019	*Spoon Knife 4*	Raymaker and Allen	Autonomous Press	Grey	Autism	Anthology	2
2019	*Uncomfortable Labels*	Dale	JKP	Professional	Trans / Autism	Single	1
2020	*Non-Binary Lives*	Twist et al.	JKP	Professional	Trans	Anthology	1
2020	*Spectrums*	Sparrow	JKP	Professional	Trans / Autism	Anthology	35
2020	*Our Autistic Lives*	Ratcliffe	JKP	Professional	Autism	Anthology	3

(5 books: 3 focused on autism and 2 on autistic-trans experience). The remaining 67% appeared in anthologies (66 individual narratives in 10 books: 7 focused on autism, 2 specifically on the non-binary experience, and 1 on the autistic-trans experience). A full 40% of all publications to date have been published by JKP. A node also forms around Maxfield Sparrow who, as either author or editor, is responsible for 4 books and 39 (55%) of all narratives. Autistic-trans autobiographies have increased steadily since the first text was published in 2003, with 2 published by 2004 and the remainder since 2013 (3 each, or 40% of the total, in 2017 and 2020).

Themes

These themes represent the four most common topics mentioned across these 71 individual autobiographical narratives. "Autism diagnosis" related to individual author's experiences of diagnosis as both trans and autistic. "Community" deals with individual experiences of autistic-trans, trans, and autistic communities. "Coming out" (as trans) examines the authors experience of coming out as and being trans. Finally, "gender" highlights autistic-trans people's unique experiences in this area.

Autism diagnosis

This theme dealt with authors' experience of and feelings about autism diagnosis. It includes experiences of receiving a formal diagnosis as either an adult or child and of self-diagnosis. There was, in fact, often overlap between self- and adult diagnosis. Many individuals who sought an adult diagnosis, for instance, spoke about learning from their parents that autism had been queried and, in some cases, diagnosed when they were children. In these cases, parents often responded by refusing to acknowledge the diagnosis/potential for diagnosis and/or hiding it from their children. Many identified their parents and others, including trans healthcare specialists, as failing to support them in seeking a diagnosis of autism as an adult. This often resulted in autistic-trans people and their parents failing to acknowledge or address the areas in which resources were needed.

> I started bugging my therapist at the gender clinic. He didn't "see it"; he didn't think autism spectrum disorder (ASD) was a "good diagnostic fit." But I got him to administer some metrics. Lo and behold, I scored high on the Ritvo Autism Asperger Diagnostic Scale. He referred me to the Autism Society, whose doctors gave me an official diagnosis. Now my gender clinic screens all transgender and gender nonconforming patients for ASD. (Qwyrdo in Sparrow 2020, 79)

Several individuals described an autism diagnosis as allowing them to better understand themselves and to feel more comfortable interacting with the autism community.

> I got my formal autism diagnosis a few days before my 20th birthday. I didn't really need the services or accommodations that came with it at that point. I had been living without them for so long. For me, a diagnosis was a pass to join the autistic community, make friends, and do advocacy work. I threw myself into the autistic community, happy at last

submissions, and provided free wrap around publication services.

to have found people like myself. (Gaeke Franz in Sparrow 2020, 136–37)

Community

Community was another common theme in autistic-trans autobiographies. Many spoke about having trouble accessing the autistic community as a TGNB person or vice versa. In the latter case ableism was a barrier, while in the former transphobia was the key issue. A common response to this impasse was the creation of in person and online autistic-trans community spaces. Autistic-trans individuals spoke of these community spaces and groups as providing the exemplars of autistic-trans life that they wished were available to them when they were younger. These communities also appear to have fulfilled a desire to share things about their experience with others. On the other hand, it was noted that autistic-trans community spaces can be very 'white' and unwelcoming for people of color.

> When I'm around other trans people or in queer spaces, they're usually either all-white or extremely intolerant of my stimming, or both. … I am sustained by people who can understand that I'm not really joking when I say that my gender is "fuck colonialism," and provide me with a cultural or at least ideological anchor against which I can feel a little less bereft, a little less like white people have managed to take not only my homeland and cultures away from me but also any chance at a coherent gender identity. (//kiran foster in Brown et al. 2017, 233–35)

Coming out (as trans)

This was the most common theme. It captures the tendency of autistic-trans individuals to "try out" and exhaust all other possible identities before accepting themselves as trans and includes those who knew and accepted their trans identity without question. This theme is particularly observable in the autobiographical materials of individuals who published both before and after identifying as trans (Jones 2013, 2016; Lawson 2004; Lawson and Lawson 2017; Sparrow 2020).

> In terms of my gender identity, I was also one of those people who "always knew." I didn't know of the word "transgender" until much later, but I always knew that I was "really a boy." Throughout my childhood, I had always resented being told that I was a girl, but I also knew I would get in trouble if I tried to explain to the adults in my life that I was really a boy. (Kerry Chin in Sparrow 2020, 201)

Many individuals received hostility from the larger (and often cisgender) LGBTQ community for affirming and expressing their trans identity.

> At the time, I identified publicly as a stone soft butch. I had found drag king shows a socially acceptable way to pack and bind, to see if I was comfortable in my male skin. A lesbian in the LGBTQ community told me after a performance, "Don't be a man. You aren't a man, just a stone diesel dyke." It hurt me deeply. It was the one community that had seemed to accept me as me, and suddenly I was met with discrimination again. It became the day I learned transphobia exists in all communities—the day I began to distance myself from that community. (Jordan in Sparrow 2020, 155)

Similarly, many autistic-trans people were told by trans healthcare professionals and their parents that they couldn't be both trans and autistic. One result of this suspicion is that autistic people are often made to wait longer and 'jump through more hoops' prior to receiving trans healthcare (Strang et al. 2018a; van Schalkwyk et al. 2015).

As noted, many autistic-trans individuals discussed wishing that they had known that being TGNB was a possibility and/or that they knew someone who was while they were growing up. Ultimately this didn't stop them from coming to understand themselves as TGNB, but it did make the process more stressful and isolating. Many spoke of this eventual realization as an epiphany and in terms of divergent knowledge and ideas coalescing suddenly.

> Nonbinary. That's a word—a concept—I wish you had known when I was five and asking questions. Or genderqueer. Or gender nonconforming. I can hardly begin to imagine how my life would have unfolded had I simply known there were people who were neither boys nor girls, had I known there were people not defined by what's between their legs. (Qwyrdo in Sparrow 2020, 78)

On the other hand, many autistic-trans autobiographers spoke about seeing gender roles and gender itself as inherently arbitrary and meaningless. Perhaps unsurprisingly a majority (38 out of 63 individuals) self-identified as nonbinary or genderless.

> I never learned to see my body as a woman's body in the sense that a woman's body is an actor in socio-sexual relations. My body is the support structure for me, my intellect, my memories, my sensory experiences. If it has a gender, that gender lives on the outside, not in here where it would make a difference to how I feel or see the world (except in so far as I am shaped by how my gender causes the world to see and feel about me). (Meyerding in Miller 2003, 165–66)

Conversely, other individuals experienced gender and gender identity as "embodied" and all encompassing, such that their gender was intertwined with and inseparable from their experience of being autistic, and vice versa.

> It goes like this: Somebody I have to work with to survive will respect at most two of the three things that are most central to who I am: my race, my gender, or my neurodivergence… I am the sum of my parts, and any and all care I've received has fallen short because it's attempted to treat my parts separately if it considers them at all. (//kiran foster in Brown et al. 2017, 233)

Gender

The final theme captures the way in which autistic-trans people discussed their unique experiences and concepts of gender. As noted, most autistic-trans autobiographers identified explicitly as nonbinary. Others identified with uniquely *autistic genders* such as autigender, identified as metagender or gendervague, and/or spoke of feeling genderless—a phenomenon that has been noted to be quite common among autistics (Davidson and Tamas 2016). Jones (2016, 130), for instance, remarked that "there are many words for my gender, including metagender, bigender, genderqueer, genderfluid, gendervague… but the word that best captures my own gender is 'epicene.'" Sparrow

elaborated on this in Brown and Burill (2018, 126), writing:

> I cannot separate my gender identity from my autism. We Autistics have a word for that: gendervague. One definition of gendervague is "a gender identity that is highly influenced by being neurodivergent, and feels undefinable because of one's neurodivergence." Another definition is, "your gender is not definable with words because of one's status as neurodivergent."

Regarding not understanding gender, Alyssa Hillary notes that when they wrote "about the erasure of Queer Autistic people for *Criptiques* (Wood 2014) … Autistic people compared asking about their gender to asking how many miles per gallon an electric bike got… Some of us didn't 'get' gender in the neurotypical way" (Brown and Burill 2018, 84). Likewise, ren koloni (in Sparrow 2020, 181) asserts that

> you do not have to know what your gender is. "Man" and "woman" don't have to make sense to you. Even new words, the ones we made to make sense to more of us, like "demigirl" or "autigender" or "bigender" or "neutrois," don't have to make sense to you. You don't have to know what you like to be called, or what you like to wear, or what you like your body to feel like. Gender is a journey, and you don't have to know where you're going to end up. If you're lost, find yourself in the little things (like we autistics always do).

DISCUSSION

Since 2003 the English-language autistic-trans autobiographical medium has grown from 0 to 71 narratives published in 15 books (see Table 1). This genre is highly unique and tends to occur in anthologies that collect the writings of autistics, autistic-trans, and/or trans people. Only 5 publications used a conventional autobiographical format in which a single, or in one case a couple's (Lawson and Lawson 2017), self-narrative is shared. Autistic-trans autobiography is also unique in its tendency to be grey market or self-published (60% of all texts). All other texts are under the imprint of JKP. Grey market and self-publication may present a relatively lower barrier to new, unique, and unconventional narratives like these.

Perhaps one of the most interesting aspects of autistic-trans autobiography is the discussion of experiences of gender that are unique to this group, such as autigender. Jordynn Jack (2012, 1) notes that "autistic individuals view gender as a copia, or tool for inventing multiple possibilities through available sex/gender discourses." While it was not uncommon for autistic-trans autobiographers to identity with gender in a binary or unambivalent manner, as Davidson and Tamas (2016, 59) observe, many such individuals

> highlight the draining and relentless emotional labour that doing gender "typically" requires, and many on the spectrum respond by explicitly rejecting or simply neglecting its confounding demands, identifying with neither side of the m/f divide in attempts to give up the ghost of gender.

Until recently autistic-trans people have been thought to be a conceptual impos-

sibility or not competent to speak for ourselves (AlterHéros n.d.; Strang et al. 2018b). This may have contributed to professional publisher's lack of interest in the narratives of autistic-trans individuals. Public awareness of individuals who are both trans and autistic has also been minimal, and research and academic literature have focused largely on the etiology and pathos of this overlap (Jack 2011; Yergeau 2018). Indeed, autistics are often characterized as "so rhetorically impaired that they remain unoriented toward all that is normative and proper, whether empathy or eros or gender (performance and concept unto itself)" (Yergeau 2018, 27).

Within this context, autistic-trans people have been rhetorically deployed to undermine the provision of trans healthcare on both an individual and societal level (Hruz 2020; (Adams 2018; Hurst 2019; Yergeau 2018). This argument posits that (a) the overlap of transgender identity and autism appears high; (b) autistic people may simply be "fixated" on or "obsessed" with gender; (c) many trans individuals may be eligible for a diagnosis of autism; and therefore (d) all trans people should be subjected to autism screening and increased gatekeeping in order "protect" vulnerable autistic people from transitioning (Strang et al. 2018b; Suissa and Sullivan, 2021; Turban and van Schalkwyk 2018).

Autistic-trans autobiographers often discuss attempts to supress their gender identity or negotiate its replacement with a series of other, seemingly more socio-politically acceptable identities (e.g., gay, lesbian, drag king, butch, etc.). This may also reflect autistic-trans peoples' willingness to experiment and "try out" different genders and gender expressions (Davidson and Tamas 2016). It has been observed that autistic people tend not to moderate their honesty and so coming out as trans may be connected to their inability and/or unwillingness to hide or suppress this aspect of their being (Walsh 2020; Walsh et al. 2018).

Some autobiographers spoke about the growing tendency of trans healthcare practitioners to screen all applicants for autism (Strang et al. 2018a). Qwyrdo (in Sparrow 2020, 79), for instance, explained that due to their self-advocating for an autism assessment, their gender clinic now "screen[s] *all* [transgender] and gender nonconforming patients for [autism spectrum disorder]." While healthcare access and quality may be improved by educating providers about all aspects of a person's experience, many practitioners continue to feel "that for autistic people, trans identity is little more than an obsession or a compulsion… [and] that autistic people might "misinterpret" their autism-related social oddities and exclusions as genderqueer identity" (Yergeau 2018, 71).

Transgender healthcare professionals may exercise additional caution when faced with autistic-trans individuals who do not fit the expected transgender narrative (Dewey and Gesbeck 2016). Growing evidence suggests, however, that autistics may be less likely to recite the conventional transitional narrative (e.g., binary identity, presenting as "typically" gendered) due to a different experience of gender identity, or because they simply do not perceive or care about the need to make their healthcare providers comfortable in exchange for healthcare (Adams and Liang 2020). Walsh (2020, 3) offers a

> more parsimonious proposition… that autistic people are more likely to identify as trans due to differences in perception and cognition leading to a reduction in the likelihood that social conditioning will pre-

> vent them from becoming aware of their gender identity when it differs from the gender assigned to them at birth.

Autistic people who do not perceive the need to give a conventional transitional narrative may, therefore, be at a marked disadvantage in accessing transgender healthcare simply because this process is not accessible.

Trans healthcare professionals' tendency to exercise greater caution with autistic clients reflects the "double empathy" problem, whereby both autistic and neurotypical individuals lack insight into each other's respective cultures and world views (Milton 2012). However, where the neurotypical perspective is seen as fundamentally normal, it is autistic people who must travel further in bridging this gap. Trans healthcare professionals can thus view their expectations of trans identity, as observed and measured among neurotypicals, as normal and autistic performances of this identity as fundamentally abnormal and "wrong" (Gillespie-Lynch et al. 2017). As a result, practitioners may withhold transgender healthcare until such a time as the autistic person's performance of gender becomes (or appears to become) more neurotypical, resulting in longer and even perpetual waiting periods (Adams and Liang 2020).

Ian Hacking (2009), in speaking of a phenomenon that he calls the looping effect, argues that autobiography collectively creates the language to identify experiences that exist, but for which there are no or inadequate words. Subsequent autobiographies build on and evolve this language, creating something new, but no less real. Indeed, Hacking (1999, 119) is careful to note that autism and sexual identity are "both socially constructed and yet 'real'." We see this phenomenon in the iterative creation of names for uniquely autistic genders. Hacking (1996, 370) further opines that "to create new ways of classifying people is also to change how we can think of ourselves, to change our sense of self-worth, even how we remember our own past. This in turn generates a looping effect because people of the kind behave differently and so are different." Judith Butler (1990, 2004) speaks of gender in similar terms, where it is both true that one becomes gendered by continuously performing a gender and that it is deeply felt, immutable, and *real* (see Finlay 2017). The looping effect impacts how both autistics and healthcare professionals come to see and define autism and, ultimately, the diagnostic requirements to which autistic-trans people are held. Trans people, for their part, are often required to give a common narrative of this experience to receive healthcare. This narrative, at best a linguistic oversimplification to make it possible to talk "about what was hitherto unknown," subsequently becomes a measurement by which TGNB people are judged *real* and deserving of healthcare (Hacking 2009, 1467).

Autistic-trans autobiography creates the possibility of identifying and *making real* the unique experience of these individuals, allowing them to challenge those narratives that delay or prevent access to trans healthcare (Hacking 2007, 2009). The new narrative, however, may subsequently be repurposed to measure other autistic-trans individuals. The key issue seems to be that the healthcare field, at least with regards to diagnosis, has difficulty encompassing and allowing for a diverse and continuously evolving breadth of experience.

Limitations

The genre of autistic-trans autobiography is very new and rapidly evolving. While this content analysis presents an overview of the genre, it does not exhaustively record or

identify everything relevant about or important to autistic-trans people. For instance, this analysis does not include material from blogs, an area that future researchers will likely find fruitful. As indicated by the looping effect, we can expect autistic-trans autobiography to evolve rapidly as more people publish their experiences. Accordingly, all analyses of this field must account for the heterogeneity of this group and their experiences, goals, and needs regarding gender identity and healthcare. Nevertheless, this analysis provides context for future research, especially that which utilizes a broader sample or conducts an in-depth analysis of select texts.

CONCLUSION

As seen in this mixed methods content analysis of autistic-trans autobiography, autistic-trans individuals most often cite their experiences of autism diagnosis, community, coming out as trans, and gender as meaningful in their lives. This contrasts significantly with the existing and increasingly voluminous research and academic literature on this co-occurrence. The latter tends to fixate on the etiology of the coincidence of transgender identity and autism and its subsequent implications for access to transitional healthcare. This focus has the result of pathologizing autistic-trans individuals, undermining their bodily autonomy, and allowing them to be weaponized against other transgender individuals. What is more, it does nothing to challenge the difficulty that the wider public has with comprehending that transgender people can also be autistic.

It is useful to examine these challenges within the context of the double empathy problem (Milton 2012), the looping effect (Hacking 2009), gender performance, and access to transgender healthcare. In all respects, however, an accurate understanding of autistic-trans experience must include the voices of these individuals themselves. The autobiographical texts examined in this article demonstrate that autistic-trans people are, like all transgender people, a heterogeneous community with a multiplicity of goals and needs.

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ORIGINAL ARTICLE

Tipping Points and Shifting Expectations: The Promise of Applied Trans Studies for Building Structural Competency

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In 2021, the United States experienced the most active year on record for anti-trans legislation. In 2022, we are witnessing the renewal of this legislative harassment, with increased success on the part of anti-trans lawmakers. When these bills are passed into law and, importantly, even when they are resoundingly defeated or fail to reach an actual vote, the harmful rhetoric and ideology that is attached to them reverberates throughout trans communities resulting in social and psychological harm for transgender, nonbinary, and gender diverse people. The burden of addressing and offsetting this harm is often placed on the shoulders of other trans people who serve as grassroots leaders in their communities. This article argues that while this support is lifesaving for individual trans people, transformative change requires an increase in *structural competency* in our mainstream social institutions, and makes the case for applied trans studies as a pathway to that end.

KEYWORDS applied trans studies; embodied knowledge; peer support; transgender standpoint; structural competency
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The experience of being transgender in the United States has shifted in ways that were hard for me to foresee the day I picked up the June 9, 2014 issue of *TIME* magazine from a large chain bookshop in Spartanburg, South Carolina. It had been four years since I started my own medical transition in a doctor's office two miles away from where I sat in my overstuffed chair, drinking my over-steamed latte, sheepishly reading a magazine suggesting I could maybe calm down a little bit with my social gender dysphoria. We had reached a *tipping point*, after all. To be sure, there has been an unimaginable increase in the general public's awareness of transgender experience. An increased presence in scripted, reality, and news media has resulted in trans people and their concerns taking up otherwise inaccessible space in the minds and homes of millions

of people (Billard and Gross 2020; Capuzza and Spencer 2018). As awareness continues to increase and more trans people feel comfortable being visible as such in their everyday lives, our central social institutions are being pushed by diverse factions of stakeholders to either facilitate or eliminate gender diversity. Increased activity meant to empower or constrain gender diversity has emerged in nearly every social context and institution.

Seven years after Black transgender actress and activist Laverne Cox appeared on the cover of *TIME*, we seem to have reached another tipping point. The American Civil Liberties Union (ACLU) named 2021 the most active year on record for anti-trans legislation in the United States (Krishnakumar 2021). Right wing activists and anti-trans lawmakers tested out the viability of their approaches in statehouses across the country in 2021, slightly tweaking them at each iteration to see which approach would hold up under legal scrutiny (strict or otherwise). In many cases, trans and queer activists worked tirelessly to defeat these proposals. They organized public protests and facilitated outreach campaigns; they attended state and local legislative sessions and gave impassioned public testimony on behalf of trans youth and young adults; they created community care spaces to process the political moment and facilitate the provision of direct services and mutual aid during the onslaught of attacks; they built coalitions made up of diverse stakeholders, trans people, and cis allies who were already leading a variety of social justice organizations across their communities (e.g., Branigin 2021; Brown 2022; Rummler 2022). Working together, these activists demonstrated the kind of power that can be seized when individuals come together as a community, make the decision to approach social problems with a collective orientation, and combine resources so that everyone has what they need to contribute to the best of their ability. Unfortunately, these efforts also revealed the limitations of our power and the remaining work that is required from all of us beyond the defensive strategy of political whack-a-mole that has gripped our movement in recent years.

In 2022, we are witnessing the renewal of this legislative harassment. State and local lawmakers concentrated in the US Southeast, but increasingly spread out around the country, have already put pen to paper to prevent and sanction the provision of life-saving medical care to trans kids and young adults; rule out the acknowledgement of trans and queer identities in public education; make it illegal for trans kids to play sports on teams that reflect their gender identity; punish people for using the restroom or a fitting room in a public space; offer safe harbor to those who shapeshift religious doctrine to condemn, rather than love, thy neighbor; and in some cases to frame the provision of support by a parent, caregiver, teacher, or other authority figure as child abuse or grooming (e.g., Burns 2022; Carlisle 2022; Ishisaka 2022; Yi 2022). To rally support, proponents of this legislation rely on tropes that stigmatize trans, nonbinary, and gender diverse people as dangerous, predatory, deceptive, and sociopathic (Sessa-Hawkins 2021).

An especially cruel and harmful component of the recent string of negative policy proposals, the majority of this legislative harassment targets trans youth and young adults, as well as the adults or authority figures in their lives who might offer them support and resources (e.g., Branigin 2022; Sosin 2022). Even when bills are defeated, and conservative activists are unable to use the power of law to control trans people, the rhetoric does a fair amount of the job for them. A research group in the United

States conducted focus groups with trans and gender diverse youth to explore the perceived impact of the political climate on young trans people's well-being (Paceley et al. 2020; Paceley et al. 2021). They found that anti-trans rhetoric leads to the development of dangerous social environments, noting increased suicidal ideation, increased feelings of isolation, and decreased self-worth (Paceley et al. 2020). Ultimately, this rhetoric leads to increased psychological distress among trans youth, and "emboldens peers to perpetuate bias-based bullying and harassment, which is itself associated with poor mental health, suicidal ideation, suicidal behavior, poor academic performance, and substance abuse among [trans and gender-diverse] people" (Paceley et al. 2021, 3).

SOCIO-POLITICAL REVERB

When these bills are passed into law and, importantly, even when they are resoundingly defeated or fail to reach an actual vote, anti-trans lawmakers and their allies manufacture and encourage the spread of harmful rhetoric and ideology that is necessary to support the content of their legislation (Billard 2021). In turn, this arms everyday citizens with dangerous ammunition and deputizes them in the culture war fever dreams of right-wing America. In Texas, pharmacists are reporting parents of trans children to child protective services—scaring, threatening, and potentially dividing families who are following current standards of care as outlined by national and international medical authorities (Sosin 2022; Yurcaba 2022). In Alabama, schoolteachers are outing trans kids to their parents and peers, placing them at risk of emotional abuse, physical violence, and potential abandonment (Cohen 2022). Under the guise of protecting children, these consequences put trans, nonbinary, and gender diverse youth and young adults directly in harm's way.

Even when they are defeated, efforts at enacting anti-trans legislation have widespread effects for trans, nonbinary, and gender diverse people. The rhetorical and ideological work that goes into attempts at discriminatory policies affects outsider views of trans people, but that work also contributes to internalized stigma, poor mental health, and expectations of poor treatment, thus creating a hostile social climate and poor outlook for trans people (e.g., Grzenda et al. 2021). This socio-political reverb results in disparate life chances and disproportionate disadvantage throughout the life course and across social contexts and institutions.

The minority stress model was originally developed to connect lesbian women's (Brooks 1981; Rich et al. 2020), and later gay men's (Meyer 1995, 2003), experiences of poor mental health to the heteronormative social conflicts they experience related to their sexuality. Importantly, this model was developed to push back against the widespread assumptions that lesbians and gay men experienced negative mental health outcomes due to a sexual minority identity in and of itself. According to the minority stress perspective, the social stigma attached to sexual minorities—and not merely a sexual minority identity—results in a lower social status for lesbians and gay men. Lower status, according to the theory, results in higher rates of prejudice and discrimination and the accumulation of fewer resources with which to cope. According to the minority stress model, the experience of negative life events, their anticipation, and the internalization of their meaning leads to poor mental health outcomes for sexual minorities.

The minority stress model was later expanded to explain the high rates of depression, anxiety, and suicidality among trans people. Rather than poor mental health outcomes being a characteristic of trans identity, psychologists Michael L. Hendricks and Rylan J. Testa (2012) suggest that trans people experience gender minority stress that overlaps with and operates alongside sexual minority stress. Hendricks and Testa suggest a pathway from gender-related negative life events, the fear and anticipation of future negative events, and the internalization of transphobic stigma to suicidality and psychological distress among trans people. Trans-specific negative life events include a range of anti-trans experiences including microaggressions, rejection, emotional abuse, and physical violence. Whether the events are experienced or anticipated, their presence in the lives of trans people often results in hypervigilance, avoidance, and self-isolation (Rood et al. 2016), exacerbating mental health disparities and reducing coping resources.

As hostile political rhetoric aimed at trans people increases, so too do experiences of minority stress (Gonzalez et al. 2016). In this ongoing wave of legislative harassment, trans people are positioned as deranged, deceptive, and dangerous in order to justify state-sponsored control, discipline, and punishment. The ideology necessary to justify removing a child from a loving home because their parent or guardian filled a prescription, written by a licensed physician, for life-saving medical care, or the argument necessary to make sense of terminating a teacher who recommended a book from the library to a student who asked for literature that reflected gender-diverse experiences like their own, requires us to lower our expectations for the humanity of trans people. Low expectations allow the stigmatization of trans, nonbinary, and gender diverse people, heightening their chances of experiencing discrimination, rejection, or violence due to their gender identity. One research group found that transgender adults who live in US states with anti-trans policies report more suicide attempts than their peers in states without legislation that negatively targets their community (Perez-Brumer et al. 2015). In hostile political climates, encounters of anti-trans bias become ubiquitous, trans people come to expect them, and adapt their lives in order to avoid them (Rood et al. 2016). Over time, some trans people may accept this treatment and its associated implications, leading to even higher rates of depression, suicidality, and other negative mental health outcomes (Bradford et al. 2013; Goldblum et al. 2012; Herman 2013; Lefevor et al. 2019; McLemore 2018; Miller and Grollman 2015).

EMBODIED KNOWLEDGES

As a ninth-grade student in South Carolina, I got caught writing a note to my first girlfriend during my Spanish class. It was mostly benign, but definitely included cheesy high school crush stuff and angsty reflections on my growing gender dysphoria. I was embarrassed and a bit annoyed that my letter was taken, but assumed my teacher threw the note out. When it resurfaced a few weeks later at a parent-teacher conference, I had forgotten all about it. My mother always showed up to those conversations, and parent-teacher conferences were usually really good days for me; I was an anxious student, had very few friends, and focused on academic achievement as a means of control and a pathway out of my hometown. But my academic achievement was not the focus of the parent-teacher conference on that particular evening. My teacher thought

that my sexuality and gender identity were more important topics to discuss with my mother than my ability to conjugate verbs. While the class note itself was standard fare for ninth-grade love—wistful longings, hyperbolic emotions, and way too much emphasis on lyrics from popular music—the object of my affections and the meanings attached to that were of the most concern to the adults in my life. When my mother walked out of my classroom, she called me a liar and said I had broken her trust. I've always felt like she never looked at me the same way again, never saw me quite the same way. My Spanish teacher stopped interacting with me or looking my way at all. As hard as I tried, I did not pick up the Spanish language that semester. "What did you expect?" Mama asked, in no way looking for an answer, when she saw my report card that term.

Around that same time, I was beginning to understand that my social status across a variety of institutions was directly connected to my gender nonconformity and its impact on others' perception of my sexuality. At home, school, church, and other community spaces, where I was once held in high esteem as the well-behaved child, the straight-A student, or the youth group leader, I was now considered untrustworthy, a disruption, and a bad influence. My expectations fell alongside my social esteem, and I came to anticipate a world that was hostile to people like me. I began to expect that mistreatment would come my way, and that expectation changed how I understood my place in the world. Over time, I withdrew from friends and family, and my faith in social institutions steadily declined.

Like many people, for better or worse, I came to know trans people and the trans community through media representations. Likewise, I came to understand the social sanctions that would befall me if my gender rejected a cisnormative standpoint. The first trans man that I ever encountered was through film. His name was Brandon Teena. He died in Humboldt, Nebraska from a gunshot wound on December 31, 1993. He also died from stigma, as local authorities mocked, dismissed, and failed to protect him after he reported being brutally attacked by the two men who, days later, murdered him and his friends in a revenge plot. At thirteen years old, I grieved with those who loved him, as I watched the film *Boys Don't Cry* on a loop. I did not know at the time why I was so moved by this story of a transgender man. I did know, somehow implicitly, that I should hide my grief. Upon one viewing, I was interrupted by my mother's boyfriend. Feeling the need to defend my emotions, I said, "People are so cruel." He snapped back, "What did you expect?"

Ten years later, I saw the film again as a college student, attending a screening for an LGBTQ cultural event on campus. Those same giant feelings of grief returned to my chest, the ones that would show up when I was caught off guard by having a gender experience that was understood as trans. By the time we reached the violent climax in the narrative arc of the film, the other attendees watched in horror as emotional, physical, and sexual violence was inflicted on this young trans man. I quickly excused myself before the final shot and the follow up panel discussion. I was angry at the event organizers for screening this film. I was angry with my friends for being shocked by trans-antagonistic violence. I was angry at myself for identifying with Brandon. I repeated the words of my parents in my head, *what did you expect,* as I sped away from campus. When I reached the parking lot of the hotel-turned-low-income-student-housing where I lived near campus, I thought my grief would swallow me whole. It would be a few more years before I would understand that grief as part of my own

gender experience, less tied to the tragedy of Brandon's life and death and more tied to how it reinforced the ideas I held related to my own.

I started my own gender transition process my first year of graduate school. This serendipitous intersection allowed me the opportunity to spend an enormous amount of time educating myself on all things trans. I read every article and book I could find on the subject. As I consumed all of this content, I recognized similar feelings of grief that had nearly consumed me years prior, first in middle school and again in college as I came to understand my identity through the life and death of Brandon Teena. I began to wonder what I may have thought about trans experience (my own and others') and how my self-concept and identity may have been different if a Hollywood version of Brandon Teena had not been my first trans peer. I wanted to understand how trans people were given the cultural material to make sense of themselves. I wanted to understand the possibilities of what we could expect for ourselves and from those in our lives.

The first piece of independent research that I did in graduate school was a content analysis of documentary film focused on trans men and trans masculinity. One of the first films that I found was *Southern Comfort,* the story of Robert Eads. Robert died in Toccoa, Georgia from ovarian cancer on January 17, 1999. He also died from stigma, as provider after provider denied him necessary treatment due to his trans status. Robert explained that providers were more concerned about the comfort of their other patients than they were for his life. I grieved with his chosen family, more than a decade after his death, as I watched the end of his life play out on screen. He smoked cigarettes, drank coffee, and spoke in a thick southern accent about the medical providers who had left him for dead. His drawl comforted me, bringing the possibility of southern trans experience into being even as it was narrating the premature end to his own life. As Robert recalled his failed attempts to access life-saving medical care, I remembered medical providers an hour and a half north of Toccoa, more than a decade after Robert's death, refusing to touch me or look me in the eyes as I sought gender-affirming care. I was not shocked to hear that Robert's experiences had been much worse than my own had been to that point; I had learned to expect that they would be.

Around the same time that I was grieving for Robert Eads, a Southern trans elder I would never have the opportunity to meet, several of my friends from college started to identify as trans. One came out by sharing a link to a video he posted on his YouTube channel, where he had been documenting his experience of social and medical transition. I watched the videos with mixed feelings. I was excited for my friend, and for myself knowing another trans man in real life. Yet, I was incredibly scared for him, for us. What could we expect? In one of his videos, he described the loneliness he felt as a trans man in the South, lamented a future that he may never get to see, and floated the idea of moving to the West Coast in search of community. (All trans masculine Google searches seemed to lead to the Bay Area in 2011.) This is what I expected. A few videos later, he had decided to stay put and build a community of his own. Alongside a couple of friends in a coffee shop one afternoon, he started Gender Benders (GB), a grassroots support group for trans, nonbinary, and gender diverse people in the area. Within a few months, the group was thriving. That is *not* what I expected.

On a few trips back home, I attended some of the GB coffee meetups or group hangouts. I got to know other trans people from the area, heard their stories of family

and community, and started to recognize the limitations of my expectations related to trans life. By this point, my college friend who helped start the group had moved on to other opportunities and to seek other resources. Yet, the leadership built on the connections made over weekly coffee meetups, expanding the organization's local and online presence, and eventually providing resources and community to thousands of trans Southerners. Much like my friend, most folks involved in the organization come and go as their needs are met or as their needs change. In the summer of 2014, I attended Camp GB, a long-weekend retreat for trans folks to spend time in community and to access resources. It was the first time that I had been in a space that was completely centered on and designed by trans people. In that environment, I was able to develop a more well-rounded set of expectations about trans life in the region, and a better understanding of my own needs as a trans Southerner. I realized that I needed trans connection, and I needed to do whatever I could to make sure others had access to trans community.

In the summer of 2015, I attended camp as a member of the leadership team. The group had grown significantly, gathered a lot of support, and was ready to move beyond donated air mattresses and makeshift basement dorms. We looked around and found the perfect spot in the north Georgia foothills of the Blue Ridge Mountains, a picturesque campground tucked away in the woods of Toccoa, Georgia. It was not until we pulled our own caravan of trans cowboys through the town that Robert Eads referred to as "bubba town" that I remembered that this was where he spent the 53 years of his life.

Over the next several years, we would bring hundreds of trans Southerners to Toccoa, providing our community with access to mental and physical healthcare; peer connection and social support; recreation and fellowship; skill-building for grantmaking and community organizing; and a relaxing retreat that was centered on trans people caring for and loving other trans people. We ate every meal together in the large camp dining hall. We laughed, played games, and had fun together. We cried and processed our grief together. And we built relationships that helped us see and love ourselves in ways that had previously been denied to us. At Camp GB, we raised each other's expectations, and we sought to exceed them every time we came together.

OPPOSITIONAL KNOWLEDGES

Peer support plays an outsized role in interrupting the psychological consequences of stigma, discrimination, and other identity-related stress among trans people. Indicating access to peers, and the potential support they may offer, is directly related to lower levels of distress among trans people in the bulk of psychological research on the subject. This work notes that peer support is a protective factor against mental health issues broadly and against gender-related psychological distress in particular. For example, Bariola and colleagues (2015) and Testa and colleagues (2014) show that when trans people have more frequent contact with their peers they are able to develop greater resilience.

In my own and others' research on trans and gender-diverse Southerners, a regular theme emerges indicating that one way that sourcing support from the trans community facilitates positive mental health is through self-acceptance and the ac-

ceptance of trans identity broadly. By coming into contact with community-based counter-narratives to the rhetoric of legislative harassment, trans people gain access to a new way of framing their experiences. This new frame situates their gender experiences within a community of shared others, provides them language for explaining their experiences to others, and potentially normalizes their previously stigmatized experiences of gender for them and others in their lives.

Philosopher Talia Mae Bettcher wrote in 2007 that framing trans people as "evil deceivers and make-believers" transforms us into villains deserving of the rude, hostile, and violent reactions received from those uncomfortable with, offended by, or surprised by our gendered bodies, identities, or experiences (see also Billard 2019). As Bettcher argued, the stigma that is attached to our identities, and the framing used to justify interpersonal violence against us, poses the sometimes silent, sometimes roaring question, *what did you expect?* Before trans was an identity or experience that was intelligible to me, I did not have access to the collective knowledge necessary to form an oppositional viewpoint of my mistreatment. I was unable to separate others' reactions to my gender nonconformity from its (and ultimately my own) inherent value.

As communication scholar Sarah E. Jones (2020, 268) writes, when trans people do not have the resources to challenge them, cisnormative

> ways of knowing can function as a deterministic power—molding who trans people can be, how they exist in the world, and what rights they do or do not have [...] by controlling the social, organizational, and legal opportunities available.

It was not until I encountered trans ways of knowing through interaction with other trans people and gained insider explanations for my experiences within trans-centered community, that I was able to develop what sociologist KL Broad (2001) termed a "transgender standpoint." That is, my connection to a collective transgender identity enabled a way of knowing gender that included, explained, and celebrated those of us who operate outside of its normative construction. In Broad's (2001, 1151) conceptualization, a transgender standpoint questions "the dominant gender categorization system that assumes stable gender categories." Further, Broad (2001, 1151–52) writes:

> a transgender standpoint might examine how the processes of binary gender constraints (in medicine, psychology, and law) serve to pathologize transgender expression (such that transgender individuals disproportionately end up under medical supervision or in the criminal justice system) and marginalize transgender people from gendered social structures (e.g., sex-segregated jobs and marriage, etc.) and services (e.g., welfare and child support).

As a young person attempting to make sense of my own experiences of gender and the reactions it prompted from others in my life, a cisnormative standpoint was the only one available to me. Through trans community, I was able to access a transgender standpoint that radically reframed my expectations and explanations for the treatment I received as a trans person. As Bariola and colleagues (2015, 2112) write, "for marginalized people, identification with similar others allows for the development of a positive in-group identity, encourages positive self-appraisal, and allows access to group-level coping."

Testa and colleagues (2014) explain that simply having a prior awareness that

other trans people exist and prior engagement with trans people enhances psychological well-being when trans people first begin to explore their identities. During early trans identity development, these factors may result in trans people being less fearful, less suicidal, and more comfortable in their newly formed identity. Knowing that trans people exist and having previous interaction with trans people was so influential to mental health that, in one study, it cut the rates of suicide in half (Testa et al. 2014). This body of scholarship provides "support for the value of transgender individuals connecting with similar others, possibly providing the opportunity to question stigma from the majority culture and reappraise their experiences in a self-affirmative way" (Bockting et al. 2013, 949).

A growing number of studies suggest peer support is especially powerful when it occurs within trans community spaces. In and through connections with trans community organizations, individual trans people are offered a structure that facilitates the content, timing, availability, and distribution of peer connections. In an article I co-authored with my colleague Baker Rogers (Johnson and Rogers 2020), we show that some peer support structures, like those that offer regular opportunities for creating and maintaining relationships with other trans people, facilitate strong networks and norms through regular, intentional programming that destigmatizes and normalizes gender diversity, while encouraging positive frames for understanding a range of trans experiences.

STRUCTURAL COMPETENCY

Both as an academic researcher and in collaboration with community partners, I have completed over five years of ethnographic fieldwork, conducted more than 100 in-depth one-on-one interviews, and conducted 10 focus groups across the South, as well as surveyed more than 5,000 trans, nonbinary, and gender diverse Southerners. The first takeaway from this mass of data is clear: peer support is a gamechanger for the mental, physical, and social well-being of individual trans people. The power of peer support for the well-being of trans people is not a new finding. From the natural and social sciences to the fine arts and humanities, scholars thinking and writing about trans people consistently report that peer connections lead to positive outcomes (Armangau and Figeac 2022; Fairchild 2022; Gosling et al. 2021; Johnson and Rogers 2020; Kia et al. 2021; Wilson and Liss 2022; Worrell et al. 2022).

However, the *structural* dynamics of peer support are often overlooked by researchers, whose unstated assumptions are that the benefits of peer connection are consequences of organic one-on-one relationships. The scholarship that documents the effects of this support tends to neglect those who are facilitating this resource for their communities. A key consequence of this neglect is a partial understanding of the potential and impact of peer support for those receiving it, as well as those facilitating it. As Joksimovíc (2020, 126) writes, leaving these leaders out of the collective conversation is a form of "systemic erasure" and "epistemic injustice." Not only does it erase their accomplishments, but it erases the price they pay and the personal resources that they are required to use to achieve them.

An additional takeaway of my own community-based research into trans community emerges as a signpost guiding us to act, while warning us of the risks: Embed-

dedness in trans community shifts some of the burden of identifying, locating, and accessing that support from individual trans people in need to the grassroots leaders who are organizing it and facilitating others' access to it. The burden of individuals managing cisnormative ways of knowing and being does not disappear in the presence of peer support. Rather, it is transferred to other individuals: leaders who are organizing peer support groups and social gatherings; connecting trans youth to opportunities for self-expression through advocacy, activism, and the arts; educating their neighbors, including K–12 teachers, healthcare providers, social service agents, and other resource gatekeepers or state actors in their communities; and, when traditional service infrastructure fails, organizing events or paying out of their own pockets in order to provide healthcare, food, education, and housing to trans people in their communities.

Since my first weekend at Camp GB in 2014, I have tried to understand how its components could be scaled up to bring the most trans people into community with each other, provide the best resources, and do the work to shift institutional norms in favor of trans lives. Community leaders' aptitude for and commitment to creating and providing resources for others is rooted in their embodied knowledge of familial alienation, resource deprivation, and social isolation. It is strengthened by the oppositional knowledge gained from the collective creation of a transgender standpoint. We might understand trans grassroots labor by situating it in what Hil Malatino (2022, 48) refers to as a "t4t praxis of love" that is about "being with and bearing with; about witnessing one another, being mirrors for one another that avoid some of the not-so-funhouse effects of cisnormative perceptive habits that frame trans folk as too much, not enough, failed or not yet realized." To scale up the transformative power of grassroots trans labor, we must first provide for the trans people who have accepted the burden of this praxis. To maximize the potential of this t4t praxis of love, however, we must raise our collective expectations of where and how trans people are allowed to come together and support each other, and which institutions and individuals we hold accountable to making that happen.

Rather than shifting fully to a mutual aid model of trans community support, defined by Dean Spade (2020, 7) as the "collective coordination to meet each other's needs, usually stemming from an awareness that the systems we have in place are not going to meet them," we must build structural competency by holding social institutions accountable to a praxis of love for transgender, nonbinary, and gender diverse people. In practice, this looks like everyday institutions engaging with the embodied and oppositional knowledges of trans people—listening and responding to our experiences, needs, and desires—without adding to the burden of the trans people they serve, or those who occupy positions in their organizations. One pathway to structural competency is an institutional investment in applied transgender studies scholarship, a field that is determined and uniquely situated to "identify, analyze, and ultimately, improve the material conditions transgender people face in daily life" (Billard et al. 2021; see also Billard, Everhart, and Zhang 2022). This competency takes shape when institutions move beyond inclusion (Johnson 2015) to anticipate and intentionally design for, rather than merely respond to, gender diversity by creating spaces that center trans bodies, trans minds, and trans emotions. Engaging with applied trans studies scholarship facilitates this competency by expanding institutional definitions of gen-

der—requiring institutional stakeholders to rethink who and what counts as trans (Labuski and Keo-Meier 2015)—so that they may account for a range of gendered experiences in their policies and practices. Through structural competency, our everyday institutions become robust against sociopolitical tipping points that destabilize trans communities. Through a reliance on applied trans studies scholarship, rather than partisan talking points, institutions may design for empowerment and guard against constraint for transgender, nonbinary, and gender diverse people.

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BOOK REVIEW

The Transgender Issue: An Argument for Justice by Shon Faye
Allen Lane, London, UK, 2021
ISBN 978-0-2414-2314-1 (hardback), 320 pp. £20.00

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Shon Faye'sfirst book, *The Transgender Issue*, is an uncompromising text underpinned by a socialist framework that sets out "an argument for justice." *The Transgender Issue* resists palatable and often depoliticised ideals of trans "rights" and "equality" in favour of the language and praxis of liberation. The book acknowledges the ways in which systemic and structural forms of oppression and violence reduce the liveability of all lives while focusing specifically on their impact on trans people. Faye does not aim to create an argument that would facilitate the inclusion of trans people in a corrupted capitalist society organised by misogyny and racism. Rather, Faye aims to explore what forms of living otherwise become available to us when we consider transness as a liberatory framework. As a result, Faye's text demonstrates how the demand for trans liberation echoes and overlaps with the demands of workers, socialists, feminists, sex workers, anti-racists, and queer people. In doing so Faye creates a thesis for change dedicated at its heart to coalition.

Staying with the methodological distinctions in *The Transgender Issue,* it is meaningful to acknowledge how Faye orchestrates moments in which trans people can speak *through* her position as a writer. In this narrative-disrupting intervention, Faye contests the persistent expectation that trans individuals need to employ autobiography as a method in seeking and establishing justice. Faye echoes the concerns of scholar Viviane Namaste (2000, 273), who, in her seminal book *Invisible Lives: The Erasure of Transsexual and Transgendered People*, asserts "autobiography is the only discourse in which transsexuals are permitted to speak." Faye contends that while trans memoirs have been important in destigmatising and demystifying trans people's understand-

ing of themselves, the requirement that trans people consistently write from the position of the confessional reduces the methods and genres available to us when speaking both publicly and politically. Faye (2021,15) delivers a short and concise remedy for this requirement: "you don't have to know the intimate details of my private life to support me."

As such, Faye's writing moves to decentre herself and employs a methodology that is cognisant of the ways in which race, ethnicity, class, and education structure who speaks and who is listened to. Faye (2021, 15) makes known the intersections of her social identities that allow for this book to be manifest—namely that she is a "middle-class, white trans woman with a university degree and a strong support network of friends and family." In doing so, Faye acknowledges the ways in which class and race are instrumental in producing a "hierarchy of verisimilitude" (Malatino 2020, 40) which favour white and middle/upper class trans people. In this sense, race and class are undoubtedly mobilising forces in constructing transnormative subjectivities which reify transness within racial capitalist understandings of gendered subjects. In response to the codes of transnormative discourse, Faye moves to amplify the voices of trans people who are not as routinely heard. This method is evident in Faye's writing as she becomes embedded in various community contexts, speaking and sharing information, capturing the texture of people's stories while wholly maintaining their dignity and personhood—a practice not often achieved by the media when telling stories about trans lives.

Trans lives are increasingly presented as controversial culture war topics to "debate" across the UK and (increasingly) Irish media. Faye's book demonstrates that over the past five years, public discussions about trans experiences have been dominated by a media frenzy that rarely includes trans people. We are reduced to a talking point, a debate, or an "issue." Despite increased "positive representation" for trans people, largely localised in media outputs from North America, the material reality of trans life remains unchanged. This is a central motif throughout the text as Faye asserts that positive representation does nothing on its own to achieve redistributive justice. This lack of redistributive justice in the wake of the transgender "tipping point" is evident in the rise in anti-trans attitudes, transphobic legislation, and trans-antagonistic violence that has been reported since 2015 (Carlisle 2021; Haug 2021; ILGA-Europe 2022). Ultimately, *The Transgender Issue* communicates the ways in which media representation—when produced within the cosmology of capitalism—is uninterested in facilitating the protection of trans people. Thus, instead of prioritising representation, in seven incisive and illuminating chapters, Faye addresses a myriad of aspects relevant to trans life, without ever being dogmatic, to orient us toward more ambitious possibilities for justice.

Each chapter is layered with a combination of theory, qualitative and quantitative research, and professional anecdotes, providing a comprehensive introduction for anyone encountering anti-capitalist, transfeminist, abolitionist, and trans liberatory theory and ideals for the first time. In addition to trans people and representation, Faye addresses the needs of trans children and young people; healthcare and institutional transphobia in medical contexts; the significance of class in the experiences of trans people; the centrality of sex worker liberation in trans liberation; state-orchestrated violence against trans people; and the urgency for solidarity between trans peo-

ple, the LGBTQI+ community, and feminists.

This book's structure builds on its liberatory ambition in that it engages the reader in a considered education, outlining the reality of trans oppression before introducing the abolition of capitalism, carceral violence, and white supremacy as central tenets of trans liberation. Throughout the book, transphobia is revealed as a direct product of capitalism, racism, and state power, and transphobia persists because these forces remain unchallenged. In an invigorating and intelligent conclusion, Faye makes direct calls to us not individually, but collectively. Faye is explicit in acknowledging that the existing freedoms afforded to trans people have all been championed by left-wing politics, however she is firm that our full emancipation will never come through parliamentary politics alone. Instead, Faye leaves us with a rubric for "a transformed future" built on protest, civil disobedience, mutual aid, and coalition.

Trans people in the UK and Ireland have recently been subjected to the legitimising of trans conversion therapy (Gallagher and Parry 2022); the publication of anti-trans rhetoric leading to the boycott of Ireland's most popular broadsheet (Trans Writers Union, n.d.); ongoing discrimination toward trans women in sport (Ingle 2021, 2022); a lack of appropriate and timely transition-related care (Ferreyra-Carroll 2021); and outspoken transphobia from world leaders (BBC Sport 2022; Hayes 2022). Faye's book seems almost clairvoyant in its anticipation of what has come since its publication in the context of trans life in the UK and Ireland. In the wake of this ongoing anti-trans rhetoric and violence, *The Transgender Issue* is a book that rarely leaves my bag. This text is considered, rigorously researched, measured, and convincing, and has proved invaluable to my work in advocating for the needs of trans young people in Ireland. I recommend this book wholeheartedly as I am certain it will offer endless learnings to those arriving in search of information and to those already deeply invested in our fight for liberation. I am grateful for the precision, candour and dedication demonstrated in this book but mostly I am grateful for the logic for hope and possibility that Faye has provided us with.

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AVAILABILITY OUTSIDE THE UK

This book is available in the USA under the title *The Transgender Issue: Trans Justice is Justice for All* from Verso, New York, NY, 2022. ISBN 978-1-8397-6839-2 (paperback), 320 pp. $19.95.

BOOK REVIEW

Side Affects: On Being Trans and Feeling Bad by Hil Malatino University of Minnesota Press, Minneapolis, MN, 2022 ISBN 978-1-5179-1209-3 (paperback), 240 pp. $21.95

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I was sitting in my living room attending a virtual biweekly event for transgender people to discuss our mental health. For the first time, I thought about how all of us—trans folks of various gender modalities, ages, and points of transition—just felt kind of *bad*. At first, we discussed how difficult it is to find trans-competent therapists—a task troubled by the exorbitant costs of care in the United States. We suggested books, shared providers' emails, and nodded along when folks stopped short of expressing the full weight of simply *being* as a trans person. Our conversations were sporadic, filled at times with stories marked by long silences coupled with flickering camera screens. At some point, we agreed that no one told us transitioning would make us *feel bad*.

Every so often, you must grapple with a book that you thought you knew how you would feel as you read it. As a trans person, I am used to feeling bad. As a trans person, I am *not* used to hearing (or reading) other people articulate those bad feelings. Hil Malatino's new book, *Side Affects: On Being Trans and Feeling Bad* somehow captures the knowing glance cast toward the only other trans person in the room, the shudder of the wrong honorific, and the vexation of needing to perpetually defend your existence.

Side Affects describes itself as a reckoning with feeling bad and the bad feelings specific to trans ontology. Moving beyond individualized feelings, Malatino locates fatigue, numbness, envy, rage, and burnout as structurally produced phenomena that

shape trans ways of being. Organized into six chapters, *Side Affects* can be read in any order and each chapter can stand alone. When read together, though, Malatino's explorations of fatigue, numbness, envy, rage, and burnout weave together affective attunements so often understood, but often unspoken by trans folks.

Each chapter opens with theoretical musings, Malatino's own experiences with the respective bad feeling, and an application of the theoretical implications of said bad feelings to trans media about transition. Drawing heavily on Lauren Berlant's (2011) theorization of cruel optimism, the first chapter on fatigue analyzes how transition vlogs affirm a particular vision and timeline of transition that becomes the measurement for transness and transition progress. For many, access to transition-related medical care is hindered by a variety of oppressive structures and the aspirational marker of "post-transition" is always just out of reach. An inability to reach a desired future places trans people in "lag time," where they are subjected to continual wearing away, making life exhausting.

The second chapter articulates how repeated misrecognition disorients our understood embodiment. Thinking through Sara Ahmed's (2006) work in *Queer Phenomenology* and Gayle Salamon's (2010) work in *Assuming a Body*, Malatino approaches cultivated tolerance for moments of confusion and refusal by others to argue that numbness, flat affect, and emotional disengagement are a response to persistent disorientations. Malatino directly states that numbness should not be "stigmatized, dismissed, or easily glossed" or be suggested to dissipate "post-transition" (76). Numbness is a vital affect that makes room for uncertainty in the aftermath of misrecognition so that we may survive our own hypervigilance generated by instability.

Carefully navigating through envy, the third chapter reads envy as a response to structural inequities, rather than failings of the moral self, through Sianne Ngai's (2007) work in *Ugly Feelings*. Envy alerts us to what might be possible and indicates where deprivation occurs. Moving beyond the self, envy hints at a political consciousness that tells us we deserve more than just survival. Envy invites us to think about what is possible when we deem our desires acceptable rather than acquiescing to transnormative narratives of "dysphoria" that link transness to hardship.

Rage appears in the fourth chapter as a key resource for trans survival that orients us towards transformation. Drawing on the works of Ahmed, Judith Butler, María Lugones, and Baruch Spinoza, Malatino argues that rage moves us from disorientation by breaking our understanding of the present, providing a renewed and transformative orientation towards an alternate space-time. Trans people are frequently dependent on relationships and institutions that sustain our survival while simultaneously threatening it. For example, doctors often pathologize transness while supplying us with hormones, and we must often cohabitate with people who refuse to gender us correctly in our shared homes. Malatino contends that, in order to live, trans people must break with what enables their survival, thus compromising their livelihoods. Rage becomes a "sense-making tool" of these series of breaks, becoming both a breaking point and a break from the present. Trans rage alerts us to injustice while providing a sense of what could be possible with an infra-political ethics of care that bears witness to rage and encourages trans world-building.

The landscape past tired, or burnout, is the central affect of chapter five. Trans burnout comes specifically from economies of scarcity that influence access to medical

care and recruit trans subjects to perform voluntary "gender work" without addressing structural transantagonism. "Voluntary gender workers" help shepherd newer trans people into discourses that maximize their chances of receiving the services they need from the health system. This labor is exhausting, but unlike conventional paradigms of burnout, it revolves around consumption rather than production. Trans people are forced to shape themselves into the ideal consumer of biomedical services to access needed resources, creating a hierarchy of "good" and "bad" trans patients who do or do not fit a pathological model of transness. No matter where one sits on the hierarchy—as an enforcer attempting to help others navigate the system effectively or as a dropout who rejects these models altogether—they cannot perpetually maintain a perfect trans consumerist affect. No matter what approach one takes to the medical system, they eventually find themselves at an impasse. This unique, consumption-focused model of burnout breeds exhaustion and annoyance with oneself and others.

Side Affects concludes with a chapter that traces how trans discourses of healing are entangled with psychedelics, New Age spirituality based in cultural appropriation, and racial exclusion. Working through a series of archival correspondences between Harry Benjamin—a key proponent of mid-century transition care—and Robert Masters—an LSD researcher and sexologist—Malatino finds explicit remarks of racial eugenics. Malatino questions how the racist and colonial legacies of Benjamin and Masters' work shape transition access and discourses of spirituality that emerge in modern-day practices of self-care for trans folks. Drawing on Arun Saldanha's (2007) theorization of "white viscosity," Malatino argues that utopian visions that rely on a collection of disparate cultural practices that romanticize wholeness or self-actualization by fetishizing non-Western practices make white bodies stick to each other. Even trans practices of healing are not exempt from the structural disparities that impact the negative affects described in the first five chapters of this book. Malatino concludes this chapter with an anecdote about the banality of happiness, shedding light on why and how they came to their decidedly unhappy subject matter in *Side Affects*.

Malatino's thoughtful navigation of the negative affects experienced by trans folks makes this text necessary reading scholars in trans studies; women's, gender, and sexuality studies; philosophy; and beyond. I am particularly excited to see how scholars take up Malatino's concluding chapter on white viscosity and New Age movements to think about how capitalism influences trans folks' practices and packaging of healing. *Side Affects* offers robust applications of theories from Ahmed, Berlant, Butler, Salamon, and Spinoza, as well as Gilles Deleuze and Félix Guattari, that are often considered opaque, rendering them clear in their relatability to trans experience. As I parse through my trans peers' reflections on mental health, Malatino's theorizations of fatigue, numbness, envy, rage, and burnout help me interpret how structural powers impact our emotional lives. At a time of increased attacks on trans people's sense of being, *Side Affects* provides a guide to explore intense experiences that offers a partial balm.

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