BULLETIN OF APPLIED TRANSGENDER STUDIES

VOLUME 2 ISSUE 3–4 WINTER 2023

BULLETIN OF APPLIED TRANSGENDER STUDIES

published by Northwestern University Libraries on behalf of the Center for Applied Transgender Studies in Chicago, Illinois, USA

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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.

ISSN 2769-2124

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ORIGINAL ARTICLE

Transgender In Court: Judicial Interpretations of Gender Identity from 1966 to 2022

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As the number of transgender legal cases reaching American courts increases, a growing body of scholarship has begun to examine how judges and institutions struggle to reconcile gender variance in a system with deeply entrenched gender normativity. Scholars have examined how judges become the interpreters of gender when presiding over cases concerning transgender inclusion and civil rights, constructing narratives of what it means to be transgender and codifying it as law. This paper presents a novel systematic analysis of judicial frameworks courts use to adjudicate gender identity. Analyzing 70 court opinions from 1966 to 2022, I examine how judges rhetorically describe gender variance and gender variant people to anchor them within deeply entrenched gender normativity. Updating and recontextualizing past scholarship within the current post-Bostock transgender rights crisis, I present a typology of four categories of judicial interpretation—biological gender essentialism, medicalism, assimilationism, and deferential to the litigant—and note other rhetorical and juridical trends for interpreting gender variance. I argue that the frameworks that most likely lead to a trans litigant's victory are ones which reify the gender binary and pathologize transgender people, and discuss the problematics of that success.

KEYWORDS transgender law and litigation; gender identity adjudication; transgender legal cases; judicial interpretation of gender; gender normativity in court
DOI 10.57814/7576-X746

When presiding over sex classification and trans discrimination cases, judges become the legal interpreters of gender and codify their understanding into law.[1] Judges con-

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[1] Terminology for gender variance is continuously evolving. Because some court opinions and sources referenced in this paper use "transsexual" and others use "transgender," I use "trans" to avoid confusion.

struct their beliefs of what gender and sex are and how bodies are categorized, and trans litigants must "prove" they are their asserted gender within these frameworks in cases concerning discrimination, legal name changes, access to health care, and more. In ruling on the validity of a transgender litigant's claims, a judge must mediate competing epistemologies and explain the basis on which they define the boundaries of gender. Here, the judge becomes the arbiter of what gender is and constructs the boundaries of gender when deciding how to categorize the trans person before them. The court can probe a transgender litigant and ask: "When is a man a man, and when is a woman a woman? And the court, not the transgender person, gets to answer" (Vade 2004, 297).

This paper examines the negotiation of gender and gender variance[2] through court adjudications where judges deliberate on the tenability[3] of the litigant's asserted gender identity. Queer[4] people unsettle conventional categorizations of gender, and judges and institutions struggle to reconcile gender variance in a system with deeply entrenched gender normativity. When judges decide claims raised by transgender litigants on the basis of gender tenability, "they comment on and help construct not only transsexual identity but their own identity as confident interpreters of gender" (Keller 1999, 339). Often, judges seem perplexed by having to define gender, yet at the same time feel constrained to make the litigant legible in their normative worldview, not unlike other members of society in everyday social interactions (Keller 1999, 348). They draw on non-legal sources such as gender stereotypes, medical and scientific tes-

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[2] I use the term gender variant/variance broadly to refer to people whose gender identity and/or expression does or is perceived to not match stereotypical gender norms associated with their birth-assigned gender. This includes transgender binary, nonbinary, and intersex people, as well as gender-nonconforming people. Sometimes I use transgender interchangeably with gender variant since transgender identities are the focus of the essay, but some people who fit the above definition do not self-identify as transgender. For instance, masculine women may fit the above definition of transgender, yet not all masculine women identify as transgender. Similarly, drag queens and kings defy conventional expectations of maleness and femaleness, but not all drag queens and kings self-identify as transgender (Vade 2004, 297).

[3] Susan Ellen Keller (1999) explains: "The different models for understanding transsexual identity can be plotted along an axis of 'tenability,' a term used by sociologist Dave King. According to King, '[t]enability … refers to the issue of whether or not the behaviour is considered acceptable on the basis of some standard-whether medical, religious, political or whatever.'"

[4] Queer, being used here as an umbrella term for gender and sexual minorities, is a contentious term. As Dylan Vade (2004) explains: "There is a debate concerning the appropriate use of words such as 'queer,' 'dyke,' and 'fag.' These words can certainly be used as epithets. Some people within the LGBT (Lesbian, Gay, Bisexual, and Transgender) communities prefer that people outside of the LGBT communities not use these terms. Yet, within parts of the LGBT communities, the words are reclaimed and used proudly." This article uses 'queer' in a descriptive and celebratory, not derogatory, sense. For a more detailed discussion, see Michelangelo Signorile, "The Word 'Queer' Belongs in the Mainstream," Newsday, November 25, 2003.

timony, "common sense" reasoning, and facts about the litigant's childhood. This has involved invasive evidence-collecting like gathering testimony from family and community members, scrutinizing the litigant's genitals,[5] inquiring whether they urinated seated or standing,[6] noting what undergarments they wear,[7] and evaluating what sexual acts they perform with their spouses (Romeo 2004, 727–28). Judges have also often held a litigants' body, dress, behavior, and lifestyle against higher gendered standards than their cisgender (i.e., non-transgender) counterparts (Vade 2004, 271–72). Judges have cast doubt on a trans litigant's identity based on traits or choices that cisgender people enjoy innocuously, like having a unisex name or working in a traditionally gendered occupation.[8]

Sometimes a judge's explanation of why a litigant is male or female takes on an editorializing undertone, reflecting on existential implications of destabilizing the sex binary and labeling gender variance as immoral, fraudulent, and perverted. Judges have described transgender people in remarkably insulting ways such as comparing them "gargoyles of medieval architecture, with their distortion of human and animal figures,"[9] analogizing gender transition with the desire to transform into a donkey,[10] and reciting an expert's testimony about how they are "among the most miserable people I have ever met."[11] Occasionally a judge will affirm a litigant's identity and explain the criteria the litigant met that legitimized their gender, like undergoing certain surgeries or wearing appropriately gendered clothing. Legal constructions of gender variance, and what it takes to "prove" you are your gender in court, send symbolic messages about the social meanings of male, female, normative, and deviant (Levit 1998, 64). It also has material implications for transgender legal equality and the distribution of life chances by administrative and legal systems (Spade 2015, 5).

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[5] M.T. v. J.T., 140 N.J. Super. 77, 355 A.2d 204, 1976 N.J. Super. LEXIS 895 (Superior Court of New Jersey, Appellate Division March 22, 1976).

[6] Kantaras v. Kantaras, 884 So. 2d 155, 2004 Fla. App. LEXIS 10997, 29 Fla. L. Weekly D 1699 (Court of Appeal of Florida, Second District July 23, 2004).

[7] Meriwether v. Faulkner, 821 F.2d 408, 1987 U.S. App. LEXIS 8105 (United States Court of Appeals for the Seventh Circuit June 4, 1987).

[8] See Phillips v. Michigan Dep't of Corrections, 731 F. Supp. 792, 1990 U.S. Dist. LEXIS 2332 (United States District Court for the Western District of Michigan January 26, 1990), where a judge remarked on expert testimony claiming that a trans woman was not truly a woman because she had a unisex name (Lindsey) and worked in a male-dominated job (being a female impersonator).

[9] In re Petition of Richardson to Change Name, 1982 Pa. Dist. & Cnty. Dec. LEXIS 332, 23 Pa. D. & C.3d 199 (Common Pleas Court of Dauphin County, Pennsylvania September 24, 1982).

[10] Ashlie v. Chester-Upland School District, 1979 U.S. Dist. LEXIS 12516 (United States District Court for the Eastern District of Pennsylvania May 9, 1979).

[11] Anonymous v. Weiner, 50 Misc. 2d 380, 270 N.Y.S.2d 319, 1966 N.Y. Misc. LEXIS 1868 (Supreme Court of New York, Special Term, New York County May 18, 1966).

LAW AND IDENTITY

Law generates and maintains identity categories, and scholars of gender adjudication have much to learn from critical race theorists in subjecting the legal system to radical critique (Currah 2002, 714). Scholars have explored how "the modern adjudication of sex puts courts and agencies to work in ways that resemble the administration of an earlier set of socially constructed categories: racial classifications and the racial caste system" (Ezie 2011, 168). Endeavors to police non-white bodies and maintain racial hierarchies of privilege and subordination created the legal construction of whiteness. When people went to court to challenge their designation as slaves, to defend their status as free persons, to seek citizenship, to determine the school district in which a child belonged, and to bring accusations of reputational injury, the courts were tasked with making racial determinations of who was white and what "whiteness" was (Ezie 2011, 168–69). In his book, *White By Law,* Ian Haney Lopez (1996, 542–43) explains how naturalization cases especially "forced the courts into a case-by-case struggle to define who was a 'white person'" and if "race was to be measured by skin color, facial features, national origin, language, culture, ancestry, the speculations of scientists, popular opinion, or some combination of the above… the courts had to wrestle in their written decisions with the nature of race in general and of white racial identity in particular." In deliberations on race, courtrooms were sites of racial theater, requiring that litigants performed a racial identity while simultaneously constructing the categories and borders of race through these performances (Ezie 2011, 171).

A similar process can be recognized within the legal constructions of "manhood" and "womanhood" to maintain a hierarchy between the sexes and imbue bodies with social meanings. Constitutional discourse has long ingrained a biological model of sex and gender focused on a natural order, and the courts read the Constitution in ways that preserve a hierarchy of power between the sexes. Historically, this has taken the form of claiming biological differences between men and women matter socially, and therefore must be inscribed legally (Levit 1998, 66). For example, in 1873 Justice Bradley of the US Supreme Court waxed poetic about separate "spheres and destinies" for men and women when denying Myra Bradwell admission to the Illinois bar, claiming that "the constitution of the family organization, which is founded in the divine ordinance, as well as in the nature of things, indicates the domestic sphere as that which properly belongs to the domain and functions of womanhood. (Levit 1998, 66). The Supreme Court employed similar arguments in *Muller v. Oregon* in 1908 to uphold a law restricting women's working hours, concluding that males possessed "superior physical strength," and that "woman's physical structure, and the functions she performs in consequence thereof" justified state intervention (Levit 1998, 68). In this case, and countless others, sex is rendered as biological, ideological, and teleological; a woman's "inferior" biology is evidence of her natural, God-given predisposition for subordinate social roles, and the law must acknowledge and maintain them.

Like legal constructions of race and sex, gender variance is adjudicated as a mixed question of fact, social traditions, ideology, and law. However, trans identity presents legal puzzles distinct from race and sex. Unlike racial minorities and cisgender women, trans litigants face a second line of scrutiny from judges: skepticism of the identity on which the discrimination or reclassification claims are based. Judges tend to not deliberate over the existence of race or if a cisgender woman is a woman. They start with the assumption that such categories exist and then their construction becomes a site of judicial ideation. However, for trans litigants, the judiciary can decide that gender variance is a fiction and gender variant identities are expressions of moral deviancy and psychological disturbance. Any acknowledgement of the trans litigant's claims represents an instance of flexibility on the boundaries of gender, even if they ultimately deny the claim (Keller 1999, 381).

Furthermore, "transgender" is a medico-juridical identity, meaning medicine and law are inextricably bound when interpreting and regulating a gender variant person (Enke 2012, 73). The standards for legal transition, more often than not, have demanded proof of medical transition or written approval from healthcare professionals, who have historically used inflexible criteria for their diagnoses. Activist and scholar Dylan Vade (2004, 272) illustrates this inflexibility with an anecdote from his time in legal aid:

> Since, by and large, the legal and medical communities have a particular view of what it means to be transgender, in order to get rights and/or medical care, transgender people, in these settings, have to conform themselves to the expectations. I have gone to countless transgender support group meetings where transgender people shared: "only if you say x, y, and z about yourself will this doctor/clinic provide you care," or "only if you say x,y, and z about yourself will you get a letter from the doctor that will then allow you to change the gender on your driver's license." Since the Social Security office only recognizes male and female gender identities, I counsel people that using that setting to talk about their complex genderqueer identity may not be the most effective.

Only some genders and gender presentations are intelligible to the courts, medical professionals, and society at large. When trans people cannot be "recognized" by them, they lose their personhood (Garrison 2018, 614). This reflects how "claiming a new public gender identity involves active negotiation" and demands "a story of selfhood that not only claims affiliation with their preferred gender category, but also disclaims affiliation with the sex category assigned to them at birth" (Garrison 2018, 618). What gender presentations are courts willing to accept as legitimate? When confronted with a gender variant person, how do judges re-anchor them within gender norms? How do they articulate the boundaries of gender using tropes or narratives, and when do we see moments of doubt or flexibility in their use?

METHOD

In this article, I examine court opinions from cases involving transgender litigants to investigate how judges reconcile the litigant's gender variance with their preestablished normative views of gender, and how those views may get inscribed into legal discourse. I read the majority opinions of 70 transgender rights cases at the district and appellate level, including the two United States Supreme Court cases with trans litigants, *Bostock v. Clayton County* (2020) and *Farmer v. Brennan* (1994). Legal matters represented in the universe include name and gender marker changes, marriage validity, incarceration, workplace discrimination, school facilities exclusion, parental standing, sports participation, a crossdressing ordinance, Medicaid access, and bathroom access in a private building. To find cases, I looked at cases utilized in past scholarship, precedents cited in recent high-profile cases, and news coverage of trans rights developments, as well as calling upon personal knowledge of important court cases. I then used LexisNexis's Shepardization to snowball with cases that had been cited in the opinion or ones which cited the case. The cases were selected if the legal issue positioned the judge to interpret the plaintiff's gender and rule based on a perception of its legitimacy. Regretfully, I found too few cases regarding intersex and nonbinary litigants to base any findings on them and they have been removed from the case universe. The earliest case used is from 1966 while the latest is from 2022.

Because gender is a nebulous concept, every judge may interpret gender in a different way and elaborate their rationale through different descriptors, criteria, and explanations. Therefore, no prescribed rubric or set of searchable keywords would accurately capture judges' feelings towards gender variance. I read through each opinion to tease out what was written about gender and identified recurring patterns and themes.

Drawing on the past scholarship, I developed a list of rhetorical devices to flag as I read opinions. Following Susan Ella Keller (1999), I looked for the pronouns used for the litigant, name(s) litigant is referred to by, use of metaphors and imagery for describing gender variance, and criteria for how they decide if a transgender person is or is not their asserted gender. Many of the devices are only tangential to the legal outcome; something as small as the pronouns used to refer to the transgender litigant speaks volumes about the judge's perception of the legitimacy of their identity claim. Tonal language is similarly indicative of how they interpret a litigant's gender. For example, a judge writing "Jeanette has altered her body to appear as if she were female" suggests significantly more skepticism than "Jeanette transitioned and lives as a woman." Thus, scrutinizing word choices is key to revealing the judges' attitudes towards gender variance.

I also identify narratives that judges use to reconcile gender variance with the gender binary. Chinyerie Ezie (2011) provides one such approach in their discussion of how law and medicine has naturalized myths of innate binary sex differences and pathologized gender variance. Similarly, Paisley Currah (2003, 716) references the "medical model" of transsexuality used in litigation, where gender variance is conceptualized as a psychological disorder and therefore it is unlawful to discriminate against transgender people based on a pathological condition. I term this "medicalism." I looked for narratives of gender variance as a physical or spiritual affliction curable through medical treatment, including "disordered minds, disordered bodies" tropes (Ezie 2011, 159), "trapped in the wrong body" descriptions (Vade 2004, 271–72), fact-finding from expert medical testimony and medical records, and scrutiny of bodies—particularly genitalia and surgical alterations of them. I also looked for legal conclusions made on the basis of surgery or medical treatments (for example a judge authenticating a litigant's gender because they underwent surgery), and allusion to gender variance being a disorder that deserves legal protection.

Vade (2004, 297) recounts his experience working with transgender litigants and explains that judges value conformity to gender stereotypes when authenticating gender, such as a trans woman who dresses femininely and played with dolls when she was young. This provides a model for my analysis that I term "assimilationism," a term

I borrow from gay and lesbian politics that describes when queer people appeal to heterosexual social norms to gain equality and protection rather than challenge the dominance of those norms (Hequembourg and Arditi 1999, 664). Here, I use it to describe when a litigant's gender is authenticated based on the litigant's perceived conformity to cisgender/patriarchal stereotypes of manhood and womanhood, and/or ruling that a litigant is their gender because their community validates it.

Vade (2004, 297) also argues that courts rely on a sex-gender distinction where sex is more important and real than gender and that a transgender person's biological sex is an insurmountable truth that can never be erased. I looked for presentations of a sex/gender dichotomy where sex is immutable, natural, and real while gender is changeable and less than real, and I borrow the term "biological gender essentialism" to describe it.[12] I paid special attention to court's attempts at defining sex and gender and a fixation on a litigant's genitals, since, as feminist scholars Suzanne Kessler and Wendy McKenna put it, genitals are an essential sign of gender as natural and dichotomous (Currah and Moore 2009, 114).

Finally, I also looked for signs that a judge was willing to affirm the litigant's identity and trust their self-identification. Cases where the judge defers to a lower court for a determination on the litigant's gender do not qualify. This is specifically for if a judge deferred to the litigant and took the self-asserted identity at face value.

ANALYSIS

After examining 70 judicial opinions, I identified four types of legal reasoning and some subtypes within them. These are medicalism, biological gender essentialism, assimilationism, and deferential to the litigant. In this section I present each of the four types and their subtypes and how they reveal themselves in the texts of the opinions. Table 1 lays out an overview of these types.

Medicalism

The first type of reasoning on Table 1 is medicalism, the belief that gender transition could only be legitimized through medical interventions and expert testimony. Medicalism was the most frequent and persistent method of legal conceptualization across all courts, decades, and legal matters. Elevating common sense reasoning with a scientific veneer, judges adopted a conceptualization of sex as changeable with appropriate medical procedures in order to treat a psychologically disturbed mind. The medical model of gender emerged as an alternative to biological gender essentialism by explaining gender variance through pathology. Since biological sex is viewed as an

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[12] "Essentialism—the idea that social groups have meaningful biological differences that explain group-level variation in traits (e.g., ability, personality) and behavior—is a pervasive psychological belief. Broadly, essentialism increases the perceived dissimilarity between social groups and implies observed group differences are inborn, inevitable, and unchangeable" (Wilson et al. 2019, 883). Biological gender essentialists are "people who hold strong gender essentialist beliefs [and] view gender as an inflexible dichotomy (e.g., man or woman) resulting from underlying biological factors such as chromosomes or hormones" (Wilson et al. 2019, 883).

Table 1. Judicial interpretations of gender variance

Type	Reasoning	Examples and subtypes
Medicalism	Sex/gender can be meaningfully changed with appropriate medical intervention.	*Sex as medically alterable.* "Only after Petitioner undergoes his planned sex reassignment surgery will this court grant legal recognition to petitioner's name change."
		The most miserable patients. "A transsexual experiences severe mental anguish over the incongruence between their psychological and physical gender, and has sought medical treatment to alleviate this suffering."
Biological Gender Essentialism	Sex/gender is natural, immutable, and assigned at birth.	*Your gender identity must be the same as your sex, so you lose.* "Throughout the pendency of this case, Petitioner remained both biologically and anatomically identical to biological females—not males."
		Your sex and gender identity are different and sex matters more, so you lose. "Plaintiff claims to be a transsexual woman, whose sense of self differs from their biological makeup. This may be true, however it is generally accepted that a person's true sex is determined at birth by an anatomical examination by the birth attendant."
		Your sex and gender identity are different and sex matters more, so you win. "Discrimination against a plaintiff who is transgender for failing to act and/or identify with his or her birth sex is no different from the discrimination directed against a woman who does not act sufficiently feminine. Thus, it is encompassed by the court's previous rulings on sex discrimination, since the discrimination is based on non-conformity with Plaintiff's birth sex."
Assimilationism	Gender is socially earned through conformity to gender norms and stereotypes.	"Petitioner has been described as a loving mother and wife, and their husband, family, and community accepts them as a woman. They appeared before this court and, were it not for the fact that their background was known to the court, the court would have found it impossible to distinguish this person from any other female."
Defer to Litigant	The litigant's self-asserted identity is respected and uncontested.	"In the complaint, Plaintiff alleges that he identifies as a male, and being a transsexual male he may be considered part of a subgroup of men. There is no reason to permit discrimination against that subgroup."

objective truth, judges rely on medical testimony as objective evidence that biological sex could be transgressed. A trans person's testimony is not considered objective (Vade 2004, 300).

Medicalism is based on the belief that only two genders, male and female, exist and that a trans person suffers from a rare disorder, which means their mental gender is incongruent with their physical gender. This disorder leads to severe anguish and self-harming behavior, as well as antisocial deviant behavior like cross dressing or perverted sexual practices. The affliction can be treated with appropriate medical care from specialized clinics and care teams. To begin this treatment, a trans person must receive a diagnosis of "gender identity disorder" or "gender dysphoria," which is considered by the courts to be a severe psychiatric disorder. The diagnostic criteria have changed over time, but since the 1970's have generally included an on-going desire since early childhood to be the "opposite" gender, a desire to physically modify one's body, and heterosexual desires aligned with the gender with which one identifies (Romeo 2004, 725). Many clinics required that patients live as their asserted gender for years before they would permit surgery to ensure that the patient was truly trans.

In this preoperative period, medical professionals looked for strict conformity to gender norms and stereotypes as proof of a legitimate gender identity. For example, one expert testified in court that they did not believe the litigant had passed the "real life" test because she had chosen an ambiguously gendered name and because some of the work she did was in a male profession (she worked as a "female impersonator," also known as a drag queen).[13] If successful at convincing the medical professionals, one could attain surgery and hormones. Once the body and brain were harmonized, the transition to a new sex was complete and the trans person would be considered worthy of legal recognition.

The most miserable patients

In a truly binary-sexed world, gender variance would not exist. Therefore, characterizing gender variance as disordered is essential to reconciling it with the belief that the gender binary is natural and fixed. As Paisley Currah (2003, 716) notes, "We must remember that the purpose of any pathologizing discourse is not simply to define the 'sick,' but also to describe and identify the 'healthy,' and to set the boundary between them." Courtrooms became the site of medical theater. Expert testimony used sensational language to illustrate trans litigants' anguish and emphasized their "sickness" through vivid descriptions of self-harm. Language emphasizing victimhood garnered sympathy, placing the trans person at the mercy of misfortune and undeserving of their suffering. One doctor testified that the transsexual was "among the most miserable people I have ever met."[14] Another's definition of transsexuality emphasized the litigant's agony: "a transsexual believes that he is the victim of a biologic accident, cruelly imprisoned within a body incompatible with his real sexual identity."[15] A third definition conjured images of spiritual suffering, saying that "they consider themselves to be members of the opposite sex cursed with the wrong sexual apparatus."[16] Descriptions of litigants as "cruelly imprisoned" in the wrong body made multiple appearances, invoking carceral imagery to portray the litigant as in need of medical treatment to become free.

Judges imposed their own perceptions of medicalization, describing gender affirming care in shocking language and highlighting the litigant's mental disturbanc-

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[13] *Phillips* 1990 U.S. Dist. LEXIS 2332.

[14] *Anonymous*, 1966 N.Y. Misc. LEXIS 1868.

[15] *Meriwether*, 1987 U.S. App. LEXIS 8105.

[16] Richards v. United States Tennis Asso., 93 Misc. 2d 713, 400 N.Y.S.2d 267, 1977 N.Y. Misc. LEXIS 2670 (Supreme Court of New York, Special Term, New York County August 16, 1977).

es such as calling hormone therapy “chemical castration”[17] or declaring that “someone eager to undergo this mutilation is plainly suffering from a profound psychiatric disorder.”[18] Judges also fixated on self-harming behavior to confirm that gender variance is a severe malady. For example, the opinion in *White v. Farrier* (1988) lists all four of the litigant’s previous attempts at self-castration and which instruments were used, and the opinion in *Wolfe v. Horn* (2001) links the litigant’s gender identity disorder to histories of depression, alcoholism and suicidal impulses. In cases where the trans litigant succeeded, judges tended to highlight the litigant’s suffering and sympathetically framed medical transition as a therapeutic relief.[19] Where trans litigants failed, judges often cast litigants as deranged and gender transition as barbaric.[20] The body of medicalist cases erected a barrier between the “sick” trans person and the “healthy” cisgender person, and concluded that the only way of curing the former was by converting them to the latter.

Sex as medically alterable

At the crux of medicalism is the belief that although sex is a biological reality, sex can be meaningfully changed with appropriate medical intervention. The majority of these cases elevate genital reassignment surgery as a necessary condition for a successful transition. In judicial opinions there were typically two justifications for this: 1) irreversible genital modification demonstrated a commitment to living as the other sex or 2) conceptions of maleness and femaleness often centered the ability to perform penetrative heterosexual intercourse, even if such intercourse would not lead to procreation. Regarding the first, judges feared that allowing self-identified trans people to legally reclassify their sex would open the door to criminals changing their identity documents for fraudulent purposes. To make sure trans people were not “perpetrating fraud upon the public,” judges sought out evidence that litigants were “permanently committed to living as a member of the opposite sex.”[21] Courts assumed that someone superficially interested in transitioning genders, or who sought to perpetrate fraud, would not go to such drastic lengths as surgical genital modification. Thus, genital surgery became a hurdle for trans litigants seeking legal reclassification.[22]

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[17] *Meriwether*, 1987 U.S. App. LEXIS 8105.

[18] Maggart v. Hanks, 131 F.3d 670, 1997 U.S. App. LEXIS 34413 (United States Court of Appeals for the Seventh Circuit December 9, 1997).

[19] See Pinneke v. Preisser, 623 F.2d 546, 1980 U.S. App. LEXIS 16219 (United States Court of Appeals for the Eighth Circuit June 27, 1980): “[M]edical testimony establishes that this treatment, sex reassignment surgery, is the only procedure available for treatment of the condition from which Pinneke suffers, transsexualism, and was medically necessary for her, based upon an individualized medical evaluation.”

[20] See *Maggart*, 1997 U.S. App. LEXIS 34413: “Someone eager to undergo this mutilation is plainly suffering from a profound psychiatric disorder.”

[21] *In re* Harris, 707 A.2d 225 (Pa. Super. Ct. 1997).

[22] See Matter of McIntyre, 552 Pa. 324, 715 A.2d 400 (Pa. 1998): “this court holds that the complete and irreversible act of sex reassignment surgery will legally change the person of Robert Henry McIntyre into Katherine Marie McIntyre. Only after petitioner undergoes his planned sex reassignment surgery will this court grant legal recognition.”

Furthermore, some judges who struggled to define gender turned to the most common gendered pastime for direction—sexual intercourse. Heterosexual penetrative sex has clearly delineated and hierarchical roles based on gender, and it is imbued with social meaning. In the heteronormative societal imaginary, a sexually dominant male penetrates a sexually submissive female with his penis, and the act of giving is masculinized and receiving is feminized even between same-sex partners. Therefore, gaining the sexual abilities of the other sex or losing the sexual abilities of one's sex assigned at birth constituted a transformation worthy of recognition. In *M.T. v. J.T.* (1976), the court notes that an examination of the litigant's vagina revealed that "her vagina had a 'good cosmetic appearance' and was 'the same as a normal female vagina after a hysterectomy'," capable of being penetrated by her husband's penis.[23] As such, the litigant was no longer a male "since she could not function as a male sexually either for purposes of 'recreation or procreation.'"[24] Alternatively, in *Frances B. v. Mark B.* (1974), a trans man's marriage was invalidated because he did not have a penis and thus could not fulfill the obligations of a husband.[25] Additionally, courts were particularly worried about trans people tricking heterosexual people into marrying someone of the same sex, with one judge fearing that permitting a trans person to change their name "would start us down the slippery slope to judicially legislating same-sex marriages."[26] Defining gender by conformity to heterosexuality mitigated the threat gender variance poses to heteronormativity by demanding that trans people conform to heterosexual anatomy and lifestyles.

Some cases, particularly more recent ones, permitted other types of medical intervention as grounds for a successful transition, including hormones and breast removal or augmentation. Still, judges used normative cisgender bodies as barometers for gender tenability. Litigants who were successful under medicalist frameworks changed their bodies to match their cisgender counterparts as closely as possible, undergoing years of psychological evaluation and expensive procedures. Those who could not or did not want to adhere to cisgendered norms were dismissed as illegitimate or mentally ill. Medicalism puts trans people in what Dean Spade (2006, 328) rightfully calls a "double bind"—it is just as pathological not to adhere to gender norms as it was to adhere to them.

Biological Gender Essentialism

The second type of legal reasoning, as identified in Table 1, is biological gender essentialism, where judges declared that a litigant's biological sex superseded feelings of gender dysphoria, medical procedures, and other markers of gender transition. The majority of these cases are at the appeals court level concerning marriage validity and workplace discrimination. In this approach, the court conceptualizes trans people as someone whose self-identity is in conflict with their real biological and anatomical

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[23] *M.T.*, 1976 N.J. Super. LEXIS 895.

[24] *M.T.*, 1976 N.J. Super. LEXIS 895.

[25] Frances B. v. Mark B., 78 Misc. 2d 112, 355 N.Y.S.2d 712, 1974 N.Y. Misc. LEXIS 1341 (Supreme Court of New York, Special Term, Kings County April 23, 1974).

[26] *In re* Application of Marriage License for Nash, 2003-Ohio-7221, 2003 Ohio App. LEXIS 6513 (Court of Appeals of Ohio, Eleventh Appellate District, Trumbull County December 31, 2003).

sex. The biological model of gender categorizes all bodies into one of two strict categories, male or female, based on anatomy at birth. This sex designation is viewed as dimorphic, innate, and unchangeable.

The traits that determine one's biological sex include external genitalia, internal reproductive organs, secondary sex characteristics, and chromosomes, but these are relied upon in inconsistent combinations. As gender-affirming medical care has become more advanced and accessible, biological gender essentialists have had to devise new indicators of one's "true" sex, such as one North Dakota lawmaker who attempted in 2022 to legislate a definition of gender as being established by one's DNA (SB 2199, 68th Legislative Assembly of North Dakota). The model further assumes that those with male biology present a masculine gender identity and those with female biology present a feminine gender identity, and that those presentations are the natural product of their sex. Since biological sex is immutable, being trans is something you *do*, not something you *are*. Starting with this premise, judges typically express biological gender essentialism following one of three legal narratives as identified in Table 1.

"Your gender identity must be the same as your sex, so you lose."

Deviation from the biological sex binary is considered unnatural, and transgressive performances of gender are characterized as artificial. Some cases, especially earlier ones, refuse to acknowledge a legal difference between gender identity and sex. They concluded that sex should be given its "traditional definition" of biologically determined and immutable when interpreting statutes.[27] All medical transitions, no matter how convincing, are futile attempts to artificially recreate what can only be bestowed by nature. Judges have ridiculed trans litigants' medical transitions, with one proclaiming that a woman "cannot be created from what remains of a man"[28] and another stating that "assuming, as urged, that defendant was a male entrapped in the body of a female, the record does not show that the entrapped male successfully escaped."[29] One judge likened a trans woman's desire to change her legal name to a "freakish rechristening" that would "pervert the judicial process."[30] Fully denying self-identification on its face, no trans litigant could succeed. The use of this narrative waned as medicalism and the other two types of biological gender essentialism increased in frequency. However, the Eleventh Circuit revived the logic in 2022, ruling that a transgender boy was legally identical to a cisgender girl because of their immutable biological traits.[31]

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[27] Sommers v. Budget Marketing, Inc., 667 F.2d 748, 1982 U.S. App. LEXIS 22775, 27 Fair Empl. Prac. Cas. (BNA) 1217, 27 Empl. Prac. Dec. (CCH) P32,318 (United States Court of Appeals for the Eighth Circuit January 8, 1982).

[28] Ulane v. Eastern Airlines, Inc., 581 F. Supp. 821, 1983 U.S. Dist. LEXIS 10383, 35 Fair Empl. Prac. Cas. (BNA) 1332, 34 Empl. Prac. Dec. (CCH) P34,334 (United States District Court for the Northern District of Illinois, Eastern Division December 28, 1983).

[29] *Frances B.*, 1974 N.Y. Misc. LEXIS 1341.

[30] *Richardson*, 1982 Pa. Dist. & Cnty.

[31] Adams v. Sch. Bd. of St. Johns Cnty., 57 F.4th 791, 2022 U.S. App. LEXIS 35962, 29 Fla. L. Weekly Fed. C 2011 (United States Court of Appeals for the Eleventh CircuitDecember 30, 2022).

"Your sex and gender identity are different and sex matters more, so you lose." Here, judges acknowledged the litigant's sincerely held identity but concluded that biological sex carries more legal weight. Although both exist and may differ, biological sex is considered real while gender identity is less than real. For example, the court in *Littleton v. Prange* (1999) agreed that "there are individuals whose sexual self-identity is in conflict with their biological and anatomical sex," but held that a post-operative trans person is still their birth sex because "[t]here are some things we cannot will into being. They just are."[32] Similarly, in 1977 the Supreme Court of Oregon acknowledged that a trans woman underwent a sex change but decided that birth certificates were meant to record sex at birth and not any time after and denied her petition for legal reclassification.[33] In *Hispanic Aids Forum v. Estate of Bruno* (2005), the New York Supreme Court reversed a decision protecting a clinic serving Hispanic AIDS patients whose landlord suspended their lease due to complaints about trans people using bathrooms in the building. The court's rationale relied on the conclusion that "the defendants' designation of restroom use, applied uniformly, on the basis of 'biological gender,' rather than biological self-image, was not discrimination."[34] Although a judge could recognize, and perhaps even sympathize with, people with lived experiences of gender variance, biological sex was considered superior to self-identification and was more deserving of legal recognition.

"Your sex and gender identity are different and sex matters more, so you win." Biological gender essentialism denies the reality of gender variance and discredits trans people's lived experiences. Yet, in employment discrimination cases, biological gender essentialism has become key to achieving protection for trans people under Title VII of the Civil Rights Act. The reshaping of biological gender essentialism followed the US Supreme Court's ruling in *Price Waterhouse v. Hopkins* (1989). In *Price Waterhouse*, a female senior manager in an accounting firm had been denied partnership in the firm because she was considered too masculine. This constituted sex discrimination because it would not have occurred but for her sex, and an employer could not punish employees for failure to conform to the stereotypes of one's sex. The Sixth Circuit utilized this logic to protect trans people's gender expression in *Smith v. City of Salem* (2004). Because trans people defy the expectations placed upon their birth sex, the judge drew a direct comparison between trans employees and the cisgender *Price Waterhouse* plaintiff: "[D]iscrimination against a plaintiff who is a transsexual—and therefore fails to act and/or identify with his or her gender—is no different from the discrimination directed against Ann Hopkins in Price Waterhouse, who, in sex-stereotypical terms, did not act like a woman."[35] This was a pivot point for trans workplace protections, but one only possible by making trans people equivalent to gender-nonconforming cisgender employees.

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[32] Littleton v. Prange, 9 S.W.3d 223, 1999 Tex. App. LEXIS 7974 (Court of Appeals of Texas, Fourth District, San AntonioOctober 27, 1999).

[33] K. v. Health Div., Dep't of Human Resources, 277 Ore. 371, 560 P.2d 1070, 1977 Ore. LEXIS 1124 (Supreme Court of Oregon March 3, 1977).

[34] Hispanic Aids Forum v. Estate of Bruno, 16 A.D.3d 294, 792 N.Y.S.2d 43 (N.Y. App. Div. 2005).

[35] Smith v. City of Salem, 378 F.3d 566 (6th Cir. 2004).

Fastening gender identity discrimination onto sex stereotyping reasoning situates gender variance as merely an atypical derivative of a litigant's legible biological sex. This proved remarkably persuasive and culminated in the United State Supreme Court's *Bostock v. Clayton County* (2020), where the Court delivered a landmark ruling that Aimee Stephens, who had been fired after coming out as transgender, was the victim of sex discrimination. Trans people's gender expression was therefore protected under Title VII as an extension of their sex and the sex stereotyping doctrine. For example, if a male employee and a female employee bring their wives to a company event but only the female employee is punished, her sex is the distinguishing factor. Similarly, if a cis man and a trans man both wear the men's employee uniform but only the trans man is fired, "the individual employee's sex plays an unmistakable and impermissible role in the discharge decision."[36] Thus, "to discriminate on these grounds requires an employer to intentionally treat individual employees differently because of their sex."[37] This transforms gender identity into a subordinate legal category—one which is changeable, secondary, and reliant on sex for legal recognition.

The ruling in *Bostock* upholds biological sex as an unshakeable, controlling truth of the plaintiffs' existences. A trans person who has transitioned in conformity with normative gender standards, who "passes" fully and has medically transitioned, remains anchored to their assigned sex at birth under the law. Although the opinion affirms Aimee Stephens' identity in the factual portion of the opinion, explaining that "Stephens presented as a male" before transitioning, the legal ruling necessarily reduces her to her biological sex.[38] The Court expounds that the dissimilarity between Stephens and other women is fixed as an incident of her birth. It is not her identity as a transgender woman, but rather her ineffaceable biological sex, that creates a route for her to seek legal repair. The opinion by Justice Neil Gorsuch alludes to this distinction, saying:

> When an employer fires an employee because she is homosexual or transgender, two causal factors may be in play—both the individual's sex and something else (the sex to which the individual is attracted or with which the individual identifies). But Title VII doesn't care. If an employer would not have discharged an employee but for that individual's sex, the statute's causation standard is met, and liability may attach.[39]

Gender identity is merely a "something else," even if the employer intended to discriminate against trans people. The incorporation of trans people under Title VII is indeed a win for trans employees everywhere. Yet, the victory comes at a cost to trans legal equality by undercutting legal legitimization of gender variance and positioning it as secondary to sex.

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[36] Bostock v. Clayton County 140 S. Ct. 1731, 207 L. Ed. 2d 218, 2020 U.S. LEXIS 3252, 104 Empl. Prac. Dec. (CCH) P46,540, 28 Fla. L. Weekly Fed. S 294 (Supreme Court of the United States June 15, 2020).

[37] *Bostock*, 2020 U.S. LEXIS 3252.

[38] *Bostock*, 2020 U.S. LEXIS 3252.

[39] *Bostock*, 2020 U.S. LEXIS 3252.

Assimilationism

The third reasoning on Table 1 is assimilationism, where litigants socially earn their gender by conforming to gender norms and stereotypes. Trans litigants were victorious in the few cases with assimilationist reasoning, although assimilation was never the dominant method of reasoning. Judges usually buttressed medicalist conclusions with descriptions of social gender compliance as evidence that the medical transition was successful. Even when judges did not overtly turn to gender conformity as a standard, adherence to gender norms often flavored their interpretations of the trans litigants. Judges took notice of what attire litigants wore to appear in court,[40] what undergarments they preferred day-to-day,[41] their participation (or lack thereof) in gendered childhood activities,[42] if they experienced satisfying relationships with family and others while presenting as their gender,[43] and if they convincingly passed as their gender among the general public.[44] One judge marveled at their own inability to find a fault in the litigant's gender presentation: "The applicant appeared before this court and, were it not for the fact that petitioner's background was known to the court, the court would have found it impossible to distinguish this person from any other female."[45] Yet, no judge was persuaded to rule in favor of a trans litigant based on their passable gender presentation alone.

Defer to Litigant

Judges seldom gave legal weight to a trans litigant's self-identification unless it was backed by scientific testimony and a diagnosis. But in these few cases, all trans litigants succeeded on their claims. In some earlier cases involving legal name changes, judges invoked personal freedom and judicial restraint, declaring that "a person has a right to a name change" and that a trans person's gender presentation is "a matter which is of no concern to the judiciary."[46] In later appellate equal protection cases concerning youth in schools such as *N.H. v. Anoka-Hennepin School District* (2020), *Doe v.*

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[40] *In re* Dowdrick, 1978 Pa. Dist. & Cnty. Dec. LEXIS 434, 4 Pa. D. & C.3d 681 (Common Pleas Court of Cumberland County, Pennsylvania February 2, 1978).

[41] See *Meriwether*, 1987 U.S. App. LEXIS 8105: "She has feminine mannerisms, wears makeup and feminine clothing and undergarments when permitted, considers herself to be a female, and in fact has been living as a female since the age of fourteen."

[42] See *M.T.*, 1976 N.J. Super. LEXIS 895: "M.T. testified that she was born a male… As a youngster she did not participate in sports and at an early age became very interested in boys."

[43] *In re* Estate of Araguz, 443 S.W.3d 233, 2014 Tex. App. LEXIS 1573, 2014 WL 576085 (Court of Appeals of Texas, Thirteenth District, Corpus Christi - Edinburg February 13, 2014).

[44] See *Harris*, 707 A.2d 225: "For twenty-two years, petitioner's visage has been such that, but for those times when he must present official identification, he convincingly passes among the general public as a woman. As such, we find that a legal name change would benefit both petitioner and the public at large and, in accordance with good sense and fairness to all concerned, should have been granted."

[45] *In re* Anonymous, 57 Misc. 2d 813, 293 N.Y.S.2d 834, 1968 N.Y. Misc. LEXIS 1197 (Civil Court of the City of New York, New York County September 17, 1968).

[46] Matter of Eck, 245 N.J. Super. 220, 584 A.2d 859, 1991 N.J. Super. LEXIS 5 (Superior Court of New Jersey, Appellate Division January 11, 1991).

Boyertown (2018), and *G. G. v. Gloucester County School Board* (2016), rulings in favor of trans litigants turn on self-identification, saying that trans boys (none have had trans girls) are similarly situated to cisgender boys solely because of their asserted identity and persistence living as their identity without medical treatments.[47] This approach is inextricable from the litigants' perceived youthful innocence. Past and present demonization of trans people as sexual perverts and corrupting influences has led to courts bearing down on trans people in public spaces, but trans children are considered less of a threat. Trans children, treated as sexless and morally pure, are afforded judicial sympathy that their adult counterparts are not. Further research should explore the implications of the judicial construction of transgender youth, especially as it relates to the political panic around gender affirming care.

CONCLUSION AND IMPLICATIONS

To better understand how judges define gender in cases where the litigant's gender is a legal question, this article offers four main types of reasoning, and several subtypes, extrapolated from 70 court opinions. These types emerged from analyzing the rhetoric deployed by judges as they established gender categories and set criteria for a body's membership in the categories. This work reflects the evolution of trans law and politics into 2022. While this is not the first article to analyze judicial opinions to uncover social and legal constructions of transgender identities, this is the first to do so post-2011.[48] To say that much has changed since then would be an understatement. *Obergefell*, *Bostock*, state legislature upheavals, the Trump administration and escalation of Christian nationalism, momentum of TERF ideology, onslaughts on the bodily autonomy of pregnant people, culture wars around visible queerness, and more have transformed the political conditions of trans existence in the United States. Observations from previous scholarship have been revisited with a retrospective lens. For example, grafting gender identity discrimination to sex discrimination in 2004 marks a novel extension of biological gender essentialist reasoning. While previous works were conscious of this development, we can now trace its impact to the United States Supreme Court's endorsement in *Bostock* and critique how its emergence amplified the dominant view of gender identity as inferior to biological sex.

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[47] Doe v. Boyerton, 897 F.3d 518, 2018 U.S. App. LEXIS 20792, 2018 WL 3581456 (United States Court of Appeals for the Third Circuit July 26, 2018); G. G. v. Gloucester County School Board, 822 F.3d 709, 2016 U.S. App. LEXIS 7026 (United States Court of Appeals for the Fourth Circuit April 19, 2016); N.H. v. Anoka Hennepin School District, 950 N.W.2d 553, 2020 Minn. App. LEXIS 272 (Court of Appeals of Minnesota September 28, 2020).

[48] The most recent work of this nature, as far as the author is aware, is Chinyere Ezie's "Deconstructing the Body: Transgender and Intersex Identities and Sex Discrimination—The Need for Strict Scrutiny" published in the *Columbia Journal of Gender and Law* in 2011. Ezie's work offers a rigorous analysis of legal and rhetorical constructions of sex as it relates to the adjudication of trans and intersex identities and argues for the application of strict scrutiny. There's also *Before Bostock: The Accidental LGBTQ Precedent of Price Waterhouse v. Hopkins* by Jason Pierceson (University Press of Kansas, 2020), which focuses on a much narrower slice of adjudication (employment discrimination) than is covered in this article.

This work is a novel systematic analysis of judges' rhetorical constructions of gender variance, presenting a cohesive scheme for understanding legal interpretations of gender identity. This article deepens the previously identified categories of medicalism and biological gender essentialism rhetoric and contributes the assimilationism and "defer to litigant" types. The scarcity of assimilationism in court opinions reveals how courts view social relationships as a substandard metric of gender tenability, and how earning one's gender socially among family and peers does not translate into legal legitimacy unless authenticated with medical evidence. The uncommonness of deferring to the litigant suggests a hesitancy to bestow self-identification with legal weight for fear of destabilizing binary sex categories and undermining their social authoritativeness. This typology hopefully can be a tool for further investigating the treatment of trans people by the legal system.

The endurance of medicalism over five decades is another noteworthy discovery, and its continued deployment by courts is all the more striking alongside state legislatures' attacks on gender affirming care in the 2010s and 2020s. Medicalism, as used by the courts, perpetuates an oppressive conceptualization of gender as based in the makeup of one's body and its proximity to cisness. However, many trans litigants have succeeded under medicalism, although those rulings turn on the ongoing pathologization of gender variance. Additionally, medicalist standards have loosened over time, shifting from a fixation on genital reconstruction to considering a wider catalog of medical interventions. If courts continually conclude that legal recognition turns on medical transition, might this offer further insight into right-wing suppression of gender affirming care as a movement tactic?

Tracing the evolution of biological gender essentialism reveals that favorable court opinions are often pyrrhic, reimagining and redirecting oppression instead of alleviating it. Victory can only be achieved by inserting trans people into the normative gendered hierarchies without challenging the hierarchy itself. Now, it is true that trans people materially benefit from name changes, workplace nondiscrimination protections, safer conditions in prison, and other legal outcomes. And yet, these wins come at a cost. This framework does not challenge essentialist assumptions, threaten categorization based on sex, or demand legal recognition of self-identification. Rather, it reifies the sex binary as natural and authoritative while carving out a precarious space for trans people within those two categories. The legitimacy of the categories themselves remains uncontested, to the detriment of trans people everywhere.

Furthermore, these cases aid in understanding power as "bottom-up" and depersonalized, where for gendered roles and behavior "the disciplinarian is everyone, yet no one in particular" (Cooper 1994, 438). The four types of reasoning in these opinions stem from engrained social norms on what gender is and how gendered bodies ought to look and act. When a judge gestures to genitalia, clothing, chromosomes, or mannerisms in assessing the tenability of a litigant's gender, they are reciting cultural norms that have been impressed on them. These sites of power exist far beyond the courtroom, but they take root in legal analysis. This is perhaps where a biopolitical analysis falters and a disciplinarian approach can be useful in tandem. In transgender rights cases, the judge is both a social actor attempting to reconcile gender variance with their ingrained belief systems and a state actor who can wield the power of the law to codify and enforce their view of gender. Analysis of these cases reveals how the legal system produces and reinforces gender categories on dual axis; male and female, and natural and deviant. To preserve the gender binary and defend the dominance of gender normativity, trans people must be read as victims of psychological or spiritual disturbance. Then, a trans person's self-identified gender is only tenable if authorized by medical experts and if their desired presentation falls in line with gendered social norms. Should these boxes be checked, a judge may allow a trans person access to judicial processes in accordance with their gender identity. The courts stamp out disruptive gender expressions and renders them legally illegible, and therefore legally nonfunctional. By doing so, the state maintains a hierarchy of power that disadvantages trans people and delegitimizes gender variance.

This article is limited in its case sample and analytical depth. With no cases representing nonbinary or intersex litigants, there is a significant gap in assessing how those identities are interpreted by judges and how these sections of the LGBTQI+ community experience legal marginalization. Additionally, there is no way to be certain that this case universe is representative of the entire body of gender identity adjudication.

While this article addresses the interaction between a litigant's gender identity and sexual orientation, further research should take an intersectional approach to analysis and examine how the race, class, dis/ability, and social capital of a litigant may contribute to a judge's willingness to authenticate their gender identity. This is particularly critical for cases related to incarceration where litigants often face overlapping oppressions based on race, class, drug user status, poverty, citizenship, sex work, and criminality. Building on these findings with an intersectional lens is necessary to appreciate the complexities of legal marginalization and domination.

How judges interpret gender in their legal rulings represents the conditions trans people experience by participating in public life. They construct narratives to negotiate gender variance, impose standards on bodies to authenticate self-identification, and create rules to regulate their existence. Courts do not simply reflect gender normativity; courts manufacture it. They create and impose static, legible boundaries on what gender is allowed to be. Yet, trans litigants consistently succeed in disrupting their attempts to uphold a fixed gender-sex binary. How this disruption unfolds, and how courts embrace or rebuff it, will continue to shape the treatment of gender variance under the law.

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ACKNOWLEDGEMENTS

The original version of this article was completed as an undergraduate honors thesis. Thank you to my mentors and reviewers at Macalester College: Patrick Schmidt for supervising this research, and Myrl Beam, Lesley Lavery, and Duchess Harris for reviewing my work. Thank you to Paisley Currah, the *Bulletin* Editor, and the anonymous reviewers for providing helpful feedback on this article. Thank you to my best friend Austin Wu for his continued support. Finally, thank you to all of my trans siblings whose strength in the face of persecution inspires me every day.

APPENDIX 1: LIST OF CASES

United States Supreme Court

Bostock v. Clayton County (2020)
Farmer v. Brennan (1994)

Federal Appeals Court

Adams v. Sch. Bd. of St. Johns Cnty. (2022) (US 1st Cir.)
EEOC v. R.G. (2018) (US 6th Cir.)
Doe v. Boyertown Area Sch. Dist. (2018) (US 3rd Cir.)
G. G. v. Gloucester Cnty. Sch. Bd. (2016) (US 4th Cir.)
Glenn v. Brumby (2011) (US 11th Cir.)
Smith v. City of Salem (2004) (US 6th Cir.)
Schwenk v. Hartford (2000) (US 9th Cir.)
Farmer v. Moritsugu (1998) (DC. Cir.)
Maggart v. Hanks (1997) (US 7th Cir.)
Farmer v. Haas (1993) (US 7th Cir.)
White v. Farrier (1988) (US 8th Cir.)
Meriwether v. Faulkner (1987) (US 7th Cir.)
Supre v. Ricketts (1986) (US 10th Cir.)
Ulane v. Eastern Airlines (1984) (US 7th Cir.)
Sommers v. Budget Marketing (1982) (US 8th Cir.)
Kirkpatrick v. Seligman & Latz, Inc. (1981) (US 5th Cir.)
Pinneke v. Preisser (1980) (US 8th Cir.)
Holloway v. Arthur Andersen & Co. (1977) (US 9th Cir.)

Federal District Court

G.G. v. Gloucester County Sch. Bd. (2015) (E.D. Va)
Radtke v. Misc. Drivers & Helpers Union (2011) (D. Minn.)
Trevino v. Ctr. for Health Care Servs. (2008) (W.D. Tex.)
Tronetti v. TLC Healthnet Lakeshore Hosp. (2003) (W.D. NY)
Wolfe v. Horn (2001) (E.D. Pa.)
Farmer v. Hawk (1998) (D.D.C)
Phillips v. Michigan Dep't of Corrections (1990) (W.D Mich.)
Farmer v. Carlson (1988) (M.D. Pa.)
Lamb v. Maschner (1984) (D. Kan.)
Ulane v. Eastern Airlines (1983) (N.D. Ill.)
Doe v. McConn (1980) (S.D. Tex.)
Ashlie v. Chester-Upland School District (1979) (E.D. Pa.)
Darnell v. Lloyd (1975) (D. Conn.)

State Appeals Court

N.H. v. Anoka-Hennepin Sch. Dist. No. 11 (2020) (Minn. Ct. App.)
In re N.I.V.S. (2015) (Tex. 4th Dist. Ct. App.)
Beatie v. Beatie (2014) (Ariz. Ct. App.)
In re Estate of Araguz (2014) (Tex. 13th Dist. App.)
Hispanic Aids Forum v. Estate of Bruno (2005) (N.Y. Supreme. Ct.)

Kantaras v. Kantaras (2004) (Fla. 2nd Dist. Ct. App.)
In re Application of Marriage License for Nash (2003) (Ohio Ct. App.)
In re Heilig (2003) (Md. Ct. App.)
In re Gardiner (2002) (Kan. Supreme. Ct.)
Goins v. West Group (2001) (Minn. Supreme. Ct.)
In re Gardiner (2001) (Kan. Ct. App.)
Goins v. West Group (Minn. Ct. App.)
Littleton v. Prange (1999) (Tex. 4th Dist. App.)
In re Harris (1997) (Pa. Super. Ct.)
Maffei v. Kolaeton Indus. (1995) (N.Y. Supreme. Ct.)
Matter of Eck (1991) (N.J. Super. Ct.)
G. B. v. Lackner (1978) (Cal. 1st Dist. Ct. App.)
Richards v. United States Tennis Asso. (1977) (N.Y Supreme. Ct.)
K. v. Health Div. (1977) (Or. Supreme. Ct.)
Doe v. State, Dep't of Public Welfare (1977) (Minn. Supreme. Ct.)
M.T. v. J.T. (1976) (N.J. Super. Ct.)
K. v. Health Div. (1976) (Or. Ct. App.)
Frances B. v. Mark B. (1974) (N.Y Supreme. Ct.)
Anonymous v. Weiner (1966) (N.Y Supreme. Ct.)

State District Court

Adams v. Sch. Bd. of St. Johns Cnty. (2018) (M.D. Fla.)
Diamond v. Owens (2015) (M.D. Ga.)
Norsworthy v. Beard (2015) (N.D. Ca)
Lopez v. River Oaks Imaging & Diagnostic Group, Inc. (2008) (S.D. Tex.)
Kantaras v. Kantaras (2003) (Fla. Trial Ct.)
Matter of McIntyre (1996) (Pa. Common Pleas)
In re Anonymous (1992) (Civ. Ct. of City of New York)
In re Ladrach (1987) (Ohio Common Pleas)
In re Petition of Richardson to Change Name (1982) (Pa. Common Pleas)
In re Dowdrick (1978) (Pa. Common Pleas)
In re Dickinson (1978) (Pa. Common Pleas)
In re Anonymous (1970) (Civ. Ct. of City of New York)
In re Anonymous (1968) (Civ. Ct. of City of New York)

ORIGINAL ARTICLE

Gender-Affirming Surgeons' Attitudes toward Social Media Communication with Patients

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Online spaces are increasingly important for transgender people who are considering gender-affirming surgeries to find information, ask questions, and communicate with each other. While many surgical resources are community-generated, the onus of providing medical information about surgery should be on the surgical team. We sought to understand the potential for an online space for surgeon and community engagement. We assessed gender-affirming surgeon perspectives on online communication and communities by conducting a survey (*N* = 55) to understand current social media use and gauge surgeons' opinions related to participating in online spaces. We found that gender-affirming surgeons were not generally in support of a new online platform for patient-surgeon communication, with 67% responding that a new platform was not needed. Participants identified potential negative implications including risks to patients (e.g., misinformation, liability, and platform use in emergency situations) and risks to surgeons (e.g., the additional burden that the platform would place on their already-limited time, changes to surgeon culture, and safety concerns related to online harassment). Potential positive implications include opportunities to improve patient education and enhance patient care. Our results establish empirical understanding of social media use patterns among gender-affirming surgeons and may inform the design of resources to enable trans patients to receive the information and care that they require when considering and undergoing gender-affirming surgery.

KEYWORDS transgender health; gender-affirming surgery; doctor-patient communication; health communication; social media
DOI 10.57814/eltc-mt51

Online spaces such as social media sites are increasingly important for transgender people who are considering gender-affirming surgeries to find information, ask questions, and communicate with each other (Augustaitis et al. 2021; Chuanromanee and Metoyer 2021). For instance, many trans people gather to discuss surgeries in communities on sites like Reddit, Discord, Facebook, and on trans-specific sites like TransBucket and ModClub. These spaces fill critical knowledge gaps that have been identified including information on long-term outcomes, clinic safety, and preoperative requirements. Online spaces are vital for community-building and filling needs unmet by the medical establishment.

While many surgical resources are community-generated, the onus of providing medical information about surgery should be on the surgical team. Yet in an increasingly hostile political environment for both trans patients and gender-affirming care providers, those who disclose personal information about gender affirming surgery online may have greater risk for experiencing harassment, mistreatment, or misappropriation of their information. Patients and surgeons need safe online spaces where they can communicate without fear of harassment and abuse. Additionally, in patient-only online spaces, there is potential for misinformation about gender-affirming surgeries to circulate, usually from well-meaning but ill-informed community members and allies (Augustaitis et al. 2021). Many trans people considering surgery would value the opportunity to communicate online with gender-affirming surgeons, who can provide factual information and lend expertise to combat faulty claims that may arise in these spaces (Augustaitis et al. 2021; Chuanromanee and Metoyer 2021).

As a further barrier to care, there is a paucity of gender-affirming surgeons, and many patients travel long distances (even internationally) and spend months or years on waiting lists for surgery. Those who do have local surgical teams typically do not have more than one choice, outside of the few largest cities in the United States and may lack access to specific techniques. While there was a relative increase in access to non-local providers during COVID-19 due to changes in telehealth rules (U.S. Dept. of Health and Human Services 2023), many providers have returned to requiring in-person consultations, costing additional financial and time resources. Increased access to formal, freely available information from gender-affirming surgical teams can help inform patient decision making in a cost-effective and efficient manner.

We sought to understand the potential for an online space for surgeon and community engagement. As a first step, we assessed gender-affirming surgeon perspectives on online communication and communities. We conducted a survey ($N = 55$) to gauge surgeons' opinions and concerns related to participating in such a space. We found gender-affirming surgeons were generally not in support of a new online platform for patient-surgeon communication, with 67% responding that a new platform was not needed. Private practice surgeons and those who currently frequently used social media were more likely to support such a platform. Participants also provided potential negative and positive implications of a new platform facilitating patient-surgeon communication. Potential negative implications include risks to patients, such as misinformation, liability, and platform use in emergency situations, and risks to surgeons, such as the additional burden that the platform would place on their already-limited time, changes to surgeon culture, and safety concerns related to online harassment. Potential positive implications include opportunities to improve patient education and enhance patient care.

This work contributes an empirical understanding of gender-affirming surgeons' social media use and their attitudes toward using an online platform designed to facilitate communication with trans patients considering surgery. Our results will inform the design of future resources to enable trans patients to receive the information and care that they require when considering, researching, undergoing, and recovering from surgery.

HEALTH INFORMATION SHARING IN ONLINE TRANS COMMUNITIES

Online health communities are important sources of health care information for patients, empowering them to make informed choices about their health (Nath et al. 2016). Benefits of online health communities include psychosocial support for patients and their caregivers as well as information support from peer patients and online community moderators (Gustafson et al. 2001; Huh et al. 2013). Social media is a valuable tool for the transgender community in particular for finding resources and information, decision-making, and making connections with others (Augustaitis et al. 2021; Chuanromanee and Metoyer 2021). These platforms allow people to share their experiences (Darwin 2017; Yeadon-Lee 2016) and exchange information, and most online groups provide a level of anonymity and safety to their members (Haimson et al. 2020).

Patients' and physicians' perspectives in online communities are quite different, and communication with peers addresses different needs (Hartzler and Pratt 2011; Huh 2015). Despite the benefits of online information-sharing, it can be difficult for patients to find validated, non-conflicting information given the volume of information that exists online (Eysenbach 2003). Increased involvement from physicians in online health communities could help address some of these limitations (Kim and Mrotek 2016; Kim and Shyam Sundar 2014). Limited prior research has examined the potential for physician involvement in online health communities to help address some of these issues, and found that clinical expertise is sorely needed in online health communities to help with clarifying medical information and helping patients understand what to expect with regard to particular health conditions and procedures (Huh and Pratt 2014). Physician engagement in online knowledge-sharing may be increased if there are practical benefits to their contributions such as enhanced reputation, greater likelihood that patients will seek future consultations, and monetary rewards (Zhang et al. 2022). Evidence demonstrates that platforms that have physicians who actively engage in information-sharing attract more patients, incentivizing online platforms to foster collaborations with physicians (Ma et al. 2022).

PHYSICIAN PARTICIPATION IN HEALTH INFORMATION SHARING

Physicians have both Health Insurance Portability and Accountability Act (HIPAA)-compliant and non-compliant means of communication with patients. Over the past decade, physicians have increasingly utilized HIPAA-compliant patient portals integrated with electronic health records to communicate with patients. This form of interaction has grown significantly following the COVID-19 pandemic, with recent single-center experiences reporting 71% of patients interacting with their hospital center utilize a patient portal (Lo et al. 2022). These messages primarily discuss medical needs, with an estimated 68% containing decision making tasks (Robinson et al. 2017). While patient portals have become a key tool for improving accessibility and continuity of care, some speculate increases in patient communication via patient portals are tied to physician burnout (Mehrotra et al. 2020; Zarefsky 2023).

Beyond formal systems integrated with the electronic medical record, some physicians interact with patients via advertising or communicating directly on social media. While surgeons have a demonstrated academic interest in social media use in general, this has not translated to gender-affirming surgery (K.G. Bennett et al. 2018). Among plastic surgery programs, gender-affirming care takes up a very small portion—less than 2%—of social media posts (Maisner et al. 2023). Analysis of gender-affirming surgery content on YouTube and Tiktok suggest over two thirds of content concern patient experience (Song et al. 2022). Despite the low production of content, gender-affirming providers use social media to engage with trans communities (such as by following trans accounts, answering questions, and helping to spread accurate medical information) to better understand trans lived experiences, which can help them to provide better care (Blotner and Rajunov 2018). However, the rate of social media use for these purposes, and granular information about social media use amongst gender-affirming surgeons, is unknown. Some physicians are consumers of social media, but there is a paucity of surgeon-produced content in gender-affirming surgery.

Beyond patient portals and social media, novel digital tools such as mobile health applications regarding surgery have typically been developed as an extension of an established individual patient-physician relationship, and the majority of platforms identified in a 2019 systematic review focused on post-operative communication or structured reporting of symptoms (De La Cruz Monroy and Mosahebi 2019). One tool was identified as including preoperative communication, and use of this tool was later found to correlate with fewer surgical cancellations (Stewart et al. 2019). Other than mobile health applications, Wellprept has been described as a digital tool for surgeons to provide standard pre-operative information to patients in advance of consultation appointments, such that more of the appointment can be utilized discussing patient-specific concerns (Stork 2023). In gender-affirming surgery specifically, there is novel development of online decision aids in masculinizing genital surgery to assist with surgical consultation (Scalia et al. 2021).

METHODS

Recruitment

Physicians who perform gender-affirming surgery in the United States or Canada with an available email were eligible for this study. We created a list of gender-affirming surgeons by gathering names from two publicly available sources: the member directory for the World Professional Association for Transgender Health, and transhealth.org. Contact information was obtained through online sources such as practice websites, academic articles, and (in cases where contact information was not publicly available) personal contacts of the authors. The project was deemed exempt from ongoing review by the University of Michigan Institutional Review Board (IRBMED HUM00218192).

Survey

To understand physician perceptions of social media and possible use of a new platform, participants completed an electronic survey with both ad-hoc elements and subscales of an instrument examining social media use developed by McGowan et al. (2012; Supplemental 1). This Likert-based instrument is informed by the Technology Acceptance Model and was validated in primary care physicians and oncologists. We utilized multiple subscales in this instrument including frequency of social media use, perceived usefulness, perceived barriers to use, ease of use, and personal innovativeness. We additionally measured perceptions of social media across four dimensions: a waste of time/an essential use of time, very risky/very beneficial, very boring/very engaging. We included Likert-based ad-hoc items related to decision making, perceived risk, and professionalism. Additionally, we included free-text questions asking about general perceptions of online patient-surgeon communication and the look and feel of a potential new platform.

Analysis

We analyzed survey results using both qualitative and quantitative methods. Individuals who did not complete >80% of the survey and took less than 1 minute to complete the survey were not included in the analysis. Subscales were summed for scoring. Descriptive statistics were performed on demographic information and Likert-based

Table 1. Participant Demographics (*N* = 55)

Characteristic	*M* (*SD*) / *n* (%)
Age	47.9 (11.9)
Gender	
Male	31 (56.4)
Female	23 (41.8)
Gender diverse	1 (1.8)
Race	
White/Caucasian non-Hispanic	29 (52.7)
Black/African American non-Hispanic	2 (3.6)
Asian non-Hispanic	12 (21.8)
White Hispanic	3 (5.5)
Middle Eastern	1 (1.8)
Native American	1 (1.8)
Pacific Islander	1 (1.8)
Multiracial	3 (5.5)
Other	1 (1.8)
N/A	2 (3.6)
Country	
USA	52 (94.6)
Canada	3 (5.5)
Specialty	
Plastic surgery	33 (60.0)
Urology	10 (18.2)
Obstetrics and gynecology	8 (14.6)
Other	4 (7.3)
Practice setting	
Academic	26 (47.3)
Private practice	21 (38.2)
Combination	8 (14.6)
Practice length	
In training	2 (3.6)
< 5 years	12 (21.8)
6–10 years	15 (27.3)
11–15 years	6 (10.9)
16–20 years	1 (1.8)
21+ years	19 (34.6)
Procedures performed	
Chrondrolaryngoplasty	16 (29.1)
Facial feminization	17 (30.9)
Facial masculinization	14 (25.5)
Hysterectomy	8 (14.6)

Characteristic (cont.)	***M* (*SD*) / *n* (%)**
Orchiectomy	18 (32.7)
Penectomy w/o genital reconstruction	9 (16.4)
Metoidioplasty	16 (29.1)
Phalloplasty	15 (27.3)
Vaginoplasty	13 (23.6)
Zero-depth vaginoplasty/labiaplasty	18 (32.7)
Other	5 (9.1)
Mean percent of practice is GAS	44.1 (35.2)
Percent of GAS consultation standardized	66.7 (35.6)
Percent of GAS counseling that could be done online	63.9 (31.5)

scales. To identify characteristics associated with perceptions of social media use, nonparametric bivariate analysis was performed. Further, logistic and ordinal regression was used to characterize variables associated with the odds of thinking a new platform is needed and future use (Table 5–6). Of note, we utilized the term "gender minority" in analysis to represent women and gender diverse individuals due to limitations in sample size in these populations. Individuals with these identities are underrepresented in surgical specialties in medicine (C. L. Bennett et al. 2020; Ellis and Khubchandani 2021). We performed all statistical analysis using Stata 17.0 (Statacorp LLC, College Town TX).

Free-text entries were analyzed through an iterative qualitative coding process. First, four team members open coded the free text responses. They then met to discuss the patterns they saw in the data. The group used Miro to sort codes and build consensus on a codebook. The codebook was then applied to the free text by four members of the research team who then met to discuss discrepancies and find consensus.

RESULTS

Participant Demographics and Characteristics

A total of *N* = 55 participants successfully completed the survey (response rate = 12%, Figure 1). Table 1 details participant demographics and characteristics. The mean age of participants was 47.9 (*SD* = 11.9). Participants were 56% men (*n* = 31), 42% women (*n* = 23), and 2% gender diverse (*n* = 1). Participants were primarily non-Hispanic white (52.7%) and Asian (21.8%). Participants were primarily from the US (*n* = 52, 94%) and practiced in 23 different states; the remainder were from Canada. Plastic surgeons (60%), urologists (18%), and gynecologists (15%) were represented in this sample, with 47% in academic practices and 38% in private practice. The median practice length was 6–10 years, but the most prevalent practice length was more than 21 years (35%). Participants performed a variety of gender-affirming procedures, with an average of 44% (*SD* = 35.2) of their practice consisting of gender-affirming surgery. On average, participants reported that 63.9% (*SD* = 31.5) of the gender-affirming surgery counseling they do with patients could be done in an online setting.

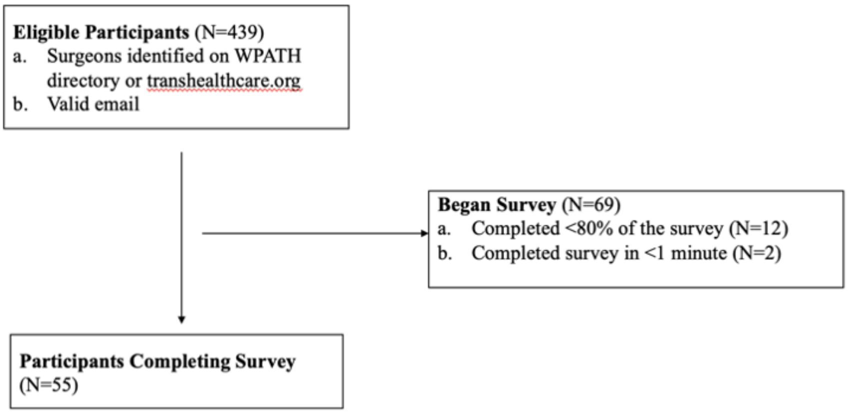


Figure 1. Eligibility criteria and participants

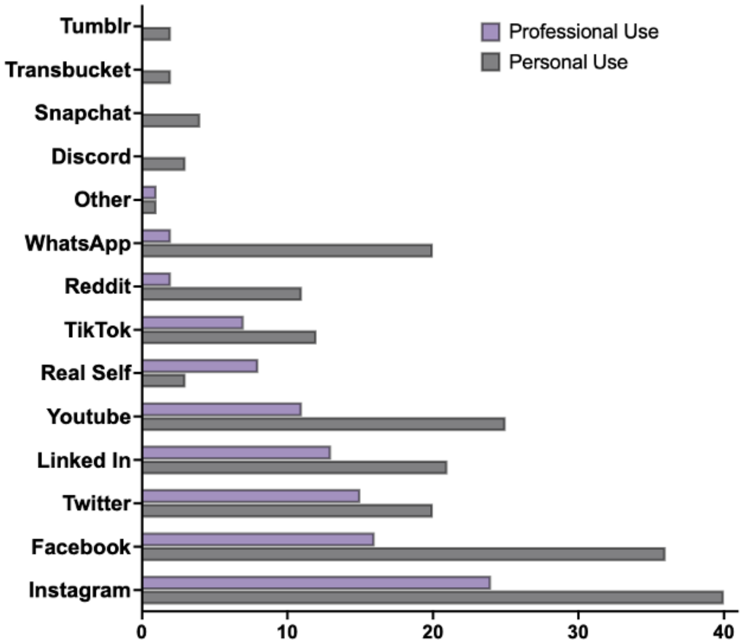


Figure 2. Number of surgeons using social media platforms for professional and personal use

Social Media Use Patterns Amongst Surgeons

Participants used a median of 3 (interquartile range [IQR] 2–5) social media platforms for personal use and 2 (IQR 0–3) for professional use. Most participants used social media daily for personal use (*n* = 34, 62%) with the top platforms being Facebook and Instagram (Figure 2). Only 20% of participants (*n* = 11) reported daily use for professional purposes, with 31% (*n* = 17) reporting no professional social media use. Approximately one-quarter (*n* = 13, 24%) reported using social media to communicate with patients. Participants responded low on the frequency of use scale (median score = 5, IQR 3–9, max score 21).

General Views of Social Media

Participants had a variety of perspectives on the role of social media use in their practice and communication with patients undergoing gender-affirming surgery. While median perceptions of social media measured through varying dimensions were neutral (waste of time/essential use of time median = 4, IQR = 3–5; very boring/very engaging mean = 4, IQR = 4–5; a bad/good way to communicate median = 4, IQR = 3–5; risky/beneficial median = 4, IQR = 2–5; see Table 2 and Figure 3), there was wide variation. Similarly, median responses were neutral to ad-hoc statements: "physicians

Table 2. Construct, Ad-Hoc, and Dimension Scores (*N* = 55)

Measures	Median Score (IQR)
Construct	
Frequency of social media use (3–21, lower is less frequent)	5 (3–9)
Usefulness (5–35, higher is more useful)	14 (9–22)
Ease of use (3–21, higher is higher perceived ease of use)	15 (10–17)
Personal innovativeness (2–14, higher is higher innovativeness)	6 (4–8)
Barriers to use (3–21, higher is higher barriers)	13 (10–15)
Ad-hoc statements	
Social media can be an effective tool for patient education	5 (5–6)
Physicians should participate in social media with patients	4 (2–5)
Patients talking about surgery online does more harm than good (reverse coded)	4 (2–5)
Discussions on social media can help patients make decisions about surgery	5 (4–6)
Physicians who talk to patients on social media are unprofessional	3 (2–4)
Social media dimensions	
A waste of time (1) – an essential use of time (7)	4 (3–5)
Very risky (1) – very beneficial (7)	4 (2–5)
Very boring (1) – very engaging (7)	4 (4–5)
A bad way to communicate current info (1) – a great way to communicate current info (7)	4 (3–5)

Note. Scores presented as medians and interquartile ranges given the low sample size and Likert-based scoring.

Table 3. Need for New Platform Stratified by Demographics and Construct Scores ($N = 55$)

Characteristic	*n* (%) / Median (IQR) Yes	No	*p*
Age[a]			
< 40	7 (36.8)	12 (63.2)	.94
40–60	8 (32.0)	17 (68.0)	
> 60	3 (33.3)	6 (66.7)	
Gender[a]			
Men	9 (29.0)	22 (71.0)	.51
Gender minority[†]	9 (37.5)	15 (62.5)	
Specialty[a]			
Plastic surgery	11 (33.3)	22 (66.7)	.98
Urology	3 (30.0)	7 (70.0)	
Ob/Gyn and other	4 (33.3)	8 (66.7)	
Practice setting[a]			
Academic	6 (24.0)	19 (76.0)	.10
Private	10 (47.6)	11 (52.4)	
Combination	1 (12.5)	7 (87.5)	
Social media scales[b]			
Frequency of social media use	6 (5–10)	5 (3–9)	.36
Usefulness	17 (10–22)	15 (8–20)	.40
Ease of use	14.5 (11–16)	16 (10–17)	.39
Barriers to use	13.5 (12–16)	13 (10–15)	.26
Innovativeness	6 (4–8)	6 (4–8)	.55

Note. [a]Chi-square test utilized, [b]Kruskall-Wallis test utilized, [†]includes women and gender diverse individuals

should participate in social media with patients" (median = 4, IQR = 2–5; see Table 2 and Figure 4) and "patients talking about surgery online does more harm than good" (reverse-scored, median = 4, IQR = 2–5; see Table 2 and Figure 4), with variation in sentiments.

Perceptions of a Possible Platform Facilitating Patient-Surgeon Communication

Overall, surgeon support for a new platform for communication with patients was low, with 67% ($n = 37$) of participants saying that another platform was not needed. Hypothetical use of a new platform was variable, with 31% ($n = 17$) of participants noting they would use a new platform daily or multiple days a week and 28% ($n = 15$) saying they would never use one if it existed. The generally negative sentiment about a new platform was supported by free-text responses to the question "Are there any other thoughts regarding social media use and communication with patients online?" Out of 24 participants who provided free-text responses, 11 (46%) were coded as viewing a new platform as negative, 14 (58%) as neutral, and only 8 (33%) as posi-

Table 4. New Platform Use Stratified by Demographics and Construct Scores ($N = 55$)

Characteristic	n (%) / Median (IQR)							p
	Daily	Multiple times a week	Weekly	Monthly	Every few months	Annually	Never	
Age[a]								
< 40	0 (0)	2 (11.1)	4 (22.2)	2 (11.1)	3 (16.7)	1 (5.6)	6 (33.3)	.41
40–60	3 (12.5)	7 (29.2)	3 (12.5)	2 (8.33)	1 (4.2)	1 (4.2)	7 (29.2)	
> 60	0 (0)	4 (44.4)	3 (33.3)	0 (0)	0 (0)	0 (0)	2 (22.2)	
Gender[a]								
Men	2 (6.5)	10 (32.3)	8 (25.8)	2 (6.5)	3 (9.7)	2 (6.5)	4 (12.9)	.10
Gender minority[†]	1 (4.4)	4 (17.4)	3 (13.0)	3 (13.0)	1 (4.4)	0 (0)	11 (47.8)	
Specialty[a]								
Plastic surgery	1 (3.2)	11 (35.5)	5 (16.1)	2 (6.5)	2 (6.5)	2 (6.5)	8 (25.1)	.37
Urology	1 (10.0)	1 (10.0)	2 (20.0)	0 (0)	2 (20.0)	0 (0)	4 (40.0)	
Ob/Gyn and other	1 (8.3)	2 (16.7)	3 (25.0)	3 (25.0)	0 (0)	0 (0)	3 (25.0)	
Practice setting[a]								
Academic	1 (4.2)	6 (25.0)	3 (12.5)	3 (12.5)	3 (12.5)	2 (8.3)	6 (25.0)	.52
Private	1 (4.8)	8 (38.1)	5 (23.8)	1 (4.8)	0 (0)	0 (0)	6 (28.6)	
Combination	1 (12.5)	0 (0)	2 (25.0)	1 (12.5)	1 (12.5)	0 (0)	3 (37.5)	
Social media scales[b]								
Frequency of social media use	9 (8–14)	7 (5–9)	7 (4–11)	5 (3–5)	7.5 (4–11.5)	3.5 (3–4)	5 (3–7)	.06
Usefulness	9 (5–18)	20 (14–22)	20 (15–29)	9 (6–10)	16.5 (10.5–26)	7.5 (5–10)	11 (5–15)	.02
Ease of use	16 (13–16)	12 (8–15)	14 (12–16)	16 (6–16)	11 (7.5–15)	13.5 (8–19)	17 (10–21)	.33
Barriers to use	14 (14–15)	12.5 (10–14)	13 (6–16)	16 (15–17)	16.5 (11–18)	12 (11–13)	13 (10–15)	.45
Innovativeness	11 (9–11)	7 (4–8)	6 (4–7)	3 (3–4)	6 (3–9)	5.5 (4–7)	5 (4–6)	.04

Note. [a]Chi-square test utilized, [b]Kruskall-Wallis test utilized, [†]includes women and gender diverse individuals

Table 5. Multivariable Logistic Regression Predicting Need for a New Platform ($N = 48$)

Characteristic	*OR* [95% CI]	*p*
Age	0.95 [0.88, 1.03]	.23
Specialty		
Plastic surgery^{RC}	(1)	–
Urology	2.0 [0.28, 13.67]	.49
Ob/Gyn and other	1.9 [0.30, 11]	.39
Practice setting		
Academic^{RC}	(1)	–
Private	15.8 [1.2, 195.20]	.03
Combination	0.65 [0.05, 8.79]	.75
Frequency of social media use		
Daily^{RC}	(1)	–
Multiple times a week	1.53 [0.09, 26.22]	.78
Weekly	N/A	
Monthly	6.18 [0.27, 13.67]	.26
Every few months	1.43 [0.02, 154.12]	.86
Annually	1.07 [0.12, 10.03]	.95
Never	1.28 [0.11, 15.40]	.85
Gender		
Men^{RC}	(1)	–
Gender minority†	1.28 [0.26, 6.22]	.76

Note. Hosmer-Lemeshow goodness of fit test = 3.17, $p = .92$. ^{RC}reference category, †includes women and gender diverse individuals

tive. (Percentages add up to greater than 100% because responses could be coded in more than one category.)

In bivariate analysis, age, gender, specialty, or social media use constructs were not associated with feeling a new social media platform was necessary (Table 3). Frequency of social media use, perceived usefulness, and innovativeness was associated with perceived future use of a new platform (Table 4). In multivariate logistic regression adjusting for age, gender, and construct measurements, practice type was associated with thinking a new platform is needed. Individuals in private practice were 16 times more likely to think that a new platform is needed than individuals who work in an academic setting ($p = .03$; see Table 5). Specialty type, frequency of social media use, age, and gender did not impact odds of thinking a new platform is needed. In ordinal regression adjusting for age, gender, practice type, and social media constructs statistically significant in bivariate analysis, participants reporting a new social media platform is necessary were 6 times more likely to say they would use a platform more often if it existed compared to those who did not want a new platform ($p = .006$; see Table 6).

Though most surgeons did not support the idea of a new platform, participants did provide feedback on what features they would want to see in a new platform if it did exist. Protections for privacy and confidentiality was the most commonly men-

Table 6. Multivariable Ordinal Regression Predicting Frequency of Future Platform Use (*N* = 53)

Characteristic	*OR* [95% CI]	*p*
Age	1.02 [1.67, 20.61]	.32
Specialty		
Plastic surgery^{RC}	(1)	–
Urology	0.30 [0.06, 1.45]	.14
Ob/Gyn and other	1.09 [0.32, 3.76]	.89
Practice setting		
Academic^{RC}	(1)	–
Private	0.42 [0.11, 1.64]	.22
Combination	0.39 [0.08, 1.89]	.24
Frequency of use	1.17 [0.96, 1.43]	.11
Usefulness	0.99 [0.91, 1.08]	.82
Innovativeness	1.13 [0.88, 1.45]	.34
Gender		
Men^{RC}	(1)	–
Gender minority†	0.32 [0.09, 1.06]	.06
Is a new social media tool needed?		
No^{RC}	(1)	–
Yes	5.86 [1.66, 20.61]	.006

Note. Hosmer-Lemeshow goodness of fit test = 48.17, p = .66. ^{RC}reference category, †includes women and gender diverse individuals

tioned feature, followed by opportunities to share photographs, video, and other media. There was disagreement on whether a platform should have a one-on-one chat function between surgeons and patients. Some stated that one-on-one chat would help preserve privacy and confidentiality, and others stated that one-on-one communication with patients should be restricted to a platform like EPIC, while a social media platform should only be used to communicate with patients more broadly.

Negative Implications of a New Platform Facilitating Patient-Surgeon Communication

Quantitative analysis demonstrated widespread perceived risk of social media use for gender-affirming surgeons. When asked to rank social media on a 1 to 7 Likert scale of very risky to very beneficial, the average score was 3.5 (*SD* = 1.7). Free-text responses supported this, with responses mentioning a variety of potential risks to both patients and surgeons (Figure 4).

Risk to Patients

The most cited risks to patients of a new social media platform were misinformation and liability (Figure 6). Some participants worried that misinformation could be spread to patients as a result of surgeons trying to "sell themselves" and their brands:

> The key is to provide accurate information. There are too many videos of providers "selling" themselves—talking about how amazing they are with so few complications. In the end, patients want reliable information. Many, and perhaps a majority of patients, want surgeons to tell them what they need to hear and not what they want to hear. A social media platform that allows the dissemination of real information regarding gender surgery would be helpful for providers and for patients. (ID43)

Participant 43 felt that the current pressures on gender-affirming surgeons to self-promote and tell patients "what they want to hear" (ID43) via social media is a major contributor to the spread of misinformation to patients.

Regarding liability, participants were particularly concerned about how interacting with patients via social media could be done in ways protecting patients' privacy and safety. One participant stated, "It's a great tool but there has to be a line with how much medical advice can be given without getting into legal issues" (ID40). A related aspect of liability is the risk that patients would attempt to utilize a social media platform in emergency situations: "This is another way that patients in emergencies will communicate instead of calling, leading to delays of treatment and possible patient injuries" (ID49). This concern highlights the need for explicit boundaries in any new platform used for communication between surgeons and patients, making clear that communication on the platform should not be taken as individualized medical advice and that, if a patient is experiencing a health emergency, they should seek emergency treatment.

Risk to Surgeons

The most commonly cited risk to surgeons of a new social media platform was the additional burden that using such a platform would place on them. Participants mentioned the burden that a new platform would place on their time, which is already extremely limited.

> It's easier for me to just see patients. It's easier for me to talk to patients. I'm already serving as my own transcriptionist dictating notes or hand typing them in an EMR. To be honest, last thing I want is more typing and uploading photos/videos. Just don't have extra time for that. I am busy being a surgeon. I'd like to continue to be efficient, that's the biggest hurdle. If I wasn't busy, then yes, I understand patients select their surgeon based more on social media these days rather than where that person trained or experience. (ID37)

Concerns about surgeons' already-limited time were enhanced by concerns about duplication of work between electronic medical records like EPIC and a potential new platform. Other responses mentioned closely related issues such as constant availability, burnout, and encroachment on personal life.

> So many reasons to not normalize physician interactions via social media with patients. As it is, work creeps into the rest of life, this is just another example of how physician time is less respected than other professions, and part of it is our own doing by being excessively available. (ID46)

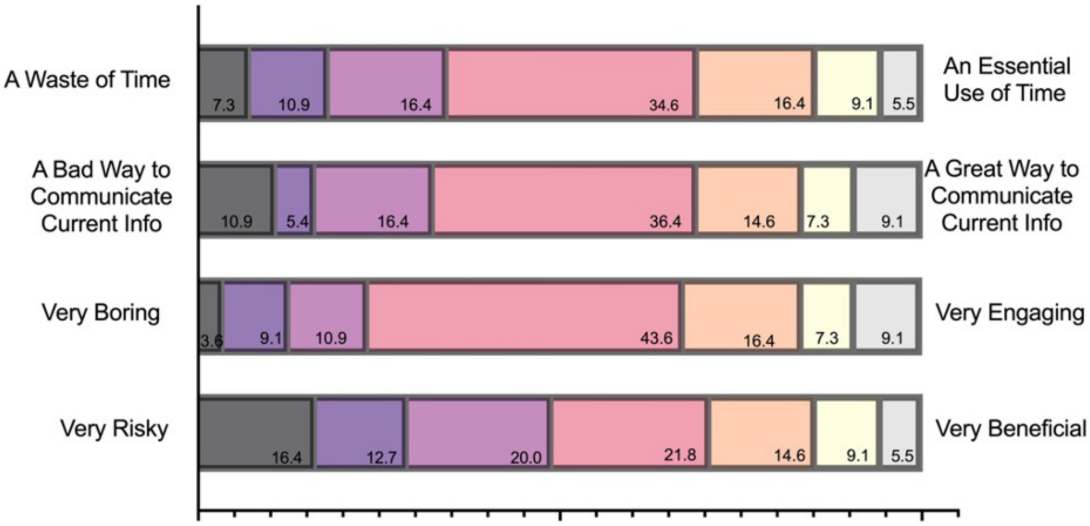
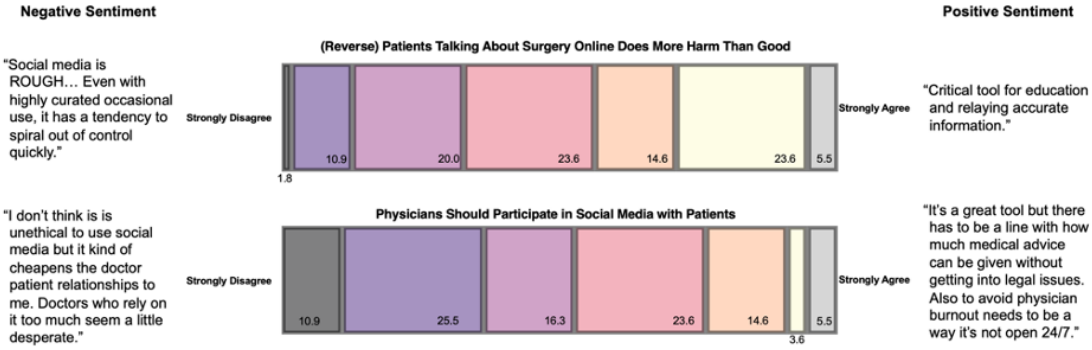


Figure 3. Dimensions of social media

Note. While median scores for dimensions suggest participants were indifferent about social media, the distribution of these scales varied, particularly for very risky/very beneficial.



"Social media is ROUGH… Even with highly curated occasional use, it has a tendency to spiral out of control quickly."

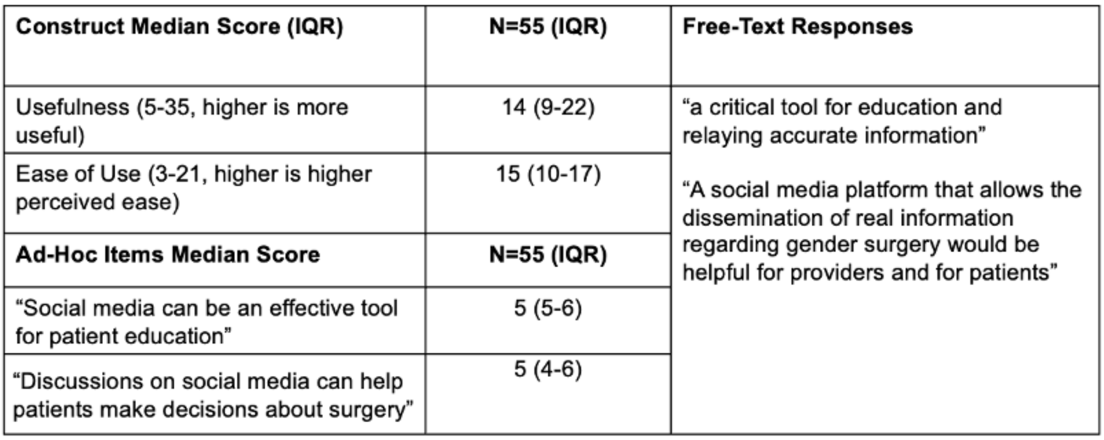
"Critical tool for education and relaying accurate information."

"I don't think is is unethical to use social media but it kind of cheapens the doctor patient relationships to me. Doctors who rely on it too much seem a little desperate."

"It's a great tool but there has to be a line with how much medical advice can be given without getting into legal issues. Also to avoid physician burnout needs to be a way it's not open 24/7."

Figure 4. Joint display of general perceptions of social media

Note. While the median survey scores suggest surgeons were indifferent about social media and interacting with patients on these platforms, there was wide variation in scores, as well as free-text responses.



Construct Median Score (IQR)	**N=55 (IQR)**	**Free-Text Responses**
Usefulness (5-35, higher is more useful)	14 (9-22)	"a critical tool for education and relaying accurate information" "A social media platform that allows the dissemination of real information regarding gender surgery would be helpful for providers and for patients"
Ease of Use (3-21, higher is higher perceived ease)	15 (10-17)	
Ad-Hoc Items Median Score	**N=55 (IQR)**	
"Social media can be an effective tool for patient education"	5 (5-6)	
"Discussions on social media can help patients make decisions about surgery"	5 (4-6)	

Figure 5. Joint display of positive implications for social media

Participant 46 compared the amount of respect that physicians' time commands to that of other professions to emphasize the burden of work encroaching on physicians' personal lives. Others brought up the issue that physicians could not be compensated for time they put into communicating via social media:

> I think in medical systems that have effective and convenient ways for patients to communicate with their physicians (through EPIC, virtual visits), adding means of communication through social media adds unnecessary burden to the physician. It can contribute to physician burnout if physicians cannot be compensated for their work through social media and need to find time on top of their normal workload to keep up. (ID27)

Several individuals also described concerns about what additional social media use would mean for surgeon identity and culture, with specific concerns about how social media could change the doctor-patient relationship and medical professionalism. One participant stated that social media use "does a disservice to our core message of thoughtful, personal care" (ID15). Another stated: "I don't think it is unethical to use social media, but it kind of cheapens the doctor patient relationships to me. Doctors who rely on it too much seem a little desperate" (ID53).

Finally, participants had concerns about online mistreatment and their safety if they were to engage publicly in social media:

> Because social media lends to anonymity in some cases, it may allow some people to remain behind the screen and communicate without keeping in mind that it's a real person on the other end. While patients are vulnerable, physicians can be vulnerable too. When physicians are vulnerable, they are often treated as if accepting abuse and microaggressions is part of being empathetic - this should be avoided. (ID27)

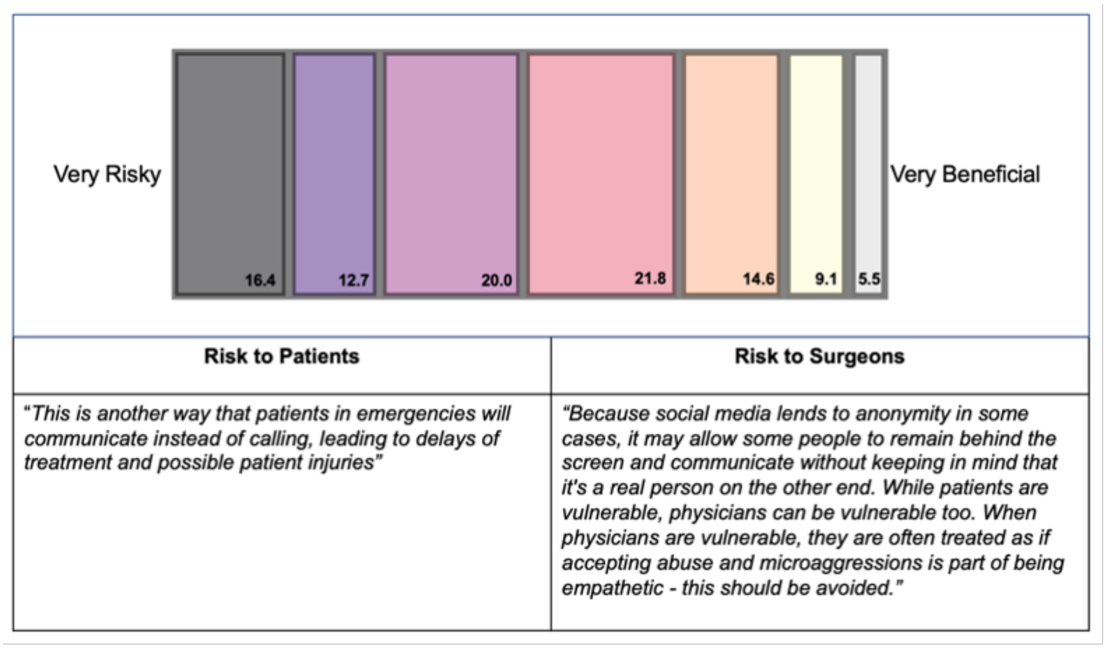
In some cases, these concerns were related to the current sociopolitical contexts of the states in which they practice medicine. One described the dangers of surgeons' social media use in states with recent restrictions on gender-affirming care as follows:

> Social media for gender affirmation surgeons is dangerous. I live and practice in [state], and the state house increasingly is introducing bills to try to limit gender affirming care. There is also a dangerous rhetoric among the right wing in [state]that conflates providing gender affirming care, especially in those who are not yet the age of majority, with grooming and pedophilia. It is an especially fraught time for physicians who try to provide best care and follow the best practice guidelines. (ID57)

Social media use can increase physicians' vulnerability to harassment. The very real risks of abuse and harassment, in addition to increased demands on surgeons' time, must be seriously considered in designing a patient-surgeon communication platform.

Positive Implications of a New Platform Facilitating Patient-Surgeon Communication

Despite overall support for a new platform being low, qualitative analysis of free-text responses also revealed potential positive implications of a new social media platform



Risk to Patients	Risk to Surgeons
"This is another way that patients in emergencies will communicate instead of calling, leading to delays of treatment and possible patient injuries"	*"Because social media lends to anonymity in some cases, it may allow some people to remain behind the screen and communicate without keeping in mind that it's a real person on the other end. While patients are vulnerable, physicians can be vulnerable too. When physicians are vulnerable, they are often treated as if accepting abuse and microaggressions is part of being empathetic - this should be avoided."*

Figure 6. Joint display of negative implications for social media

for patient-surgeon communication. Positive implications included improvements to patient education and patient care. Participants emphasized balancing risks and benefits of social media use.

Improve Patient Education

Participants reported that social media can contribute to patient education, with a median score of 5 (out of a possible 7) in response to the ad-hoc statement "Social media can be an effective tool for patient education." Free-text responses that mentioned patient education described social media as "a critical tool for education and relaying accurate information" (ID:13). Another participant stated: "A social media platform that allows the dissemination of real information regarding gender surgery would be helpful for providers and for patients" (ID43; Figure 5).

Enhance Patient Care

Participants also answered that social media can contribute in a positive way to surgical decision-making, with a median score of 5 (out of a possible 7) in response to the ad-hoc statement "Discussions on social media can help patients make decisions about surgery" (Figure 5). While no free-text responses explicitly mentioned surgical decision-making, participants did state that social media could have positive implications for patient care. For example, one participant acknowledged that social media is a difficult arena to navigate but that "done correctly, it should enhance patient care" (ID11).

Balancing Risks and Benefits

Most of the free-text responses that mentioned positive implications of social media simultaneously mentioned negative implications. Balancing risks and benefits was explicitly mentioned in several free text responses. One participant stated that there is a "fine line between education in a relatable manner and poor taste and ominous implications" (ID15). Another participant elaborated further on those potentially "ominous implications":

> I would love to harvest the benefits of social media interaction without the constant risk of over-reaction, being misunderstood despite all efforts, inappropriate contact outside of the app, etc. (ID59)

These responses highlight how a platform for patient-surgeon communication might improve patient education and enhance patient care, while at the same time ensuring that these benefits outweigh the risks mentioned in the previous section.

DISCUSSION

We investigated gender-affirming surgeons' attitudes toward an online platform designed to facilitate communication with trans patients considering surgery using both qualitative and quantitative methods. Our findings demonstrate that surgeons perceived communicating with patients via social media to be risky to both patients and surgeons. This is in line with other literature showing that physicians are concerned about compliance with HIPAA and unsure of their ethical and legal obligations when communicating with patients online (Brown, Ryan, and Harris 2014; Ventola 2014).

Given the lack of enthusiasm that most participants in this study had for using social media as a tool for communicating with trans patients about gender-affirming surgery, this raises the question of how necessary or even possible it is to have surgeons in online spaces. The necessity has been established by earlier research demonstrating that trans users in online spaces such as Reddit and Transbucket desire more participation from surgeons to increase accuracy and reduce misinformation (Augustaitis et al. 2021; Chuanromanee et al. 2021). A key issue that this earlier research has raised is the difficulty of flagging inaccurate content, demonstrating a need for improved content moderation to ensure that the information trans patients are receiving through online platforms is both correct and current. Some level of surgeon involvement in these platforms could help to ameliorate these issues. There is a growing body of evidence that online patient-physician communication can benefit both groups in myriad ways including increasing patients' understanding of medical information, strengthening the emotional connection between doctors and their patients, and building physicians' professional capital (e.g. online reputation and demand for their services) (Lu and Zhang 2019; Qiao, Yan, Wang 2021). These findings demonstrate that physician engagement in online patient communities is not only possible but can be beneficial to both parties.

Many surgeons in this study were aware of the unique constraints involved with communicating with prospective patients about gender-affirming surgery, particularly as they relate to the current sociopolitical climate in which many gender-affirming surgeons receive personal threats to their safety or their ability to do their work is threatened by anti-trans legislation (O'Reilly 2021). Based on our findings, surgeons who would otherwise be more willing to participate in an online patient communication platform may be deterred by the current cultural and political climate. There is evidence that having healthcare providers or health educators involved in an online community focused on sexual health and HIV prevention for Black men who have sex with men was critical in reducing misinformation and helping to moderate conversations around health stigma (Blackburn et al. 2021). This evidence of the positive impact of having health care workers involved in an online community focused on other highly stigmatized and politicized health topics should be reassuring to gender-affirming surgeons who have a desire to participate in online patient communication spaces but worry about what impact they might have in these communities.

Most participants did not think a new platform was needed despite the fact that many of the concerns participants had about online communication with patients were related to technical elements that could be ameliorated with thoughtful design of a new platform that incorporated solutions to these concerns. Surgeons in our study described several technical factors that would need to be present in a social media platform designed for communicating with patients about gender-affirming surgery, including a Q&A feature, options for one-on-one communication with patients, and integration with existing EMR platforms. A more complex element that surgeons felt was essential was the ability to maintain patients' privacy and confidentiality in a manner that is compliant with HIPAA. In addition to concerns about patient safety as it relates to privacy and confidentiality, participants were also concerned about surgeons' safety in an online environment. Some had previous experiences with online abuse and harassment making them hesitant to interact with patients via social media, while others feared negative online interactions given the political climate surrounding gender-affirming surgery today. To balance trans patients' desires for more surgeon involvement in social media platforms discussing gender-affirming surgery with the elements that surgeons in this study identified as necessary for their participation in such a platform, careful attention to both the technical and ethical aspects of platform development are required (Huh 2015; Huh and Pratt 2014).

Some surgeons in our study felt that social media could have positive implications for patient care if harnessed correctly, especially those who seemed to have an awareness of the historical importance of online spaces for trans individuals sharing and seeking information regarding gender-affirming health care. Yet even participants who reported current online engagement with patients were hesitant to fully embrace an online communication platform given personal negative experiences they have had when attempting to discuss gender-affirming surgery with patients in online spaces. To harness positive aspects, a new platform could contain a dedicated space for individual surgeons to make standardized information available to potential patients that would normally be given through a consultation, which participants indicated was over 60% of time spent in consultation. When patients did have formal consultations with surgeons, then, they could already have accessed the general information that takes up considerable time during a visit. The time during the consultation could be spent on discussing aspects of the procedure specific to that individual patient, ultimately leading to higher quality and possibly shorter consultation visits. Because compensation for time spent on consultations is lower than for time spent on procedures (Reid et al. 2022), reducing the time spent on consultation could be an incentive for surgeons to utilize this type of platform. Further, having content available online would allow patients to access information about techniques offered and medical requirements directly from surgeons, leading to more informed decision-making for patients seeking consultations. This could potentially lead to a higher rate of surgical procedures booked per consultation for surgical teams. For patients, this could ultimately reduce the time, travel, and financial burdens in the process of receiving gender-affirming surgery.

Additionally, a platform dedicated to facilitating surgeon-patient communication could support surgeons' participation by directly compensating surgeons for the time they spent on the platform. While it might only be possible to financially compensate a very small number of surgeons for a limited number of hours, this would still be an improvement on the current social media landscape and would ensure that there was at least some amount of surgeon oversight to help mitigate the spread of misinformation about gender-affirming procedures. Alternatively, surgical residency programs could require residents to spend a certain amount of time in online spaces with patients providing information, answering questions, and combating misinformation through patient portal responses (though this would require appropriate supervision to ensure information quality and would have to be balanced with other demands on trainees' time). While telemedicine and the use of online messaging has exploded since the pandemic, residents and medical students receive very little training on these types of interactions.

This study's results indicate that gender-affirming surgeons have relatively little interest in participating in a newly developed platform facilitating communication with potential patients; however, many of the reasons participants gave for not being interested could be addressed through the measures described here. A solution that would both address surgeons' concerns and fulfill patients' unmet needs could be a platform where individual surgeons or groups could make standardized information about the gender-affirming procedures they provide available to potential patients to reduce the portion of time spent on standardized information sharing during consultations. The platform could contain a private messaging feature for prospective patients to ask surgeons questions, and each surgeon using the platform could dedicate a limited number of hours each week to responding to patient questions with appropriate compensation. These interactions would very explicitly not be medical advice and users of the platform would need to sign agreements stating that they understood this to address surgeons' concerns about liability. To provide some level of surgeon compensation while maintaining accessibility for potential patients, one solution could be two versions of the platform: a free version where users would access standardized information on gender-affirming procedures, and a paid version that allowed users to interact directly with surgeons. Future studies should assess surgeons' willingness to participate in a platform that included the features identified as essential by participants in this study.

One limitation of this study is the response rate of only 12%. This could be related to our survey distribution method, wherein we contacted surgeons at the email addresses listed publicly on the WPATH member directory and transhealth.org, which may or may not be checked frequently. This response rate could further reflect the enthusiasm of this population for social media, and a reflection of their limited time.

Further, using the WPATH member directory and transhealth.org to identify gender affirming surgeons is a limitation in and of itself. Some surgeons who perform gender-affirming care as part of their clinical work are not members of WPATH and have not taken the steps needed to be listed as a gender-affirming surgeon on transhealth.org. These surgeons were not captured in recruitment for this study and as such some degree of selection bias influenced the composition of the final sample.

While we attempted to utilize validated measures to assess social media use and attitudes, there are few instruments available. Another limitation is that participants' responses were shaped by their own interpretations of the term "social media." Some participants seemed to be thinking of social media only as a community-facing advertising method (e.g., a surgeon page on Facebook), whereas others were thinking of platforms that allow for community members to communicate and share information with each other (e.g., reddit, Transbucket).

CONCLUSION

There will always be some risk inherent to communication between surgeons and patients via social media. Threats to privacy and confidentiality are not always predictable or preventable, though any platform developed in the future would make protecting the safety of all users a top priority. As participants in this study stated, using social media is about balancing risks and benefits. An online communication platform for patients and surgeons could provide important benefits, such as disseminating accurate information and mitigating misinformation about gender-affirming surgery for potential patients and improving patient care. Thus, developing an online platform facilitating communication between gender-affirming surgeons and patients is worthy of further study.

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ACKNOWLEDGMENTS

Funding: University of Michigan’s Institute for Research on Women and Gender (IRWG) Faculty Seed Grant.

ORIGINAL ARTICLE

The Role(s) Transgender Adults Want General Practice to Have in Their Healthcare: A Qualitative Study in Southeast England

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Transgender (trans) people experience health inequalities, which includes inequities in accessing and navigating healthcare systems. General practitioners (GP) in England have a limited role in delivering trans-specific healthcare. Few studies have explored what is positively working in GP-led primary care settings and how this can be more widely implemented. This study aims to explore the views and expectations of trans people regarding primary care services. Data were generated using qualitative semi-structured one-on-one interviews conducted with trans experts by experience who were recruited through purposive sampling. Results were analysed and coded using a thematic analysis framework to identify key themes. Positive and negative experiences of accessing and navigating general practice settings were identified by 16 trans people as experts by experience. An overarching theme was for gender-affirming services to be provided through general practice in order to reduce waiting times for specialist care and to move towards an informed consent model of care. Through demonstrating examples of good practice, general practitioners are advised to take a proactive role in providing positive gender-affirming healthcare for trans people. An informed consent model of care should be implemented to improve healthcare access.

KEYWORDS primary care; qualitative research; gender affirming healthcare; transgender; healthcare pathways
DOI 10.57814/wOe6-xy86

In the United Kingdom, an estimated 600,000 people are trans, although this is likely to be an underestimation (Government Equalities Office 2018). As the sociocultural acceptance of trans people increases, general practitioner (GP) services within primary care are likely to care for an increasing number of trans individuals, who may be seeking advice or support in relation to gender-affirming healthcare (GAHC; Holden and Shrewsbury 2021). Access to GAHC includes interventions such as gender-affirming hormone therapy and gender-affirming surgery. A holistic approach should be taken whereby all trans individuals can choose to access any, or none, of the gender-affirming interventions available to them. This is irrespective of having a "binary" or nonbinary identity, co-occurring disability, or neurodivergence.

Through the National Health Service (NHS), access to GAHC is initially through primary care, in particular general practice, where the GP coordinates referrals to a gender identity clinic (GIC; NHS England 2019). At GICs, individuals are assessed by a psychiatrist to obtain a diagnosis of gender dysphoria, following which individuals may be referred for state-funded interventions such as hormone therapy, gender-affirming surgery, vocal coaching, fertility preservation and psychotherapy. The foundation of this model relies on the psychiatric assessment of trans individuals. Waiting times for GICs are extensive, with waiting times for an initial appointment in England reported between 26–74 months, with significant regional variation between GICs (Gender Construction Kit 2023). For comparison, the NHS referral-to-treatment waiting times at the end of April 2023 showed that of 7.4 million people awaiting to commence treatment, only 5% and 0.01% respectively were waiting more than 12 and 24 months for treatment (National Health Service, 2023). Consequently, many trans individuals' access GAHC privately or through self-medication (Ellis, Bailey and McNeil 2015, White et al. 2023). The limited availability of services and regional variation in service provision has been associated with travel costs and variability in the quality of care (Heng et al. 2018).

Trans people in the UK report a high rate of mental illness, including suicidal ideation, that can be attributed to discrimination, transphobia, and delays in accessing GAHC (Bachmann and Gooch 2018; Jones et al. 2019; Wright et al. 2018). Common experiences within primary care include GPs being unwilling to provide or support access to GAHC (Harrison et al. 2020; Snelgrove et al. 2012). The Trans Lives Survey 2021 found 57% of participants avoided healthcare settings when unwell, with 14% being refused care by a GP on account of being trans (TransActual 2021). Refusal by GPs to acknowledge the presence and healthcare needs of trans people adds to a collective sense of distrust by trans people accessing GAHC in the UK.

The role of primary care and, in particular, the GP in GAHC has evolved in recent years. The General Medical Council (2023; GMC) has guidelines for GPs in prescribing "bridging hormones" as part of a harm-reduction strategy whilst trans people are awaiting GAHC, supported by the Royal College of Psychiatrists and the World Professional Association for Transgender Health (Coleman et al. 2022). In addition, there have been several pilot projects providing GAHC access from a primary care-led perspective. These services are locally commissioned to provide assessments for gender dysphoria and services such as speech and language therapy, psychological support, referrals for hormone therapy, surgery, fertility preservation and hair-reduction. These include the Sussex Gender Service (Sussex), the Indigo Project (Greater Manchester), CMAGIC (Cheshire and Merseyside), Trans Plus (London), and the East of England Gender Service.

Trans communities have suggested establishing an informed consent model would improve access to care (Ellis et al. 2015; Schulz 2018; White et al. 2023). Informed consent emphasises self-determination for trans people and shared decision making between the healthcare practitioner (HCP) and trans individuals (Spanos et al. 2021). Following the principles of informed consent, trans individuals should be able to access GAHC so long as the associated risks and benefits of any intervention(s) are clearly understood, and the individual has capacity to consent. This is irrespective of whether any specific "gender transitioning" milestones have been met, or a GD diagnosis given, that would grant state-funded access to GAHC through a medical model. This would involve GPs having a more direct role in providing GAHC through localised, community-based services. With regard to this, the World Health Organisation (WHO) declassified being transgender as a mental or behavioural disorder in the International Classification of Diseases, 11th edition (ICD-11) in 2019 (Coleman 2022). There is now no basis for trans people to undergo psychiatric assessment and medical systems should be reformed as they are upholding a now outdated presumption and diagnosis (Allory 2020; Askevis 2019). By eliminating the requirement for a psychiatric diagnosis and assessment, primary care-led services could support the depathologisation of trans identities in favour of self-determination (Ashley 2019).

The aim of this study is to gain a better understanding from trans people, as experts by experience, into what GPs and other primary care services have done well and how this can be applied elsewhere. A secondary aim of this study is to gain more of an understanding of what trans people want their healthcare to look like, what areas of GAHC could be provided within primary care, and how GPs can implement or support this from a patient's perspective.

METHODS

This qualitative interview study was developed as a result of steering group discussions regarding the locally commissioned service for trans healthcare (Sussex) about the increased need for academic research around GAHC and primary care for trans patients locally across the Sussex, UK region. A Sussex-based trans support organisation was approached for advice and support. A trans senior worker at the organisation (LW) designed and led the project. The research team also included two cisgender senior academics (CDL, MP) who supported with securing ethical approval, funding and overseeing the research process. A medical student (DH) was invited due to their previous postgraduate research on trans experiences of primary care (Holland et al. 2023). LW and DH took part in data collection and analysis and were both financially compensated for their input. All members of the research team were white and British. The team included researchers of a range of ages, and those who were queer and/or disabled and/or neurodivergent.

Study Design

A qualitative study was carried out using one-on-one semi-structured interviews with trans individuals within the southeast of England. Research was conducted and reported in line with the consolidated criteria for reporting qualitative research (COREQ; Tong 2007).

Sampling and Eligibility Criteria

Purposive convenience sampling was used to capture a range of views across people of different ages, genders, and racial identities. An aspirational quota was set to recruit greater than or equal to two trans people that were: older than 50 years, people of colour, transfeminine, transmasculine, nonbinary, and disabled and/or neurodivergent. "Transfeminine" here includes those who use the labels woman, trans woman, transfemme, or similar. "Transmasculine" includes those who use the labels man, transman, transmasc, or similar. We sought in the range of 10–15 participants for sufficient information power given the topics of interest and analysis (Malterud 2016). Participants were eligible if they were above 18 years old, trans, and eligible to receive healthcare across East and West Sussex. Exclusion criteria included those who could not speak English and/or could not give informed consent, whether verbal or written.

Recruitment and Procedure

Participant recruitment was facilitated by the trans community researcher (LW) working within the trans community. Advertisements were distributed to local charities and Sussex-based community organisations, as well as through the research team's social media. Individuals were invited to contact members of the research team via email. All prospective participants were distributed a consent form and a participant information sheet prior to interview. All participants were given the option of having a trans interviewer and a choice of online (via encrypted Zoom) or face-to-face interviews. It was emphasised that participation in this project had no influence on the support they received from any community organisations or from primary care services. Neither members of the community researcher's immediate personal network (i.e., friends and colleagues) nor individuals receiving individual support from them in a professional capacity participated in the study. Further purposive sampling of those with multiple marginalised identities was restricted by the time constraints of the project.

Interviews and Data Collection

Semi-structured interviews were designed and conducted in accordance with the process as set out by DeJonckheere and Vaughn (2019). Semi-structured interviews took place between October 2021 and January 2022. The two interviewers were DH and LW. Both interviewers were previously trained in qualitative methods. Both interviewers pilot tested the interview prior to the study to ensure there was a shared understanding between the interviewing team as to what type of language and interview style should be used.

Each interviewer conducted eight interviews each. At the interview, first demographic questions were asked before the consent form was read through with the participants. The audio recording was then switched on where participants were asked to state if they had read, understood, and agreed to the consent form. The maximum time for interviews was set to 60 minutes to support accessibility for disabled participants and researchers. All the interviews were digitally recorded and transcribed verbatim by hand using Microsoft Word by DH. Participants were assigned pseudonyms that were gender-neutral or in keeping with the common gendering of their names.

Ethical approval was granted by the Brighton and Sussex Medical School Research Governance and Ethics Committee on 27th October 2021 (ref no: ER/BSMS9923/1). All participants received a love2shop voucher of £20 for participation.

Topic Guide

Interviews were guided by a topic guide developed by the community researcher. The final version was pilot tested with DH and LW. Demographic questions were asked regarding participant's age, racial identity, their gender/relationship to gender, and whether they had a disability or were neurodivergent. The following domains were included in the topic guide: experiences of accessing GAHC; the impact of GAHC on health and wellbeing; views on the current GAHC pathway; and the role of the GP in GAHC—encompassing their views on what changes could be made to the current standard model of care. The topic guide had predetermined open-ended questions including: "What examples of trans affirming healthcare have you experienced in Sussex?" and "What impact has accessing gender-affirming healthcare had on your overall health and wellbeing?" Data collated through these interviews exploring the impact of the mixed provision of GAHC on the mental health of trans individuals has also been published (White et al. 2023). The topic guide had suggested additional follow-up questions and prompts to support the interviewers and ensure a similar, consistent approach across interviews.

Data Analysis

The data was analysed using the Ritchie and Spencer (1994) thematic framework analysis in six stages: familiarisation; coding; searching; reviewing; and defining themes; and reporting. Data analysis was conducted manually and independently by DH and LW. The coding framework and interpretation of results were discussed amongst the two researchers to establish a consensus. DH led in indexing and charting the data; LW and DH then began the interpretation process by exploring patterns in the data to extrapolate key themes. Interpretation of the results were discussed with the wider research team to reach a consensus and validate the findings.

RESULTS

Twenty-one people contacted the research team. Sixteen were included in the study (Table 1). Two did not respond to email regarding an interview, one did not attend the interview, one dropped out of the study prior to interview, and one contacted the research team after we had ended participant recruitment. Interviews conducted had a duration of 31–74 minutes, with a median time of 50 minutes.

The aspirational quota set was met in recruiting participants in the following categories: trans feminine; nonbinary; disabled and/or neurodivergent. A significant proportion of participants were either white and/or trans feminine and/or 18–39 years of age. Further purposive sampling of communities of colour would have been preferred, however the research team were restricted due to time constraints.

Due to the richness of the data acquired and the separate research questions addressed, two papers resulted from this dataset. The first paper focuses on the mental health impact of current GAHC pathways in Sussex (White et al. 2023). The data contained in this paper focuses on the experiences and expectations of primary care and broader healthcare services, from which two key themes were identified: (1) trans experiences of accessing healthcare and (2) the trans-specific healthcare pathway. Key sub-themes are expanded upon below.

Transgender People's Experiences of Accessing Healthcare

General Practitioner (GP) knowledge

Participants described a range of positive, negative, and neutral experiences across primary and general healthcare. There were various factors which influenced how these experiences were perceived by respondents. GPs being knowledgeable about trans-specific healthcare positively shaped the outcome of the consultation. This included having a GP that had supported trans patients before, understood GAHC pathways and what services GPs could provide, proactively sought to acquire further knowledge, and/or understood the practicalities and limitations of accessing GAHC in England.

> The best interaction in that I was getting valuable information, she's [the GP] obviously extremely well informed about trans healthcare and … also approaches it in a very practical manner, like understanding where the healthcare system fails trans people a lot. A lot of us turn to self-medicating and things like.
> –Matthew

A GPs proactiveness and willingness to learn were facilitators towards having a positive healthcare encounter, including advocating on behalf of the patient. However, participants described an initial apprehension to accessing primary care services due to the level of uncertainty around GPs understanding of GAHC.

> Going to the doctors for one thing, which is something I felt uncomfortable about in the past… knowing that I have a GP who's friendly and listens to me and, you know, in a general sense, in a trans sense, who respects my identity, as well, as far as I can tell. Like, it makes me feel a lot more able to engage in healthcare and without that … there's a good chance I think that I would withdraw a lot more and … possibly allow

Table 1. Participant demographics (*N* = 16)

Characteristic	*n*
Age (years)	
20–29	7
30–39	5
40–49	2
50–59	2*
Ethnicity	
White	15
Black / Person of colour	1**
Gender	
Trans woman / transfeminine	10*
Nonbinary / genderfluid	3*
Trans man / transmasculine	2*
"Unsure" / "still figuring it out"	1
Disability / neurodivergence	
Yes	9*
No	6
Prefer not to say	1

Note. *aspirational quota met; **aspirational quote not met

> healthcare issues to build up rather than say, deal with a GP who is not particularly respectful or acknowledging of my trans identity.
>
> –River

Anticipation of a negative healthcare interaction was not uncommon, especially when there had been previous negative experiences with a GP:

> Well, back in [location], what, I came out 2018? I had a very nice GP there who—she was just very nice and treated me like a normal person, which is always nice compared to like a GP I had before who would kind of just like look me up and down and make very objectifying observations.
>
> –Jamie

GPs who had this knowledge base were better able to establish rapport and provide holistic support. This benefits trans patients in the short-term and fosters an environment where they feel as though they can return to a GP they trust, for both trans-specific and general healthcare. Participants who anticipated, then experienced, discriminatory attitudes, had their feelings of anxiety reinforced and associated with accessing healthcare. These negative interactions had a long-lasting impact where some participants were subsequently avoidant of accessing general healthcare; it was perceived as more harmful to their wellbeing.

> My GP isn't so good. They're a bit old-fashioned. It's a little bit of a—it's quite a trigger when I go there. It's like, what's gonna happen today? Are they gonna be misgendering me in public?
>
> –Candice

Some GPs continued to reinforce cisnormative gender stereotypes, to the extent some participants altered the way they dressed to better access GAHC without being challenged by GPs. Additionally, some participants recounted having been asked invasive personal questions, unrelated to their health, that were used by the GP to justify access to secondary care services.

> To get on the GIC list I had to write a statement explaining why I felt that—you know, why I feel I was transgender and why I was seeking, you know, access to GIC. And basically, the GP told me that I needed to explain everything including, you know, my sex life and everything and that was very dehumanising to put that on paper and putting it on paper was, was very hard.
>
> –Alex

Participants often felt forced into the role of patient educator, which ranged from educating GPs about trans identities to guiding GPs through GAHC guidelines, prescribing, and monitoring hormones and making referrals to secondary services.

> I have to put time and effort into something that, really, I shouldn't have to do anything. It should be all on them. I mean, having to learn about dosages and names of certain drugs to tell my doctor what—I shouldn't have to tell them what I should be getting prescribed. They're a doctor. They should tell me. It's crazy.
>
> –Candice

Some participants felt as though they had to prove they were "trans enough" to GPs as a prerequisite of accessing GAHC. This was also seen as GPs prioritising the potential political ramifications of providing GAHC above the welfare of trans people. This posed additional struggles for some participants who were nonbinary or gender-nonconforming; whose gender identity and/or expression directly challenged GPs assumptions as to what GAHC "should" look like.

> I mean, as a gender-nonconforming person, as somebody who, like, I don't—personally, I don't wanna have surgery, I don't want hormones… And I think, yes, a lot of trans people do want surgery, want to go on hormones, trans people do wanna have surgeries, but I think there's almost a pressure to prove that you're trans enough? That you kinda have to want those things in order to be considered trans?
>
> –Kai

Furthermore, some participants had difficulty defining key positive or negative healthcare encounters, but rather described their experiences as an absence of overt negativity:

> Like, [the GP] still got my pronouns wrong, but at least he didn't call me miss or madame or lady.
>
> –Kai

Many participants attributed limited GP knowledge to a lack of training regarding GAHC. The need for training was especially expressed in the context of increased waiting times for specialist care, meaning that the GP may be the only point of contact for support for many years. However, there was a perception that some GPs were unwilling to educate themselves about trans-specific healthcare and take responsibility. One participant described moving to a different surgery to access bridging hormones and reaching out to their former practice:

> [The former GP] wanted his details from me, so that then she could refer anybody like me in the future to him, because that got her—that was a nice easy way for her to get off the hook for having to deal with anybody about bridging hormones. And I said, "well, do you wanna use me as a case study and work with [current GP] on this so you can get some training and some help and so that people like me in [location] can come to you and it will all be fine and you'll be able to prescribe bridging hormones and you can change your policy.?" No, no.
> –Jo

This demonstrates there may be discriminatory behaviour within primary care through a reluctance to engage with trans individuals and through maintaining ignorance, despite awareness of training opportunities.

The patient-practitioner relationship

Participants' experiences of primary care were influenced by a perceived affirmation or rejection of their gender identity. Having a non-judgmental GP was regarded highly by respondents, with examples of gender affirmation including using the correct name, pronouns, and ensuring patient documentation reflected as such. Some participants described their expectations of ideal care as being able to take part in shared decision making that was more collaborative than hierarchical in nature.

> I find that what's very important for me … in my relationships with healthcare professionals is that the relationship is not a kind of paternalistic [one]… I contrast that with healthcare professionals who have a more collaborative approach who can—like, there is an equality to the relationship of sharing of their skills and knowledge with my knowledge of my body and desire to what health actually means in my life.
> –River

If expectations of ideal care describe a deconstruction of power imbalances traditional within general practice, recognition is needed of the ways GPs hold power, on both a systemic and individual level. By being a common first point of contact for trans individuals, GPs can have a gatekeeping role in who gets access to specialist care. Some participants described a fear of disclosing health concerns unrelated to their gender identity for fear of their GIC referral or access to GAHC being taken away. This was more common amongst participants with multiple marginalised identities, especially those who had mental health issues, disabilities, or were neurodivergent.

> I haven't disclosed any of my disabilities or mental health issues to the gender identity clinic cause I'm aware that they are much less likely to allow me to continue along the medical path I've gone down. It's also prevented me from getting myself properly tested for autism… 'cause I know it might make it harder for me to continue to procure hormones if I do so.
> –Sam

On an individual level, some participants described feeling as though their health was not taken as seriously, and the GPs' lack of understanding meant their wellbeing was being disregarded.

> It makes me feel quite down and quite, kind of, not being heard… You know, if I went to the doctors and said, "my arm has been hurting for years, could you help with my arm?" they'd go, "yeah I'll help you with your arm." But if I say "my gender's been hurting for years/ can you help my gender?" they just kinda go "meh, whatever."
> –Kai

This demonstrates how important it is for trans people to feel as though they have greater agency in their own healthcare in equal partnership with a GP. It is important for GPs to recognise that trans people may be experiencing anxiety relating to previous or anticipated negative healthcare interactions. Being proactive in addressing possible concerns may help to increase trust and foster a more positive patient-practitioner relationship.

The Trans Specific Healthcare Pathway

The role of primary care in GAHC

A general perception amongst all participants was that GAHC should be primary care led. This included initiating hormone therapy and making referrals for fertility preservation, vocal coaching, laser hair removal, and both general and gender-based counselling. Participants felt better able to make informed, autonomous decisions about their healthcare in primary care, in collaboration with their GP.

> I think the main positive experiences I've had is, like, being able to have an informed consent with a GP who has let me—he's given me suggestions for what I can do with my hormones without being strict on it, if that makes sense… I've just felt like I have a lot of control and options over it that have made it a much better experience for me.
> –Sophie

Primary care-led services were perceived to be associated with a decreased waiting time compared to accessing GICs. Additionally, primary care was regarded as more accessible, with less travel requirements on the individual to access care.

> There should be more, like, decentralisation of services so that the GPs have more power to get people directly onto what they need and, like, I don't know—I feel like if you're piling up all the services in a couple of central gender clinics around the country, it just, like, makes there be so many waiting lists and stuff. And, like, I get that that's probably how the legal system in the UK has set it up so that fewer trans people can get onto healthcare because that's kinda what they want.
> –Gemma

Concerns were noted around the feasibility of GPs being able to provide GAHC. However, some participants expressed that by having more primary care-led services, GAHC may be regarded as less "niche" and GPs can take more direct responsibility for patient care and services they may eventually provide regardless.

> At some point, even if you go through the GIC process, you get discharged from the GIC, and the ongoing management of your hormones for the rest of your life falls to your GP, so if they can do it then, why do I need someone else to hold their hand to start with?
> –Emily

There were mixed experiences of participants already accessing some GAHC services across primary care. Some participants described being started on bridging hormones and being followed up for regular blood tests and monitoring by their GP. Some participants also reflected on their experiences trying to access fertility preservation on the NHS. None of the participants had accessed state-funded fertility preservation through primary care. However, some described their GP actively advocating on their behalf to local clinical commissioning groups or completing funding applications for those self-funding.

> My advocate was brilliant and worked with trans people before and was really sensitive—just very kind of consensual about how every stage—and really, yeah, did the legal research to kind of advocate on my behalf to the NHS about why I should be able to receive hormone replacement therapy—sorry, fertility preservation—on the NHS prior to hormones.
> –Melody

Allocating more services to primary care was therefore seen as an extension to care currently offered.

> He [the GP] also referred me for voice therapy, which I had no idea… Making more people aware that they can get that through their GPs is really important.
> –Sophie

A key priority for many participants was accessing hormone therapy and a GPs ability to initiate and monitor as such was regarded highly. There were mixed responses regarding surgical referrals within the remit of primary care. For some participants, surgical referrals were within the remit of the GIC as they were perceived as requiring more specialist input from secondary care. However, there was significant frustration with the current model of care, primarily the requirement for psychiatric assessment prior to being referred for state-funded surgery, and general waiting times. Moreover, some participants who thought surgical referrals should be GP-led associated as such with a shorter waiting time and greater accessibility.

> It was annoying that I couldn't get my first appoint to see the surgeon until I'd actually got those two referrals [from psychiatrists] … I would have liked to have had the opportunity to see the surgeon sooner.
> –Emily

The role of the GIC and specialist services

There was a collective preference for an informed consent model in GAHC. Some participants expressed that, whilst the majority of GAHC could be primary care-led, there be circumstances whereby more specialist input could be required. Examples given included the potential need for endocrinological input when an individual does not respond to hormone therapy in a typical manner, the continued need for specialist surgical input, and the role of psychiatry in providing additional support to trans individuals with co-occurring severe mental illness.

> It's all a bit bonkers, but we should be able to self ID. If we were, then the GIC would—literally all they would need to do is some mental health support, some hormone support for GPs in more serious cases in things, where it gets beyond the GPs knowledge, and surgery. That's

> it. They should be doing surgery referrals. That's basically all we need the GIC for.
>
> –Ellie

The majority of participants wanted gender-affirming hormone therapy to be initiated through primary care. However, some participants wanted more of an opportunity to discuss their healthcare with an endocrinologist, particularly to discuss hormones, side-effects, and other considerations, such as fertility preservation treatments.

> I think there should be… some kind of discussion you would have to have with maybe an endocrinologist explaining exactly what the effects will be, like explaining possible fertility treatments you can take beforehand.
>
> –Sam

Another view was that gender specialists should be located across different hospitals with more dispersed clinics, similar to secondary care services, and this would be more locally accessible.

> Well, I think there should just be gender specialists. I'm not sure there needs to be a gender clinic. I think if, you know… an ear, nose and throat specialist or… whatever you've got wrong with you in the health service, there's a specialist in every hospital, isn't there?
>
> –Jo

Overall, trans individuals wanted to feel as though they were receiving practical advice and support rather than being psychologically assessed. Many participants felt as though this could be delivered through primary care where the GP was fully informed in GAHC pathways.

DISCUSSION

Trans people experienced difficulties at all stages of healthcare access. The way GAHC is currently accessed in England is described by the participants as having a multitude of failings. These failings are putting the physical and psychological wellbeing of trans people at significant risk. There was an overall negative perception of accessing GAHC through primary care services and GICs with some positive experiences on an individual basis that speaks to systemic failings in GAHC provision. Additionally, recognising a good quality of care may be difficult in an environment where trans people anticipate negative reactions from healthcare providers and/or having to act as patient educator.

This is one of few studies to explore specifically positive experiences of GAHC access in primary care within the NHS. Previous studies have explored general healthcare (Heng et al. 2018; Teti et al. 2021), mental health (Ellis et al. 2015; Valentine 2018; White et al. 2023), GICs (Ellis et al. 2015; Taylor 2019), or experiences of healthcare in a non-NHS setting as a focus (Carlstrom et al. 2021; Guss et al. 2019; Ross et al. 2016). Participants from this study were additionally more likely to have accessed GAHC, such as bridging hormones, from primary care services, for which there are few studies, due to this region specifically having a Transgender Locally Commissioned Service (Sussex CCG 2021).

Multiple factors contributed to the difficulties accessing GAHC, such as a lack of GP knowledge regarding trans identities and healthcare needs, which corroborates findings from previous research. This includes anticipation of negative healthcare experiences and subsequent avoidance behaviour (Adams et al. 2013; Heng et al. 2018; Lerner et al. 2017). An additional study reported that trans individuals who had not accessed gender-affirming medication, such as hormone therapy, were more likely to experience distress discussing GAHC with their primary care doctor, including trans individuals who had no plans to seek medical intervention (Bauer, 2015). This was reflected by comments from participants of this study, where anxiety and stress stemmed from an anticipated rejection of their gender identity by GPs on the basis that they may not meet GPs preconceived ideas of what "counts" as being trans. For GPs, these preconceived ideas may be based on arbitrary social and/or medical transition "milestones," centred around the current model of care and requirement for a diagnosis of gender dysphoria, to access GAHC in England (NHS England 2019). The current NHS pathway for accessing GAHC does not reflect the diversity of gender identities and expression of trans people.

Many participants in this study reported negative experiences within primary care, which suggests a high prevalence of negative healthcare encounters. This is supported by the Trans Lives Survey 2021, where 70% of respondents reported transphobia when accessing healthcare (TransActual 2021). Regarding GICs, significant waiting times had a detrimental impact on participants health and wellbeing, which is reflected in trans peoples' broader experiences of GICs in the UK (Ellis 2015; McNeil et al. 2012).

The current model of care is perceived as paternalistic and pathologizing. This supports previous studies which have shown a general distrust of HCPs amongst transgender populations and a fear of disclosing physical and mental health concerns should they be used to deny access to GAHC (Ellis 2015). Previous research corroborates these findings that a supportive GP instils trust and improves mental health outcomes (Heng et al. 2018; McNeil et al. 2012).

Positive experiences and suggested solutions largely centred around themes of informed consent, self-determination, and working collaboratively in partnership with GPs. Under the current system in the NHS, participants emphasised proactivity and advocacy as a way GPs can have a large positive impact. This goes beyond an awareness of GAHC pathways but a knowledge of how to advocate and support trans people awaiting GIC appointments, including prescribing and monitoring bridging hormones and engaging with local transgender communities on how to improve GAHC access on a local and regional level.

With regards to expectations of ideal care, trans people wanted GPs to have a more involved role in GAHC service delivery. This is supported by frameworks as set out by the World Professional Association for Transgender Health (WPATH) which approves of an informed consent model as an alternative to required psychological assessment (Coleman et al. 2022). Studies evaluating pilot projects involving an informed consent model have generated high patient satisfaction rates (Ker 2020; Spanos et al. 2021). Whilst these pilot projects took place in Australia and New Zealand respectively, the findings from the studies showed participants associated these primary care-led services with increased accessibility, decreased waiting times and an overall depathologisation of trans identities; all themes which were associated with GP-led GAHC provision by participants in this study.

The requirement for trans people to undergo psychiatric assessment is rooted in supporting an outdated presumption and diagnosis (Coleman, 2022). As reinforced by the participants in this study, the current system requiring diagnostic assessment for GD furthers waiting lists, delays healthcare access and contributes to feelings of distrust and negative experiences within healthcare for trans people.

Primary care led GAHC was associated with greater accessibility, particularly for disabled, neurodivergent and/or working-class participants. This supports previous research highlighting geographical and socioeconomic inequality in accessing GAHC under the current care model (Heng et al. 2018). However, cisnormative attitudes in primary care isolated trans people, more so if they had other marginalised identities, emphasising the continued need for training amongst primary care staff. In particular, previous studies have shown racial discrimination negatively impacts healthcare outcomes for trans people of colour (Agenor et al. 2022; Howard et al. 2019). However, due to the low number of participants who were trans people of colour in this study, the additional impacts of racial biases were unable to be commented on.

The attitudes of GPs towards primary care-led GAHC services are mixed. Studies focusing on primary care-led GAHC services under an informed consent model have shown these services to be seen widely more positively, both from trans patients and clinicians (Reisner et al. 2015; Schulz 2018). There have been concerns expressed by some GPs about providing GAHC, seen as more "specialist" and thus beyond the remit of general practice (Crowley and Lacey 2021; Royal College of General Practitioners 2019). However, both the GMC and the Royal College of General Practitioners have published guidance and training modules available on GAHC and supporting trans patients under the current GAHC pathway (General Medical Council 2023; Royal College of General Practitioners 2019). Additionally, as expressed by many of the participants in this study, GAHC such as prescribing and monitoring hormones is the eventual responsibility of the GP following initiation of treatment through the GIC. Moreover, the generalised view of GAHC as "niche" may work to discriminate against trans people, as these views can be used by GPs to disengage with trans people entirely, including in the refusal to acquire additional training to meet the health needs of trans people.

Overall, normalising GAHC using a primary care-led informed consent model would depathologize trans identities. Trans individuals will be able to self-identify rather than having to prove their gender identity to GPs with cisnormative assumptions as to what it means to be trans. This is likely to increase the number of positive healthcare experiences trans people have in accessing GAHC. This is likely to improve the mental health of trans people in England but also individuals' overall health, as they are less likely to avoid general health services due to previous negative healthcare interactions.

Strength and Limitations

To the best of our knowledge, this is one of the first studies focusing on the positive experiences and expectations of primary care amongst trans individuals in England at a time when the introduction of the new NHS integrated care systems (ICS) may bring opportunity to reconfigure and commission new services. A key strength of this study is that it was co-produced and co-led with the trans community. This research also gave an opportunity for trans participants to express their ideas as to what they want GAHC pathways to look like in England through the publication of these findings.

The local Sussex NHS commissioning service has contributed to the training of local GPs in supporting trans patients in accessing healthcare. Therefore, this population group may have been more likely to have experienced both, or either, primary care led GAHC and/or standard referral to a GIC through the NHS (Sussex CCG 2021).

The sample used for this study was modest and self-selecting. The findings may have been strengthened from additional quantitative analyses exploring positive and negative experiences of primary care. The majority of participants were white and trans feminine which means valuable insights from people of colour and transmasculine people were missing from these data. Further purposive sampling of under-represented groups may have been achieved through a longer recruitment time. The community researcher was known by some of the participants as having a combined role as researcher, trans community member and worker at a trans support charity, which may have introduced participant bias and influenced some participant's responses. Their involvement may have served to increase participant trust in the project. To navigate this, close personal contacts and those receiving individual professional support from the community researcher were not included, and where possible the least known interviewer for each participant was chosen.

Implications for Clinicians and Policymakers

The role of the GP has been ill-defined in the context of delivering comprehensive trans specific healthcare. This continues to illicit confusion as to what trans people can expect from their GP and what care GPs understand they can provide. GPs should be made aware of the barriers and facilitators to accessing GAHC in England and their role in supporting trans patients. Under the current system, ways in which GPs can have a positive impact are through affirming one's gender, being aware of the GAHC pathway, and being proactive by signposting to relevant support services and taking additional training opportunities. GPs should be able to offer, or support early access to, hormone therapy, vocal coaching, laser hair removal and fertility preservation. This is not only in line with guidance from WPATH, but would also substantially improve trans people's mental health, especially when on extensive waiting lists under the current healthcare pathway.

Many participants accessed GAHC through private healthcare channels or through self-medicating. This creates a significant socio-economic class divide in who has access to GAHC (White et al. 2023), further exacerbated by the fact that trans people are at higher risk of homelessness and poverty (Government Equalities Office 2018; White 2015). Financial stress had a significant impact in participants lives, where continuing treatment may come at the expense of living or eating well. GPs are advised to be aware of ways to support trans individuals accessing GAHC. This may include signposting to local community support services or advocating on behalf of patients to access specialist services, such as enquiring to local clinical commissioning groups to fund fertility preservation.

On an institutional level, policymakers should consider moving away from psychiatric assessment as a precursor to GAHC access and implement an informed consent model of care in line with WPATH guidelines. This involves removing the need for a diagnosis of "gender dysphoria" or psychological evaluation to access GAHC. Trans people should be able to access early GAHC from their healthcare provider having understood the benefits and risks of any interventions. The development and evaluation of new ICS should be informed and evaluated by a representative sample of the trans community.

Areas for Future Research

Recommendations to improve access to GAHC in primary care can be evaluated, which may contribute to a growing body of evidence behind what influences positive healthcare experiences in primary care settings. Further research may include the perspectives of GPs in the facilitators and barriers to providing GAHC. Further research is needed as to the experiences of primary care by trans people with multiple marginalised identities in England, to ensure their voices are heard in commissioning and developing ICS using an intersectional framework. Additionally, there is limited research comparing the experiences of GAHC access both across different UK nations and between different regional locations in England.

CONCLUSION

There were difficulties in accessing GAHC by trans people that need to be addressed on an individual, institutional, and societal level. The experiences and expectations of trans people suggest healthcare provision should be more primary care led under an informed consent model. The current system by which GAHC is accessed in England is harmful to the health and wellbeing of trans people. There is a duty of care for GPs to be aware of trans-specific healthcare needs and take responsibility in advocating for trans patients, providing additional holistic support and advancing their knowledge.

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ACKNOWLEDGEMENTS

We would like to thank our participants for their willingness and openness in sharing with us their experiences of accessing gender-affirming healthcare. We would also like to thank the organisations who helped us with recruitment for this study. We received small seed funding for this study from Brighton University's Centre for Transforming Sexuality and Gender as well as the Individual Research Project student fund from Brighton and Sussex Medical School.

ORIGINAL ARTICLE

A Mixed Methods Investigation into the Experiences of Transgender Students in Higher Education in the UK

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Negotiating the university environment can be difficult for many students, but for transgender students there can be additional hurdles. With university often being the first experience of real independence for young people, it may also be a place where they feel they can be themselves for the first time, as they navigate an environment away from family and friendship ties from the past. Employing a transformative paradigm, I used an online survey to investigate trans student experiences across different higher education institutions (HEIs), and remote one-to-one interviews to explore in-depth perspectives and voices. I examined the challenges these students faced around themes of harassment, bullying and transphobia, representation in the curriculum, and institutional facilities and administration. Participants reported feelings of segregation and otherness resulting from difficulties changing names/genders on HEI systems and insufficient gender-neutral facilities on campus. A lack of trans representation in the curriculum was clear and students reported obstacles accessing mental health support services. I identified institutional cisnormativity as an explanation for many of the negative experiences and apparent exclusion of this student group.

KEYWORDS cisnormativity; transgender; critical theory; transformative; higher education
DOI 10.57814/820-g959

Despite increasing interest in transgender studies (Marques 2019), gender identity within post-compulsory education remains under-researched (Hafford-Letchfield et al. 2018). Beemyn (2003) proposed that it is often at college that students first have the opportunity to question their assigned gender and to identify or present themselves in a way that they feel most comfortable, as they are mostly away from people who have known them as they were growing up. Kaufman and Feldman (2004) suggested that exposure to a diversity of social interactions can encourage students to rethink normative assumptions, such as those around gender, and in Storrie and Rohleder's (2018) study, trans students identified attending university as being a key point in their gender transition—a place where they could make a "new start." For these students, being able to experiment with how they feel in a safe environment is important.

The main purpose of my research was to identify obstacles encountered by trans students in higher education in the UK, and to suggest how HEIs can address areas of concern. There is limited existing research investigating the experiences of trans HE students in the UK as a distinct group, rather than as part of research into LGBTQI+ students or as part of research into trans individuals in wider society.

The questions driving my research were: (1) What are the experiences of trans students in HE in respect of support services, institutional administration, peers, academics and curriculum, social experience and facilities? (2) How well are HEIs supporting trans students?

TERMINOLOGY

In this article I use the term HEI for Higher Education Institutions, as this incorporates all higher education in the UK—universities, colleges, and alternative providers of Level 5 education or above. I use transgender or "trans" as an umbrella term for those whose gender identity and/or gender expression does not match the sex they were assigned at birth, and/or who do not conform to conventional gender binaries of man/woman. I use cisgender or "cis" to describe those whose gender identity is the same as the sex they were assigned at birth.

LITERATURE REVIEW

Reviewing existing literature, I identified four main themes that impact on the experience of trans students in HE.

Harassment, Bullying, and Transphobia

Experiences of harassment, bullying and transphobia, and ineffective or absent methods of dealing with these issues, have been reported although much of the previous research focused on LGBTQI+ experiences rather than those of trans students as a distinct group. In a study of LGBTQI+ students from one institution in Scotland, the university was found to be failing to protect LGBTQI+ people on campus from harassment and discrimination (Marzetti 2018), identifying verbal abuse, homophobic and transphobic comments, and physical and sexual abuse. They suggested that halls of residence and social spaces were the most likely places where such harassment would occur. Similarly, Storrie and Rohleder (2018), in a study with six trans students from different UK universities, reported increased risk of transphobic abuse within drinking spaces and how some trans students felt unable to take part in social events, even within LGBTQI+ societies, due to the strong drinking culture associated with these events.

Outside of academic literature, results of online research commissioned by the National Union of Students (NUS) with LGBTQI+ higher education (HE) students (*N*

= 3,880) highlighted that only 21% of trans students (compared to 37% of cis LGB students) felt completely safe on campus, and that one in three trans participants (compared to one in five cis LGB participants) had experienced bullying or harassment on campus (Acciari 2014). In research on behalf of the LGBTQI+ rights organisation Stonewall, Bachmann and Gooch (2018b) asked 522 LGBTQI+ students, of whom 17% (88) identified as trans, about their experience at British universities. They reported that 36% of trans students and 7% of cis LGB students had faced negative comments and conduct from university staff, and 60% of trans students and 22% of cis LGB students had faced negative comments and conduct from other students. In a section looking specifically at HE in another report, Bachmann and Gooch (2018a) reported that one in seven trans students had either dropped out or considered dropping out of a course because of harassment or discrimination.

Harassment, bullying, and transphobia can take many forms, including physical violence, verbal abuse, discrimination when accessing services, and micro-aggressions. Microaggressions are subtle forms of discrimination directed towards people who are part of a marginalised community; for trans people this can include misgendering, objectification, disapproval, or condemnation of trans identities (Nadal et al. 2014), showing intrusive curiosity, or asking about "real" names or "preferred" pronouns (Khan 2019). Asking a trans person for a "preferred" pronoun is suggesting that trans identities are less authentic than cis identities, or that being trans is a preference rather than an inherent characteristic (Sevelius et al. 2020). Similarly, unless there is a requirement to know whether a person has a different legal name, asking this can be an unwelcome and unnecessary intrusion which invalidates trans identities (Turton 2021).

Hopkins and colleagues (2018) discussed how trans staff and students felt uncomfortable being misgendered, particularly with regards to power relations whereby students did not feel they could correct staff who misgendered them. This was an internal report from just one HEI, but similar results were found in peer-reviewed research with 146 LGBTQI+ participants (Formby 2015), where misnaming and misgendering were particular issues for trans students. They suggested that this could be symptomatic of a lack of awareness amongst peers and academics. Storrie and Rohleder (2018) described trans students experiencing microaggressions including being misgendered, especially where there were conflicting gender signals such as their physical presentation not matching their gender identity.

Inclusion/Exclusion in Higher Education

"Othering" is where certain individuals or groups are defined as not fitting in with the 'norms' of society and, as such, experience marginalisation and inequality (Powell and Menendian 2016). Feelings of "otherness" can arise from perceived advantages and disadvantages that occur as a result of "deviation" from "the norm" (Santis 2022, 134). "Institutional cisheteronormativity" (Marzetti 2018, 702) describes how society in general, and in this case university education, is orientated around a presumption of cisgender, heterosexual identities. Research participants in Marzetti's (2018) study illustrated how their university acknowledged LGBTQI+ student issues at a superficial level only, hosting events during LGBTQI+ History Month but not openly supporting students or understanding the issues they face. For trans students, I would suggest that "cisnormativity" in the HEI environment is the "norm" from which they can be said to "deviate."

There is limited academic research about the experiences and impact of feelings of otherness or belonging for trans students in HE in the UK as a distinct group, although some research has been conducted in the USA. Lefevor and colleagues (2019) looked at the difference in various types of support (social, family, religious and living-situation) between cisgender (*n* = 2060) and trans (*n* = 1030) students, and how these types of support might buffer psychological distress. They highlighted disparities in distress and support between trans and cisgender students and concluded that trans students may have more difficulty building and accessing support networks due to a lack of societal acknowledgement and understanding of their experience, and that this can result in a reduction in feelings of belonging, a consequence of which is increased mental health difficulties. In contrast, Hill and colleagues (2021, 269) suggested that trans students' "resiliency makes them capable of persisting and thriving at institutions that continue to not be created for them," and that beyond gender and sexuality, these students find belonging in intersecting identities such as race, ethnicity, or disability. Nicolazzo and colleagues (2017, 310–311) suggested that LGBTQI+ student organisations provided important support for students to remain in their studies, with a trans participant describing a trans student group as "a big supportive family" in which "they basically justified my complaints and also helped me try to do something," making it easier for them to manage their difficulties. They summarised LGBTQI+ student organisations as "vital domains for trans participants to create kinship networks and get the support they needed to be successful in college."

Storrie and Rohleder (2018), researching trans HE students in the UK, suggested that the opportunity for activism within student societies, whereby students can be involved in challenging institutional discrimination and supporting change, has helped some trans students feel more included and allowed them to forge relationships with others who understood them. They also suggested that trans students are frequently "objectified and othered" (Storrie and Rohleder 2018, 7), describing examples of students being asked inappropriate questions about being trans, but noted that some trans students also related a need to answer these questions, however inappropriate, as they felt responsible for educating others about trans issues. Similarly, Nicolazzo (2016) suggested that cisgender faculty, students and staff in their research felt that it was up to trans people to teacher others about gender differences.

Representation in the Curriculum

It can be argued that as the curriculum is a main component of university life, the experiences of all students should be reflected and represented in the subjects they study. Limited literature exists about trans representation in the HE curriculum in the UK. I suggest that parallels can be drawn with the representation of other minority groups where issues of power and dominance, privilege and discrimination are equally applicable.

There is a push in HE in the UK to develop more diverse reading lists, which are typically dominated by white, male Euro-centric authors (Schucan Bird and Pitman 2020). Many UK HEIs are looking at better representation of Black, Asian, and minority ethnic (BAME) students in the curriculum after student campaigns arguing that teaching should be more representative of the modern world with regards to non-white communities in the UK (Hussain 2015).

The question of representation in the curriculum is an issue across all subjects but manifests itself in different ways in different subjects. For example, a lack of minority representation for women and BAME students in the curriculum for business courses can be said to reinforce the existing issues of power and dominance of "white male privilege" in business and discourage entrepreneurship from these students (Chaudhury 2020). With the growing numbers of women entering university to study STEM (Science, Technology, Engineering and Mathematics) subjects, Ertl and colleagues (2017) argue that there is a need to adequately reflect these students in what has traditionally been a male-orientated arena.

Hill and colleagues (2021) suggested that LGBTQI+ students thrive in classes where they can see themselves represented, although representation was often only included in specific modules, such as LGBTQI+ studies or gender studies, rather than being embedded into the curriculum. Formby (2017, 208) suggested that LGBTQI+ students felt "forgotten" or "tagged on" within the content of their learning. They reported one participant's example of a statistics class where gender was used as a binary statistic, without consideration that some students may identify outside of the man/woman binary.

Pino (2016) suggested that, based on the results of a 2015 *National School Climate* survey looking at the experience of LGBTQI+ school students in the USA (Kosciw et al. 2015; Maitland et al. 2021), learning about the accomplishments of trans people as part of the curriculum provides all students with a more positive image of their trans peers, with the potential to reduce bullying and prepare students for the diverse world they will be entering when they leave education.

Trans representation is arguably even more important in professional health and social care subjects where students need sufficient knowledge around trans identities to enable them to work effectively with trans patients/clients when on placement and in their future careers. Atteberry-Ash and colleagues (2019) looked at the experiences of 12 LGBTQI+ social work students in the USA. They found a mixture of marginalisation and harmful discourse, including enforcing cisheteronormativity and issues with the language being used, including misgendering students and clients. They reported a gap between the values that social work teaches and how social work education is delivered. Specific education for students entering professions such as nursing, medicine and social work is key but lacking, according to Click and colleagues (2020), and De Vries and colleagues (2020) suggested that current curricula for health professionals in the UK do not provide sufficient teaching about gender-affirming healthcare, and that health professional ignorance, as well as systemic biases that reduce access to care, increase the inequalities that trans people face in the medical system.

Institutional Facilities and Administration

With reference to trans students in HE, the theme of institutional facilities and administration covers areas such as changing names/gender on electronic records, alternative gender options on forms and systems, and the provision of suitable toilet and changing facilities along with the acceptance of trans students being able to use the facility of their choice.

Goldberg and Kuvalanka (2018) in research specific to the experiences of trans college students in the USA, identified lack of clarity in how to change names and pronouns on university computer systems. Storrie and Rohleder (2018) made recommendations for policies to be consistent across UK HEIs and that they should include procedures for transitioning students to change their name and pronouns easily, as well as ensuring the inclusion of trans students in discussions when planning changes to facilities and policies. Lack of a third gender option for nonbinary students was a barrier reported in an overview of empirical research conducted by TransEdu Scotland with trans staff and students from HEIs across Scotland; Mckendry and Lawrence (2017) reported trans students' fear of being 'outed' by ineffective administrative processes, after navigating the challenging administrative and bureaucratic systems to change their name and/or gender on university records.

Exploration of literature pertaining to institutional facilities suggested that gendered spaces were problematic. The failure of HEIs to provide gender-neutral toilets was reported by participants in a study in New Zealand (Allen et al. 2020), and nonbinary students in a Scottish HEI reported the lack of gender-neutral toilets on campus challenging (Marzetti 2018). Trans-hostile debates around the use of women's toilets by trans women (Hines 2019) have made it harder for trans people to use toilets that corresponded with their gender identity in many areas of life, not just HE, and gendered facilities based on a male/female binary can result in nonbinary people experiencing harassment whichever toilet they use (Jones and Slater 2020). Acciari (2014) proposed that a lack of gender-neutral facilities on campus was a major issue which could lead to trans students avoiding using them or feeling unsafe doing so, and Bachmann and Gooch (2018b) reported that one in six trans students felt unable to use the toilet they were most comfortable with at university.

Gaps in the Literature

The review of the literature identified limited research investigating the experiences of trans HE students in the UK as a distinct group, rather than as part of research into LGBTQI+ students or as part of research into trans individuals in wider society.

With regards to harassment, bullying and transphobia, the literature reviewed lacked clarity regarding alternatives to support change in HEI policy and practice. My research sought to address this gap by investigating the experiences of trans HE students in the UK in respect of instances and impact of harassment, bullying and transphobia, the reporting systems in place, and the perceived ability of HEIs to address these issues. In respect of inclusion/exclusion, previous studies have largely failed to consider the impact of institutional cisnormativity, and I investigated this further in my research. Relating to representation in the curriculum, although there has been some LGBTQI+ student research, a lack of trans-specific academic research provided an opportunity to investigate further. Finally, concerning institutional facilities and administration, my research explored the current situation across UK HEIs and whether HEIs are addressing these issues.

METHODOLOGY

Theoretical Framework

Transformative paradigm

I used a transformative paradigm, with its emphasis on addressing issues of social injustice experienced by marginalised groups, to investigate the experiences trans HE students learning within a largely cisnormative environment, in order to inform practical change. The transformative paradigm grew out of dissatisfaction with existing dominant research paradigms in the 1980s and 1990s (Mackenzie and Knipe 2006). Although constructivist/interpretive approaches had begun to consider how a researcher with privilege associated with areas such as race, gender or social class for example could conduct research relating to populations without these privileges in an ethical way (Mertens 2019), these approaches were still not adequately addressing issues of social justice and marginalised people.

The following characteristics of the transformative paradigm show its relevance to my research: (1) It places central importance on the lives and experiences of marginalised communities, including the way oppression is structured and reproduced, and how lives are constrained by the actions of oppressors; (2) it analyses how and why inequities are reflected in asymmetric power relations; and (3) it links social inquiry to political and social action (Mertens 2009; Mertens 2019).

This fits very well with my study which investigates the experiences of trans HE students and the power imbalance of learning within a privileged cisnormative society, and which aims to influence policy change within that environment to reduce inequality. The goal of addressing inequality and injustice in society connects with the goal of critical theory in education, which focuses on how the educational system can reduce the barriers to education experienced by some students.

Critical theory

The aim of critical theory is to not only understand situations, but to change them (Fischer and Tepe 2011) with methodology that is "explanatory, normative and practical," exploring not only "what is, but… what could and should be" (Govender 2020, 208). I felt that critical theory in education was relevant to the focus on policy, practice, and institutions in addressing issues specific to the experiences of trans students in the HE environment. The aim of critical theory in education is both practical and political: to question how the education system can offer the best education to all, by understanding the different perspectives of students who are at a disadvantage as a result of inequality in society; to examine how the education system perpetuates or reduces inequality; and to eradicate the effects of illegitimate power (Cohen et al. 2018).

Critical theory is a powerful framework for understanding disparities as functions of power, domination and exploitation in education, within both the curriculum and the HE environment. Strunk and Bettles (2019, 77) suggested that by using critical theory in education, systemic and ideological issues are addressed through a focus on "systems, ideologies and institutions rather than on individuals," whereby although the data are collected from individual students, the focus is on the systems in which the students study. In respect of my study, critical theory as it applies in education investigates the challenges of trans students in the largely cisnormative HE environment and examines how these can be addressed by improving the systems and environments in which these students exist. Critical theoretical approaches typically acknowledge that social identities are ideological constructions (Strunk and Bettles 2019). Cisnormativity is a social construct in which cisgender identities are assumed and upheld as the norm; "a cultural phenomenon in which people privilege and normalise non-trans experiences which leads to marginalising and oppressing transgender people" (Boe et al. 2020, 158).

I analysed the data with the concept of cisnormativity in mind, and this enabled an investigation into how the construction of gender binaries governs what Foucault (1991, 187) termed "disciplinary power"—a mechanism of power that relies on everyday institutions and interactions, and that is "exercised through its invisibility." Within HE, educators and administrators are implicated in allowing certain practices to continue, such as administrative systems that deny trans students' identities and reiterate gender as a fixed binary (Frohard-Dourlent 2016). Foucault's approach to power focuses on the 'micro mechanisms' which operate in everyday life, often unperceived (Crossley 2012), and relates well to the concept of how, in the background, cisnormativity wields power over those outside of cisnormative ideals. An understanding of cisnormativity in HE and how this makes it harder for trans students, is integral to bringing about change.

Research Design, Data Collection and Analysis

I used an online survey to gather information about trans students' experiences in HE and one-to-one interviews to achieve a deeper understanding of these experiences. The quantitative data collected from the survey were used to deliver descriptive statistics, to describe what the data showed in a manageable form (Trochim 2022), rather than being used to understand patterns exhibited by the data (Babones 2016). This enabled me to collate evidence in a way that would be valued and understood by senior HEI managers in order to bring about change. The aim was not to generalise findings to all trans HE students, but to explore and explain the range of diverse perspectives and experiences using in-depth data gathered from different methods, from a range of respondents, in order to inform policy and practice.

Online survey

I chose the online survey method to allow the target participants to take part anonymously due to the sensitive nature of the research topic (Braun et al. 2021), and to reach a wide range of participants, with the target population being a relatively small group scattered across different locations (McInroy 2016). I began the survey with questions to ascertain the gender identity and pronouns of participants. I then included questions around the themes identified in existing literature: institutional facilities and administration; harassment, bullying and transphobia; inclusion/exclusion; and representation in the curriculum. I used open and closed questions and offered participants the opportunity to report on both positive and negative aspects related to these themes. I finished the survey with further demographic questions to enable me to interpret the data according to academic course of study and in reference to intersectionality with other protected characteristics. At the end of the survey, I provided a link for participants to select if they wished to register interest in the one-to-one interviews.

Interviews

The rationale for also using interviews was to allow participants to discuss lived experiences in greater detail, outside the defined questions of the survey. I used semi-structured informal guided interviews, using Skype video calling to provide participants with the opportunity to take part regardless of geographical distance. Allowing participants a degree of anonymity through the use of online interview methods can result in less inhibited responses when discussing sensitive topics, and this method has been used in other LGBTQI+ research (Jowett et al. 2011). I used a list of topics and prompts in order to allow participants to lead the discussion and talk about what was significant to them, whilst still being able to direct the flow of the conversation myself to ensure consistency across the interviews when analysing the data.

With participants' permission, I recorded the interviews and then transcribed electronically using *Otter.ai* transcription software. I replayed the recordings, and edited the transcriptions manually for accuracy, and to remove reference to names, HEIs or the area of the country where participants were studying, to ensure there was nothing to identify them. I sent the transcriptions to participants, which helped to ensure it was their voice being represented, and that any interpretation of what they had said was correct.

Limitations

I considered disadvantages and limitations to using online surveys and interviews. Given the sensitivity of the topic, participants may have been more likely from those target students who were 'out' rather than those who were not; there may also have been some degree of bias in the sample, with those more interested in activism or having experienced discrimination more likely to participate. Another limitation could be that those from a higher socioeconomic status may be more likely to participate due to ease of computer and internet access (McInroy 2016; Ward et al. 2012), as those relying on HEI computers may not feel comfortable completing the survey or taking part in interviews in shared areas on campus (McInroy 2016). Results from a Universities and Colleges Admissions Service report (UCAS 2021) showed that 18% of trans students were from "disadvantaged" areas (from the lowest areas of HE participation by young people in the UK, known as POLAR4), in comparison to 13% of for non-LGBTQI+ students. There are also potential limitations in requirement for reliable technology, and during some of the interviews there were issues with poor internet connectivity which interrupted the flow of the conversation. However, I considered this preferable to telephone, online chat, or email interviews, which would not have provided me with the ability to see facial expressions during the interviews (Irani 2019), and for participants to see me in a one-on-one "virtual" environment.

Analysis

Thematic analysis allows for the identification, analysis and interpretation of themes within qualitative data, and I used this for its flexibility in terms of varying sample size and different methods of data collection (Clarke and Braun 2017) from survey responses and interview transcripts. I used a mixture of inductive and deductive methods (Braun and Clarke 2006); I had derived the themes in the survey and interviews from previous research and aimed to extract specific information from participants in order to address the research questions, but using a transformative approach it was important that the voice of the participants was heard and to be able to identify any additional themes arising. Transcribing the interviews allowed me to become familiar with the data. I read the transcriptions several times before uploading them into *NVivo 12* software to organise the responses and identify patterns within the data, coding each interview using line-by-line coding.

I collected the survey data using *Jisc Online Surveys*, running the survey from 23rd November 2019 until midnight on 29th February 2020. I uploaded free text responses from the survey to *NVivo 12*, to organise the research using line-by-line coding in the same way as for the interview transcripts. I analysed closed questions using the *Jisc Online Surveys* analysis tools.

Ethical Considerations

Ethical considerations were important, given the marginalised population and sensitive topic. I applied to the Open University Human Research Ethics Committee (HREC) for authorisation, in compliance with the ethical guidelines of the British Educational Research Association (BERA 2011), which involved complying with an explicit protocol defining how consent to participate was sought, gained, and recorded; how data were collected, stored and accessed; and how participants were informed of their rights (Open University 2014). Requirements were met and permission to commence data collection was granted.

The trans population has been subject to ethically and methodologically flawed research practices in the past (Vincent 2018, 104), so it was important for me to be able to answer the question of "why is this study being done" and ensure my answers to this met prescribed ethical guidelines.

Researcher Background, Beliefs, and Biases

As a cis person researching the experiences of trans students, it was important to consider the insider/outsider dichotomy—whether or not a researcher should be part of the population being investigated when this is a marginalised community. A researcher studying a group or culture they belong to can bring an understanding of, engagement with, and commitment to the population that an outsider may not have (Breen 2007); however, for the insider researcher, familiarity can result in assumptions based on prior knowledge or experience (Levy 2013), with meaning communicated by "shared understanding of vague comments, innuendoes, and incomplete sentences and descriptions" (Breen 2007, 164).

I considered my position as a cisgender researcher and identified any potential problems this might generate. Thurairajah (2019) suggested that the nature of the relationship between a qualitative researcher and their participants can affect the outcome of the research, and that researchers need to identify the boundaries between themselves and participants, and the level to which these boundaries can be exposed or maintained in order to build trust and not compromise the "truth" of the participant's story.

I did not disclose to participants that I worked in HE; on the Participant Information Sheets and Consent Forms I introduced myself as a Doctoral Researcher, placing myself as a student rather than someone with a potential position of power. I used informal guided interviews to reduce the power conflict as, although steered by me, participants were able to choose what they spoke about. I allowed participants time to answer and welcomed silences as "thinking time."

I chose not to disclose to participants that I am cisgender; at the start of the interviews, I only confirmed my name and pronouns. I considered this to be important so that the focus would be solely on the participant; however, I was also concerned about how the participant would feel if they discovered I had been "hiding behind a cloak" (Thurairajah 2019, 138), particularly as I would be asking participants to be "uncloaked" in their responses. In retrospect, if conducting this study again I would declare my positionality as a cisgender researcher so that participants who may have had difficult experiences with cis researchers in the past would have that knowledge before consenting to taking part.

It was also important to ensure that my research ideas did not originate from personal experience or from preconceptions brought about by my own gender identity. Researching transgender issues involves studying an experience that is "positioned as nonnormative and consequentially conceptualised relative to the celebrated (cisgender) norm" (Galupo 2017, 241). I considered how my cisgender identity might impact how I phrased questions and tried to address this by ensuring that trans students were involved in making sure my research questions addressed their needs and were not based on my supposition of what their needs may be. To do this, I discussed my proposed questions with the Trans Officer from the student union at the HEI where I work, and then completed a pilot study with eight trans students from a single HEI, making some modifications to how questions were worded and additional questions that could be included, based on feedback from this.

Surveys could be seen as intrusive, both into the privacy of the participant and into their time. Vincent (2018) suggested a careful study of language is important when considering all research, but that particular attention should be paid to this when researching within the trans community. I explained my use of the umbrella term "trans" at the start of the survey. I used questions such as "What pronouns do you use" in preference to "What are your preferred pronouns," which showed an understanding of pronoun awareness and respect, as did the inclusion of 'neopronouns' (Vincent 2018) in the survey and an option to not provide an answer to this question. I considered how the participants might feel after completing the survey, as there was a possibility this could exacerbate feelings of exclusion or dysphoria, or increase frustration, and I included links to various support groups in the Participant Information Sheet. As knowing the aims of the study would not influence participant responses, I was able to provide useful information to help them make the decision to take part. This transparency about the aims of the research and how it might benefit the trans student community helped to reduce inequality due to my own privilege (Vincent 2018).

FINDINGS

A total of *N* = 166 participants completed the online survey. I excluded one transphobic response from analysis and excluded another as no questions had been answered.

Seven participants took part in one-on-one interviews. All survey questions were optional, so not all respondents indicated their HEI or course of study, but of those who did, there were participants from 60 different HEIs across the UK (England, Wales, Scotland, and Northern Ireland) and representation across the curriculum covering 83 distinct courses, with *n* = 64 students studying humanities courses, *n* = 38 health and social sciences, and *n* = 51 studying STEM subjects.

More trans men (*n* = 66) and nonbinary (*n* = 61) participants took part than trans women (*n* = 30). Those choosing "other" for gender identity (*n* = 7) self-described as: genderqueer male, none/neutral, man with a trans history, genderqueer (*n* = 2), agender, and questioning. More participants used he/him (*n* = 75) or they/them (*n* = 42) than she/her (*n* = 33). Of those choosing "other" (*n* = 12), all used both he/him and they/them.

The interview participants were from seven different HEIs in England, studying health and social sciences (*n* = 4) and humanities (*n* = 3). I did not ask interview participants to disclose their gender but provided them with the opportunity to share pronouns; four exclusively used he/him, one exclusively used they/them, and the other two participants used either he/him or they/them. No participants using she/her came forward for interviews; this, along with the lower numbers of trans women participants in the survey indicates that there is a need to explore further the experiences of trans women in HE.

Harassment, Bullying, and Transphobia

Where harassment, bullying and/or transphobia was reported, survey responses provided a breakdown of the type of experiences (Figure 1), where being outed without consent and purposeful misgendering were the highest reported incidents.

The five "other" responses included transphobic comments made in class being unchallenged; transphobic teaching practices; people refusing to use nonbinary pronouns "because it's linguistically challenging"; incorrect pronouns being used by someone who "doesn't 'agree' with trans people"; and a participant being told their gender identity was the result of not being allowed to do "male things" as a child and that transitioning is "dangerous and likely a mental illness." This shows that at least some misgendering is quite deliberate and used to harm, rather than being a genuine mistake. The majority either did not report the incident or did not know how or where to report such actions.

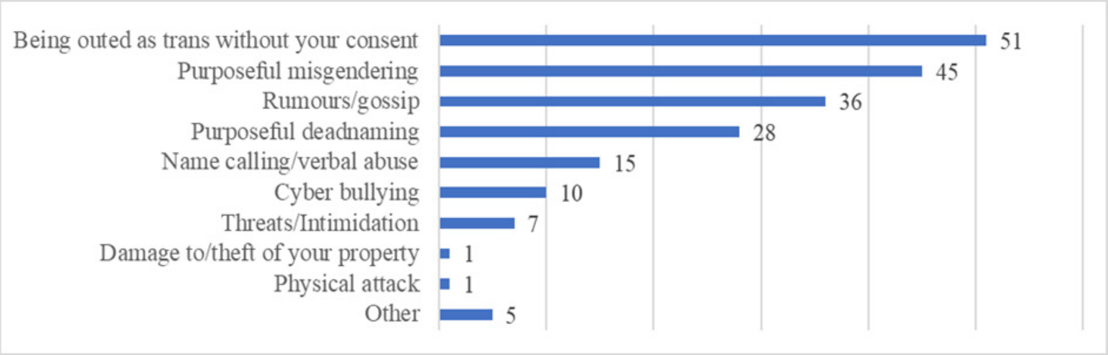

Figure 1. Have you experienced any of the following at university yourself, because of your trans identity?

One interview participant reported having experienced bullying/transphobia at university. They described how a flatmate had started calling them "it" but that, although security was involved, "not much really was done about it, which really annoyed me, but he did apologise, so what more can you ask for?" The final part of the sentence—"what more can you ask for?"—seems to imply that they did not really expect for this to be taken seriously by the HEI or for anything to be done to stop this happening again.

Other interview participants reported being aware of others experiencing difficulties, with a common theme that there was a lack of confidence in how well the HEI would deal with the issue. Some participants said they were aware of systems in place to report bullying but were not sure how to do this. Even those in a position of supporting students did not always know how to signpost to report incidents. One interview participant, who was president of their student LGBTQI+ society, commented that:

> If there is a process, which I'm sure there must be, it's not advertised to students... We just run around, talk to everyone that we know until someone tells us what we can do about it, and then help the student with it. (Participant 4)

Most of the students interviewed mentioned the negative impact of incorrect name and pronoun use. Some of this clearly resulted from ineffective administrative processes, but the impact is clear:

> It was a bit startling to see my given name printed on the card and it was a bit of a slap in the face really... All of these constant reminders are just really unpleasant and hurtful. (Participant 2)

Some students also faced misnaming or misgendering in person resulting in feeling invalidated:

> They don't check in with me about my pronouns... They don't react to my facial expressions when they call me "lady" or "girl"... They just don't notice; they don't hear it. (Participant 2)

Even when accidental, this perpetuates cisnormativity and can have a negative impact when it is in front of others:

> I've had a lecturer that's misgendered me and it was very awkward because it was in front of the class and I got a bit red and felt a bit uncomfortable but at the end she's pulled me over and says, "I am really sorry" and apologised. (Participant 3)

Some students in the survey gave examples of instances where the university had been particularly positive in supporting trans students; some of these included statements about correct use of names/pronouns:

> Lecturers have asked which pronouns I would prefer when giving information about me.
>
> Academic staff on my course have always been quick to take up preferred names and pronouns as soon as they are aware that they have changed.

Responses showed the positive impact that using a trans student's correct name and pronouns can have, as well as the negative impact of misnaming, misgendering, and other microaggressions.

Representation in the Curriculum

Although the majority of participants (*n* = 146) felt trans representation in the curriculum was at least somewhat important, *n* = 91 did not feel at all represented. Some acknowledged that representation is "easier" in some subjects than in others; Acciari (2014) suggested that LGBTQI+ representation in humanities was higher than in STEM subjects. However, one participant, studying a gender and sexuality module in English literature, described how,

> The gender side of it was a bit more problematic for me… If you are cis, you probably look at it and find it really interesting, but when you're trans, you're reading it and it's really bad… I read it and I was like, this is awful, why are they making me read this? (Participant 1)

The participant described how this made them feel and the impact it had on the rest of their academic journey:

> I felt so uncomfortable with it… I'm just some first year who isn't out to my class except for the other trans people and I'm just there, I don't want to say anything… I don't wanna tell my tutor that she's assigned a bad book… So, I just decided from that class to sort of sit in there in silence listening to people debating whether or not this character is a woman because he has a vagina. But, you know, it was not a comfortable experience. (Participant 1)

This is an example of the power relations in HE, where the student did not feel they could take issue with the book their tutor had assigned on the basis that it was derogatory towards trans people and made trans students feel uncomfortable.

One interview participant, a music student, talked about the silencing/erasure of trans people:

> There are trans composers who, some of whom are still alive, some of whom were working in the 20th century, and we didn't learn about any of them… Western classical music is founded on a system of racism and sexism and homophobia and transphobia and ableism. (Participant 6)

These examples highlight areas where trans representation really should be quite easy to incorporate into the curriculum and underlines the power imbalance of learning within a cisnormative environment.

Some participants described specific relevance of curriculum representation in health and social care subjects, where students are likely to come across trans clients/patients on placement, as well as in their working role after graduating. One participant, studying social work, commented:

> There's no trans representation so far. I know that they're trying to decolonise the curriculum now… but I think currently, they're mostly focusing on race and ethnicity. I'm hoping that queerness will enter soon… I'm fairly sure that every single person in my cohort will at some point have to deal with trans people… using the correct pronouns and a known as name, is quite important. (Participant 2)

Another, who was both working and studying in the National Health Service (NHS), felt trans representation in the curriculum was essential in providing students with the information and knowledge they need and the confidence to ask when unsure:

> It needs to be demystified and debunked… the heat needs to be taken out of it… It's about having a vocabulary for it, about feeling okay not knowing and feeling okay to be able to say "… I'm not that familiar with working with trans people, can you help me out here?… What pronouns do you like to use? How do you like to refer to things?"… It's not one size fits all. Language that I might feel comfortable with might not be suitable for somebody else. (Participant 7)

These are examples of the assumptions of cisnormativity and the privileging of cisgender knowledge in teaching, despite the difficulties trans people experience accessing healthcare and research describing how trans-inclusive teaching in these subjects would help to improve this (De Vries et al. 2020).

There were two reports of positive representation in the interviews, one of which was from a paramedic student who noted:

> We have had a couple of lectures about communication and people's identities… It was really about respecting everyone's identity and it mentioned people that had different genders and sexualities, and it was a good representation. (Participant 3)

The other was from a student studying linguistics, who described a LGBTQI+-focused module where they studied transmasculine voices and how the pitch of the voice can affect perception of gender.

Inclusion/Exclusion

Survey responses reported a good level of support from LGBTQI+ societies, and the majority (*n* = 71) confirmed that their student unions had a dedicated trans officer. Most felt that having a dedicated trans officer was beneficial, for "more representation of trans people and trans issues to the wider community," "to have our voices heard," and "to bring trans perspectives to the fore and support individual students." Some were less enthusiastic about the role, commenting: "The group is so inclusive it would only segregate trans issues to a different place and not promote equality" and "They have an LGBT+ officer and I'm happy for that to remain this way. Not a fan of splitting up the community." However, interview discussions identified a lack of trans-specific representation, and perceived challenges with LGBTQI+ societies being run by "cis white gays" (Participant 5), and that they were not representative or fully supportive of trans members.

Although most interview participants were encouraged by peer support, in many cases this was through developing support networks with other trans students, rather than from cis peers. The participant who had experienced the uncomfortable English literature class described earlier, remarked on how important this had been in helping them deal with this incident:

> It helped that I was sitting in that class with another friend who is also trans, so we could just talk about it together, and be like "this is the worst." But you know, if they hadn't been there and I was the only trans person in that class, I would have had a horrible time. (Participant 1)

This level of support felt by having peers who are able to identify with trans students' issues further stresses the importance of trans representation and the encouragement of trans participation in student union and LGBTQI+ Society events and activities.

Responses on the subject of supportive staff were varied, but particularly positive regarding support provided when trying to navigate the administrative processes for changing names on the university records. One comment also related to the visibility of staff allies:

> I love that many of the lecturers wear these lanyards with the rainbow pattern on them, which signals to the students that they are LGBTQ+ allies and can be approached… I like that I have someone I can actually turn to very visibly… It makes me feel very welcome. (Participant 2)

There were negative comments regarding a lack of understanding from university counselling services. One interview participant described negative experiences they had themselves, and experiences other students had brought to them in their capacity within the student union:

> We'd have a lot of students who come to us and be like, "I went to a counsellor, and this counsellor just blamed everything on me being gay, or just blamed everything on me being trans"… I go to a counsellor, but I can tell you that being trans is the least of my problems… I've also had the situation where they found out I'm trans, and then they wanted me to teach them about the whole process of transitioning and all this stuff that they can then go away and help other trans students, and it's like, they're supposed to be helping me… It has stopped quite a few students from wanting to access their services. (Participant 4)

Institutional Facilities and Administration

Many students in this study faced difficulties with changing their name and/or gender on university data systems and ID cards, often due to a lack of processes in place—an example of the problems that can occur due to the formal and bureaucratic procedures set up with cisnormative and binary gender assumptions. Two interview participants described having alerted the university in advance of starting their degree, with one commenting:

> I got in touch… over email with the university beforehand, to let them know I'm trans, this is my preferred name, my pronouns, can you make sure that any staff I'm gonna be in touch with are aware of this, and they're like, yeah, that's fine, no problem. (Participant 1)

However, the participant explained that this did not happen, leading to difficulties once classes began where the register used their birth name, 'outing' them to staff and peers within their first few days at university. They had to email all their teaching staff to advise of the error, but said once this was done, the teaching staff immediately changed the register so that this would not happen again. However, it still was not updated in the university's systems so the same thing happened at the start of semester two. This is an example of HEIs not having a clear process for changing student details, so all relevant staff are informed. The same participant also described the difficulties this delay caused when accessing university mental health support services:

> The information hadn't been passed on like I was expecting it to… I'd just without thinking signed off an email with the correct name. And they replied to me, like, "sorry, I don't know who I'm speaking to"… [I had] a moment of I don't know how I am meant to address myself to

> them in the emails now because I didn't know who knew what anymore. (Participant 1)

This is an example of how disjointed administrative processes can affect trans students, where the student assumes changes have been made, but are then placed in uncomfortable situations when they find this is not the case. In the survey, *n* = 72 participants had requested a change of name to be made on their university record; half felt this information had not fully filtered down to relevant academics.

There was an opportunity on the survey for participants to expand on how easy it had been to record a change of gender, and of *n* = 49 responses, *n* = 28 reported this as being an easy process, with *n* = 21 having come across barriers. Those who faced barriers described universities being reluctant to make changes, and systems requiring a great deal of work on their part to request a change. One participant was told they were not able to change their details without a Gender Recognition Certificate, which is categorically incorrect and against the Equality Act 2010 (Women and Equalities Committee 2015); two others faced specific difficulties related to being nonbinary, as there was no gender option available for them on computer systems—both reported having to choose between a binary marker or "unknown." Over half of the survey participants though found the process easy and their comments made it clear how straightforward this can be where the HEI is willing to make it so. In many cases it was resolved after a simple email and when reporting about positive experiences, one participant said changes to ID cards at their HEI were free where a name change is required, and that "Mx"—a recognised title that does not indicate gender—was a standard option for students.

Three interview participants reported that a legal name change (deed poll) was required by the HEI before they could change their name on internal university systems and ID cards. One described the difficulties this caused, having to choose between being outed to peers or to family:

> I hadn't changed my name legally because of family situations, and that can be a bit difficult because… all the online stuff, they wanted me to change my name legally to get all that changed. (Participant 5)

The lack of effective processes was frustrating for students, but also had emotional/mental health impacts. This was described by one interview participant:

> I was constantly reminded of the name I didn't choose. I don't even care all that much about the pronoun stuff, to be honest, I care way more about the name because if they call me by my old name, I just feel 21 years of frustration and anxiety building up in me… That's just all of these constant reminders are just really unpleasant and hurtful. (Participant 2)

The participant quotes in this section provide a powerful sense of the weariness of constantly being beaten down by what may be considered by HEIs to be seemingly small things. It is clear how a simple change to administrative processes could be supportive of trans students and would go some way towards reducing the negative impact on their mental health.

Students also reported challenges with gendered toilet facilities and with gender-neutral facilities often being a re-designation of disability-accessible toilets for "shared use." All interview participants mentioned a lack of gender-neutral toilets as being an issue, and two explained their discomfort with having 'disabled' toilets as the gender-neutral option:

> I always feel a bit wrong using them because of if someone who needs to use a disabled toilet comes along and is waiting 'cos I'm there instead. (Participant 1)
>
> The gender-neutral toilets are also the disabled toilets… I'm able-bodied and so I don't always feel comfortable using toilets that are specifically for disabled people. (Participant 6)

A survey participant also touched on sharing disability-accessible spaces and how this sets up marginalised groups in opposition to each other; they described how someone had stuck a sign on the door saying "for disabilities only" despite it being designated by the HEI as a gender-neutral facility. They commented, "I wish I didn't have to share a facility intended for the needs of another minority as it feels unfair to them too."

Participants talked about a disconnect between policy and practice, with policy recommendations often not being backed up by change. One participant queried the motive behind having a trans student policy:

> The fact that I'd come to this university partly because of the things they'd said they would be doing… in their trans policy, and then it made it feel like, oh, ok, you're saying you're going to do these things just so you sound good basically… they didn't seem to actually worry about following through with it. Made it feel like they put this policy in place because they have to rather than because they cared. (Participant 1)

If prospective students are investigating trans student policies when making their choice of HEI, then these should be publicly accessible. It was surprising then that of 169 HEI websites I visited, 96 had no trans policies accessible to the public.

DISCUSSION

In this section I interpret the findings in relation to the existing literature and examine assumptions of cisnormativity in HE revealed in the findings of the survey and interviews. I look at how feelings of segregation and otherness were reflected in the data, and the lack of representation for trans students in the curriculum. I also discuss the difficulties with mental health support services disclosed by participants.

Assumptions of Cisnormativity

Despite the lack of trans-specific research, parallels drawn with other marginalised groups in HE, for example Ertl and colleagues (2017) looking at the experiences of women studying STEM subjects in HE, and Chaudhury (2020) investigating women and BAME student representation in business courses, seem to imply that the privileging of cisnormative ideologies in HE which normalise binary and unmoveable gender would result in oppressive systems that can have a negative bearing for trans students.

I examined the marginalisation of trans students to identify how and where cisnormative practice occurs, and how these practices can be challenged. Using a transformative approach, I sought to identify the imbalance of power for trans students who are learning within a mainly cisnormative environment, and to transform the lives of this marginalised group by influencing change. In the survey and interviews, I identified many examples of trans students experiencing institutional discrimination—through poor administrative processes, lack of suitable facilities, inaction over transphobic incidents, absence and erasure of trans identities in the curriculum, and LGBTQI+ societies having to support students where HEI procedures are lacking.

Frequently, poor administrative processes resulted in the misnaming and misgendering of students. Even where these processes were less arduous, many HEIs failed in ensuring the changes filtered down to academic and support staff, which resulted in continued problems. Formby (2017) identified misnaming and misgendering as symptomatic of a lack of awareness about gender identity. Many of the problems highlighted could be resolved with effective training of staff and changes in administrative processes, to ensure trans students are not being misnamed or misgendered through administrative inaccuracies or ignorance.

Simple but effective administrative processes can have a huge impact on the wellbeing of trans students, and information on student data systems can have a positive or negative effect on students' feelings of belonging. The impact on trans students' mental health was clear from some of the participant responses, whether the negative impact of being "constantly reminded of the name I didn't choose… [resulting in] frustration and anxiety building up in me" or the more positive "The first time I held a preferred name ID, student ID in my hand, I cried, tears of joy."

Nonbinary students were challenged by many HEIs not having the option of a nonbinary gender marker. This is an example of institutional microaggression informed by cisnormativity, and of Foucault's (1991) idea of disciplinary power, where upholding the gender binary and forcing students to choose between 'male' and 'female' gender markers, denies the existence of those outside of this binary. Having to negotiate cisnormative assumptions of gender binary can lead to increased negative mental health outcomes (Pulice-Farrow et al. 2020).

Feelings of Segregation and Otherness

Critical theory identifies how the influence of power relations in society leads to inequality and oppression, and in this study, I found that cisnormativity in HE can lead to feelings of segregation and otherness. From the findings, I identified that a lack of gender-neutral toilet facilities is a problem for many trans students, who may feel uncomfortable both when using the toilet of their affirmed gender, if for example they have not commenced physical transition or are not confident enough to use this toilet, and when using the toilet of their assigned sex due to the dysphoria this causes. Having gender-neutral facilities can make this easier, and for nonbinary students, a lack of gender-neutral facilities forces them to choose between only two options, or, as reported by one participant, not use the facilities at all, waiting until they are back in their own accommodation, which can affect physical as well as mental health.

Several participants also mentioned that where HEIs do have gender-neutral toilets, these are often just an "all welcome" sign on the "disabled" toilet. Slater and Jones (2018) suggested "all-gender" toilets should be provided alongside gendered facilities but that this should not be through the re-labelling of an accessible toilet, and that as accessible toilets were the only option for some disabled people, trans participants "were often aware that their need for an all-gender space may compete with the needs of those with physical impairments, whose use of the space was portrayed as more legitimate" (Jones and Slater 2020, 844).

Ignoring or Disregarding Trans Experience in the Curriculum

I used critical theory in education to question how HE could offer the best education to trans students by understanding the different perspectives of students who are at a disadvantage as a result of inequality. Cisnormativity in curriculum construction and presentation can result in the erasure and silencing of trans experiences, further marginalising trans students. Page (2016, 117) noted that LGBTQI+ students are "at greater personal and academic risk" than non-LGBTQI+ peers, for example with a negative learning environment impacting students' academic achievement and goals. Trans representation in the curriculum can help to "cut through cisnormative silence" and reduce the "dominant and normative cisnormative organisation of power/knowledge" (McBride and Neary 2021, 1103).

Often, when HEIs consider the "inclusive curriculum," LGBTQI+ identities can be left out, with the greater focus in the UK being on "decolonising" the curriculum which, as identified in previous literature, tends to focus on ethnicity (Chaudhury 2020), Euro-centrism (Schucan Bird and Pitman 2020), and women (Ertl et al. 2017) rather than gender identity. Diversifying reading lists to include trans writers as part of this process is just one way of working towards improving the learning experience of trans students.

Trans Inclusion in Professional Health and Social Care Curricula

The transformative paradigm asserts that power relations within society construct and influence reality and knowledge (Mertens 2019). The privileging of cisgender knowledge in respect of teaching students in professional health science subjects impacts not only on what students learn, but on what knowledge they take with them into professional careers. De Vries and colleagues (2020) suggested that trans people can find accessing healthcare hard, regularly experiencing stigma, discrimination and marginalisation, being faced with healthcare professionals who are not adequately prepared to meet their needs, and experiencing subtle microaggressions and cisnormative processes that can make them feel invalidated and unwelcome.

Therefore, of particular concern in this study were the students reporting poor or lacking representation in professional health and social care subjects, including nursing and social work. These students may work with transgender clients/patients on placement and in their working role after graduating, so the inclusion of trans identities in the curriculum is essential yet appeared to be mostly absent. Three interview participants were studying in this area (social work, paramedic science and health sciences); one gave their experiences from all sides—as a health sciences student, an NHS practitioner, and a trans patient—suggesting that teaching practitioners to feel confident with their language is lacking, as is effective training of teaching staff, particularly those who have been in the profession for a long time. They said practitioners need to feel confident to ask if unsure and described practitioners "treading on eggshells" around trans people, in fear of saying or doing the wrong thing. On the other hand, they explained that having transitioned some years ago, the reason they might see a doctor now is most likely nothing to do with being trans, and that practitioners need to learn "when it is a thing and where you should pay attention to it… and when that's inappropriate." This is what Wall and colleagues (2023) refer to as "trans broken arm syndrome"—medical discrimination where a practitioner incorrectly assumes that a presenting condition is a result of a trans patient's gender identity or medical transition.

Similarly, the social work student was concerned that every person on their cohort would at some point work with trans people and having been shown little respect by their own lecturers and classmates with refusal to use their correct pronouns, they felt it was very important this should be included more actively in the curriculum. It was only the paramedic science student who reported more positive inclusion, describing having had lectures on communication and respecting everyone's identities. This student noted how proud they felt when this was taught and how nice it was to hear and see positive reactions from classmates.

HEI Mental Health Support Services

Without HEIs acknowledging that assumptions of cisnormativity exist, trans students may face inequalities in accessing HEI support services. Institutional cisnormativity is often embedded in the structure, culture, and processes of HE (Frohard-Dourlent 2016) and has a negative effect on trans students, often resulting in them experiencing higher rates of marginalisation and harassment, which impacts upon mental health and wellbeing. Swanbrow Becker and colleagues (2017) identified that trans students were far more likely than cis peers to report a history of trauma, and a history of suicidal ideation and/or suicide attempts.

A report by the Office for Students (2019) noted that the mental health support needs of HE students must be considered: they may be living away from home for the first time; they may be juggling study and work in order to support their finances; and of particular interest to my study, the report identified how intersectionality with other factors such as ethnicity and sexuality could impact on outcomes and support for students. Given that mental health conditions reported by students in HE in the UK in 2020/21 were almost seven times higher than a decade before (Lewis and Bolton 2023), more could be done to train mental health advisers and counsellors to understand trans students' specific needs. Trans students are often at higher risk of mental health difficulties due to a number of factors, including having experienced social exclusion, discrimination and violence, or having kept their identity hidden. Reducing the impact of cisnormativity is likely to have a positive effect on students' mental health and educational achievement (McGlashan and Fitzpatrick 2018). The lack of knowledge within HEI support services about trans students' mental health indicates a widespread cisnormative approach to student support that needs to be addressed in order to ensure this student group is able to receive effective assistance when needed.

CONCLUSION

In the context of this study, I used critical theory in education to question HE systems and practices and consider how HEIs can offer the best educational experience by understanding the perspectives of trans students who are at a disadvantage as a result of inequality in the HE environment. The results echoed claims made by earlier literature regarding a need for HEIs to improve the experiences of trans students. For example, the harassment of trans students in HE (Marzetti 2018) (Storrie and Rohleder 2018); the impact of poor administrative processes (Seelman 2014) (Goldberg and Kuvalanka 2018); and problems with trans-exclusive facilities in HE (Marzetti 2018) (Bachmann and Gooch 2018b).

My study bridged significant gaps in the previous literature, including the need for: (1) UK-specific research that provides data from multiple HEIs across the UK; (1) research that is trans student-specific rather than part of research into LGBTQI+ students or part of research into trans individuals in wider society; (3) research into the lack of trans representation in the curriculum; and (4) consideration of the impact of cisnormativity in HE.

In order to make change, HEIs need to acknowledge and question institutional cisnormativity. This can be addressed by the practices of the HEI, but to do this, HEIs need to acknowledge that these challenges exist. They need to acknowledge the privilege of a majority cisgender environment with majority cisgender decision makers at the higher levels of leadership and avoid approaches to equality and diversity in which "certain identities trump others in terms of what counts as diversity" (Calafell 2020).

Problems with cisnormativity were highlighted in the study: accidental misgendering perpetuating cisnormativity; administrative processes based on cisnormative assumptions of gender identity; binary normativity in the choice of gender markers and gendered toilet facilities. These problems result in feelings of invalidation and exclusion for trans students and the creation of an atmosphere of inequality. Small gestures around language in the teaching environment—using language that does not assume gender identity and not taking pronouns for granted—can go a long way towards making trans students feel validated. Resistance to using transphobic texts, language, pedagogies, and curricula should be constant and persistent, removing the assumption that all students share common identities and instead working to learn about, acknowledge and affirm differences. Avoiding repetition of privileged knowledge and practices will help to reduce oppression; "What is oppressive is having to experience, again and again, the privileging of only certain ways of identifying, thinking, or relating to others" (Kumashiro 2002).

Improving the curriculum in health and social care courses will help to reduce the variation that exists for trans people in health and mental health care and improve their experiences. These students must learn about how to address and talk to trans people, the value of affirming language, and how to recognise and address prejudice and bias. A lack of gender-affirming healthcare teaching means health professionals are often not adequately prepared to provide appropriate support to trans patients (De Vries et al. 2020). Better knowledge of the specific barriers and experiences that trans patients will have when accessing health and social care services, as well as the understanding that being trans is not always the number one reason for accessing medical or mental health care, are important in reducing the invalidation and invisibility that trans people frequently face. In a societal climate where trans people experience hostility and vulnerability, practitioners who are supportive, non-discriminatory and culturally competent are more important than ever.

By undertaking this study, I aimed not just to make the experiences of trans students bearable, but to ensure they receive the same exciting and amazing experience that all HE students deserve. To do this, HEIs need to be ready for trans students, providing an affirming experience founded on understanding.

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ORIGINAL ARTICLE

A Wolf in Wolf's Clothing: K. J. Zucker and Cisgenderist Research Literature

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Deeply-seeded issues of cisgenderism and discriminatory bias are continuing problems that slow equal rights advances and facilitate further harm for transgender and gender diverse communities—and research literature is no exception. A salient example of this is the historical and ongoing works of Dr. Kenneth Zucker and his colleagues. Previous research by Ansara and Hegarty (2012) has already illustrated this in detail, noting these researchers were often the most cisgenderist while having the highest degrees of influence. This review of literature examines a collection of Zucker's first, second, and third author works from 2010–2022 using Anasara and Hegarty's (2012) framework of binarism, misgendering, and pathologizing to assess cisgenderism within the writing. A lot occurred over those twelve years, including Zucker's work as chair of the *Diagnostic and Statistical Manual of Mental Disorders* work group for the gender dysphoria diagnosis, the controversial closure of his youth gender clinic in Toronto, and massive increases in visibility and discussion of transgender healthcare. In many ways, it appears that Zucker's pattern of cisgenderism has continued. This review of literature explores this pattern in detail and offers insights as to why many of these ideologies are harmful to transgender and gender diverse communities.

KEYWORDS transgender; cisgenderism; gender identity; Zucker; research literature
DOI 10.57814/028-×357

Research has the power to influence policy and thus lives, and so the duty for care in the research (and research*ers*) we publish and platform is instrumental in the potential to facilitate great progress or terrible harm. A clear example of the latter would be the body of work by Dr. Kenneth J. Zucker and other members of his "Invisible College," a connected system of authors in collaboration with each other. Zucker and his invisible college were prominently identified a decade ago as some of the most discriminatory, yet most frequently published and cited research surrounding gender identity (Ansara and Hegarty 2012). In the years since this finding, the harm of Zucker's work has only become clearer with the closure of his gender identity clinic for youth where he was accused by some clients of engaging in conversion practices (Ashley 2022, 3–9). While issues around the investigation led to apologies from Zucker's former employers and a settlement in his favor, it is nonetheless important to note that the clinic remained closed and concerns around Zucker's practices—conversion or not—remained (The Canadian Press 2018).

Despite the constantly accumulating evidence of harm, the power Zucker holds in influencing research and healthcare for trans and gender-nonconforming communities remains, including as the chair of the American Psychiatric Association (APA)'s work group that handles diagnoses related to gender identity in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*), the fifth edition text revision (*DSM-5-TR*), which was only released last year (American Psychiatric Association 2022, xviii). Yes, a researcher with years of documented accusations of cisgenderist bias and self-admission of approaches that could be considered conversion practices (Zucker, Bradley, et al. 2012) is at the helm of the work group that establishes the definitions of transgender and gender diverse experiences.

To illustrate this problem further, this article reviews published articles since 2010 where Kenneth J. Zucker was listed as first, second, or third author and was related to gender identity. The year 2010 was specifically selected as a starting point with the intention of covering at least one decade of published material, especially in order to explore the prevalence of cisgenderist ideology even after public and published critiques such as Ansara and Hegarty's (2012; 2014). This time range also allowed for inclusions of early discussions that were informing the soon-to-be-released *DSM-5*, of which Zucker would chair the work group discussing gender dysphoria as a mental health diagnosis (American Psychiatric Association 2013; Zucker 2010; Zucker et al. 2013).

Throughout the articles reviewed, concepts and approaches are critiqued and the various ways cisgenderist ideology appears is explained. Informing my own critiques will be the previous literature on this issue, as well as other literature noting the severity of this kind of harm and what a proposed alternative could include. Most importantly, much of the supporting literature is often informed by researchers of diverse gender identities and theories that value autonomy and the rights of marginalized communities to speak as the experts of their own experiences. As a point of researcher reflexivity, I too am a researcher and practitioner within the trans and gender diverse communities and the communities Zucker and others often discuss. Critical analysis of where our stories come from is an ethical responsibility, and we owe it to communities that we work with to reflect on whether they've been given the chance to tell their own stories themself (Iantaffi 2020).

ESTABLISHING BASIS FOR CRITIQUE

Understanding cisgenderism

To further understand the concerns illustrated throughout this review, it is important to outline the "what"s and "why"s of the critique—cisgenderism. In addition, we must have a shared understanding of the communities discussed. Throughout this discussion, terms will be used to describe various experiences of gender identity including "trans," "transgender and gender diverse (TGD)," and "self-determined gender." The terminology of “transgender” is likely the most commonly heard but may not be exhaustive nor comprehensive. Noting this, many have tacked on other phrasing to be more inclusive, including the recent verbiage of “transgender and gender diverse” utilized in the most recent edition of the World Professional Association for Transgender Health (WPATH)’s Standards of Care for the Health of Transgender and Gender Diverse People, Version 8 (herein referred to as “SOC8” or simply “Standards of Care”). WPATH defined TGD with the intention of broadly capturing “members of the many varied communities globally of people with gender identities or expressions that differ from the gender socially attributed to the sex assigned to them at birth” (Coleman et al. 2022, 511). As for the other terms, “trans” serves as a shorthand umbrella term for transgender and gender diverse experiences and “self-determined gender” is exactly as it states, where someone has determined their gender identity for themself rather than assuming the imposed identity that was assigned to them at birth. For identities outside of this experience, Ansara (2010) notes the term “cisgender,” which includes the Latin prefix of *cis-* meaning “on the same side.” This term captures experiences where the assigned gender someone receives happens to feel congruent with their own felt sense of gender identity. Expanding upon the concept of cisgender identity and experience, let’s now expand further and discuss specifically the concept of cisgender*ism*.

When thinking about concerns within this body of literature, framings such as “transphobia” or “anti-trans discrimination” may come to mind. While I’m not of the opinion that those descriptors would be entirely inaccurate, the specific framing of cisgenderism feels important for this discussion. Whereas discrimination or phobias are often ascribed to micro-level interpersonal interactions, cisgenderism is an all-encompassing ideology. Bias, discrimination, and hatred are the manifestation, where ideology is the *why.* Ansara frames the notion of cisgenderism eloquently, describing it as the “individual, social, and institutional attitudes, policies, and practices that assume people with non-assigned gender identities are inferior, ‘unnatural’ or disordered and which construct people with non-assigned gender identities as ‘the effect to be explained’” (Ansara 2010, 168).

Within the specific area of research literature, Ansara and Hegarty (2012) report several different mechanisms with which cisgenderist ideology can appear: *misgendering* (labeling one in a way that does not match how they have designated they would like to be referred regarding gender identity), *pathologizing* (framing gender diversity as deviant or disordered), and *binarizing* (describing sex and gender both as rigid and binary constructs, erasing and invalidating people of intersex experience and/or with gender identities outside of the binary of man and woman). Any and all of these practices contribute to cisgenderism because they take away the individual’s ability to define one’s experiences of gender and body for themself and views any attempt to do so as invalid and illegitimate (Ansara and Hegarty 2014).

How cisgenderism harms communities

The way that cisgenderism and cisgenderist ideology have the impact to harm communities should be painfully obvious. However, some detail and elaboration are always important. Especially when one does not have a marginalized experience, it is quite easy to not recognize the multitude of subtle and insidious ways in which the impacts of discrimination and oppression influenced by ideology may show up in someone’s life. As one example, literature shows time and time again that discrimination and other barriers (often that are informed by cisgenderism) create negative and harmful experiences for trans populations simply trying to access needed care or resources, if not barred from even attempting to access them at all (Kcomt 2019; Iantaffi 2020; Puckett et al. 2018). Even further, it's shown that previous experiences of discrimination or even the anticipation of discrimination based on community anecdote and aforementioned findings will often lead trans populations to avoid needed care and resources altogether (Kcomt et al. 2020).

Beyond care that is simply ill-informed or poor quality, cisgenderism can also influence and encourage care that is actively harmful and violent toward trans communities. In the most prominent example, individuals who have come to self-determine a TGD identity or are questioning their gender are not turned away as in the previous example but rather admitted into services that will ultimately attempt to change the individual's gender identity (Ashley 2022; Kinitz et al. 2022; Salway et al. 2021; Turban et al 2018). This practice falls under the larger umbrella of "sexual orientation and gender identity and expression change efforts (SOGIECE)" or "conversion efforts," which describe attempts at changing sexual orientation and/or gender identity or expression, usually to the more socially-accepted identity such as heterosexual or cisgender (Kinitz et al. 2022). Other historical terms include "conversion therapy" or "reparative therapy" although the use of "therapy" to describe these practices is ill-fitting given the proven lack of efficacy and the immense harm that tends to manifest for participants in forms such as increased rates of depression and suicidality (Ashley 2022; 2023; Coleman et al. 2022; Kinitz et al. 2022; Salway et al. 2021; Turban et al. 2018). As noted, conversion efforts can also include attempts to change sexual orientation (why another historical term some may be familiar with would be "ex-gay therapy"). For this discussion, conversion efforts will generally be referring to attempts to change gender identity or expression unless otherwise stated to also include attempts to change sexual orientation.

What is perhaps most uncomfortable about discussion of conversion efforts within the field of mental health is the ensuing reckoning when we face the hard truth that these sinister and harmful practices are a legacy of our field. We often grimace at the thought of conversion efforts as imageries of torture and electroshock fill our minds and we try to let these graphic visualizations remind us that was then, and this is now. I would point out that literature illustrates that conversion efforts are still immensely harmful even without explicit means of physical torture (Ashley 2022; Kinitz et al. 2022; Muse 2015, 2020; Salway et al. 2021). It is difficult and painful, but the harm that mental health fields have historically enacted and currently enact against queer and trans communities is no less a reality. I have often framed that mental health fields' legacy regarding conversion efforts have "haunted" our work to this day. As I think more, I retract this framing; for something to become the ghostly specter capable of such haunting, it needs to have died first.

Why Zucker?

It's undoubtedly a fair question. Ansara (2010) even notes that cisgenderism by its very nature is a systemic issue rather than a single individual's efforts. I'm inclined to agree. Having said that, Ansara and Hegarty (2012) also note that Zucker writes some of the most impactful, yet cisgenderist literature in the field and also holds immense power in vital positions to affect policy such as the *DSM-5* workgroup that oversees the diagnosis of gender dysphoria. While Zucker is not the sole source of cisgenderism in research, critique of his many contributions of cisgenderism in the literature is certainly a reasonable place to start. In addressing Zucker's high-impact role within the greater system of cisgenderism in research, one may hope that this conversation may also facilitate meaningful change within the many areas Zucker's work has influenced and continue to cite his concerning body of work. Perhaps this issue may also lead to some critical reflection on who is in the room when we decide things like the diagnostic criteria for gender dysphoria (or if it should be a diagnosis in the first place).

Arguments for affirmative and self-determined approaches

There are multitudes of reasons to suggest an affirmative, non-cisgenderist approach that lets individuals determine and define their experiences and sense of body and gender for themselves. Beyond the obvious aforementioned harm brought on by the alternative, using such an approach can have profound ability to provide individuals seeking transition and/or self-determination of their body and gender with the support they need (Ansara and Hegarty 2014; Coleman et al. 2022; Iantaffi 2020; Twist et al. 2021).

Supporting this further, Deci and Ryan's (2008) self-determination theory notes that the ability for one to have the autonomy to self-describe within their experiences can have deeply beneficial impacts. The conversations discussed thus far can be explored with self-determination theory's understanding of needs and motivations. In situations where someone's autonomy is valued, the outcomes are better. This is highlighted further when looking at different motivational orientations in the theory. Looking at an autonomous orientation compared to controlled and impersonal orientations which lack autonomy, they note "consistently, the autonomy orientation has been positively related to psychological health and effective behavioral outcomes; the controlled orientation has been related to regulation through introjects and external contingencies, to rigid functioning, and diminished well-being; and the impersonal orientation has been reliably associated with poor functioning and symptoms of ill-being, such as self-derogation and lack of vitality" (Deci and Ryan 2008, 183). In short, it is clear that the decision to take someone's autonomy to self-determination away from them in our therapeutic interactions will only result in a rapid decline in the quality of the outcomes.

SCOPE OF CRITIQUE

Naming all of the above concerns on why cisgenderist research and practices are problematic and affirming, self-determination approaches are sorely needed, it is important to address perhaps the most salient source of these ongoing issues. As noted in a thorough review and analysis of research literature around gender identity, it was found that Kenneth J. Zucker was the most severe offender of cisgenderist ideology in research as well as having some of the highest impact regarding frequency of citation and amount of publication (Ansara and Hegarty 2012). In wanting to explore further in the decade since this issue was raised by Ansara and Hegarty, a collection of literature from Zucker was collected to review further. As mentioned earlier, the parameters included published works (both journal articles and editorials) where Zucker was listed as first, second, or third author since 2010 where the title explicitly mentioned discussion of issues around gender identity. Those parameters were applied to Zucker's personal curriculum vitae that was publicly listed on his website, which became the compilation of literature to review (Zucker 2020a). In total, 29 published articles, letters, and commentaries were reviewed and will be critiqued.

CISGENDERIST LANGUAGE AND FRAMINGS IN LITERATURE

Noting the framing of cisgenderist ideology by Ansara and Hegarty (2012; 2013; 2014), language is one of the most substantial ways that ideology can be identified. In their original study of cisgenderism in research literature, specific categories of cisgenderism including misgendering, pathologizing, and binarizing were used (Ansara and Hegarty 2012). A similar framework is used in exploring this literature, noting how many of the citations contained misgendering, pathologizing, and binarizing as defined by Ansara and Hegarty in a symbolic follow-up to that study and see what (if anything) has changed in recent years within Zucker's writing. In addition, specific passages are called upon as examples and to discuss further critique.

As one note, it's also imperative to acknowledge the limitations around analyzing ideology and practice through use of particular language. Language is both contextual and ever-evolving and so there will always be some degree of nuance to be considered in these circumstances. However, best attempts are made throughout when exploring passages to use surrounding context clues to ensure understanding of what Zucker and his co-authors are trying to say, such as trying to explore what language is being used to describe a subject's identification and what is being described as their sex at birth. Having said that, Zucker and others also use sex-based and gender-based terminology interchangeably quite often, which is its own form of cisgenderism and adds to the further complication in this analysis.

Misgendering

In the original study, misgendering was defined (for children, but applicable generally) as when the researchers "categorised a child into a gender category or gendered behavioural description with which the child themselves did not identify" (Ansara and Hegarty 2012, 142). Of the 29 articles reviewed, explicit misgendering language was used in 20 of them, resulting in approximately 68.97% of the articles having misgendering language (Bedard et al. 2010; Heylens et al. 2012; Khorashad et al. 2020; Lawrence and Zucker 2013; Pasterski et al. 2015; Singh, Bradley, and Zucker 2011; Singh, McMain, and Zucker 2011; Steensma et al. 2014; VanderLaan et al. 2017; Zucker 2010, 2012, 2017a, 2018b, 2019; Zucker, Bradley, et al. 2012; Zucker et al. 2011; Zucker et al. 2013; Zucker, Lawrence, and Kreukels 2016; Zucker et al. 2019; Zucker, Bradley et al. 2012). To be clear, these articles had explicitly identifiable instances of misgendering where the ways participants would likely wish to be identified based on the stated self-determined gender identity or expression were not being used. It is also important to note, however, that some articles perhaps included misgendering but were less clear.

In one example, Zucker et al. (2017) used "gender-based" and "sex-based" language ("boy" vs. "male," "girl" vs. "female") interchangeably in ways that obfuscate any chance of knowing. In one passage, it states, "… found that gender-related themes were significantly more common for the gender-referred *boys* than that of the *male* siblings, but the difference between the gender-referred *girls* and that of the *female* siblings was not significant" (Zucker et al. 2017, 2). Without any clarification, the reader is not sure if gender-referred "girls" and "boys" was referring to the gender they had self-designated or just using gender-based terms interchangeably with sex-based terms, which would then be misgendering the children of the study. Beyond the possible concern of misgendering (which I find to be the likely instance given the pattern), the lack of clarity, detail, and care in explaining something as nuanced and contextual as gender identity is alarming, especially from a lauded "expert" on the topic.

For the mentioned articles with explicit misgendering, much of the recurring theme was around only using one's sex to describe them despite their self-designated gender being different than that of the one assigned to them at birth based on their sex. In using the sex-based language only, this often appears sanitized and neutral, hiding behind a façade of "sticking to the science." Having said that, this still manifests in an outright refusal to allow these people to be seen the way they want to be seen. In some instances, however, the researchers use sex and gender language interchangeably, which then results in misgendering that is all the more violent as it appropriates and falsifies the individual's gender in addition to their sex, rather than just ignoring it. One such instance is Heylens et al. (2012) where they research and discuss sets of trans twins (framed historically and in this article as "transsexual" and/or having "gender identity disorder"). In discussion of "female transsexual twins," they are referred to as "sisters" and with she/her pronouns, whereas the "male transsexual twins" are referred to as "brothers" and with he/him pronouns. Another significant example is in Zucker et al. (2011), where many of the case vignettes mentioned are constantly misgendered throughout with incorrect pronouns and other gendered terms (as well as several inappropriate and unnecessary comments on people's bodies, weights, and how they would be "perceived by others") The only exception to this is where one case vignette specifically has the sudden change to correct pronouns, but only after the individual has legally changed their name and taken other transition-related steps, sending the subtle but nonetheless harmful message that respecting one's self-determined gender is only appropriate once a threshold deemed acceptable by the researcher has been crossed and subjective criteria met (Zucker et al 2011, 75).

Pathologizing

The next example of cisgenderist language is pathologizing, which is, as the name suggests, making something out to be pathological. In this specific instance, pathologizing is verbiage or framing that marks "self-designated gender as a 'disorder'" (Ansara and Hegarty 2012, 142). In fairness to Zucker and colleagues, the reality that gender dysphoria is still a diagnosis in the *DSM* is an important context in this discussion of gender diversity as pathology (American Psychiatric Association 2013; 2022). In fact, it's a context that he himself has stated his awareness of despite still choosing to include it based on his justifications (Zucker and Duschinsky 2016). With that being noted, the discussion of pathologizing language will not include language necessitated by the fact that gender dysphoria is still a diagnosis, although the discussion of gender dysphoria as a diagnosis to begin with (and subsequent pathologizing impacts) is still a valid debate. Some examples of language not included that in other contexts would be pathologizing would be simply naming gender dysphoria as a "diagnosis," "disorder," etc. in reference to its diagnostic categorization, or use of other associated words such as "symptoms," "treatment," and the like. What *will* be explored rather than gender dysphoria (and by extension, transness) as a disorder at all will instead be verbiage or framing that describes the people with gender dysphoria or self-designated gender as deviant or disordered in their behavior or the way they are viewed by the researcher(s).

Explicit pathologizing beyond language associated with the diagnostic status of gender dysphoria was found in 24 of the 29 articles reviewed. This resulted in about 82.76% frequency of this cisgenderist practice in the reviewed articles (Bedard et al. 2010; Heylens et al. 2012; Khorashad et al. 2020; Lawrence and Zucker 2013; Pasterski et al. 2015; Singh, Bradley and Zucker 2011; Singh, McMain, and Zucker 2011; Steensma et al. 2014; Zucker 2010, 2012, 2015, 2017a, 2017b, 2018b, 2019, 2020; Zucker, Bradley, et al. 2012; Zucker et al. 2011; Zucker et al. 2013; Zucker and Duschinsky 2016; Zucker, Lawrence, and Kreukels 2016; Zucker et al. 2017; Zucker et al. 2019; Zucker, Wood, et al. 2012).

Language with this pathologizing impact can be quite blatant or prove to be more subtle. An instance of the subtle pathologizing language can be directed once again to Heylens et al. (2012, 752), where discussing prevalence of individuals self-determining genders other than ones assigned to them at birth was framed as "higher *risk* of being transsexual." In another example, Singh, Bradley, and Zucker (2011, 151) begin the article using "extreme gender variant behavior" in the very first sentence before going on to describe their approach in contrast to the one they are critiquing as "therapeutic approaches that attempt to 'normalize' the child's extreme cross-gender behavior (perhaps with the goal of aligning the child's gender identity with his or her birth sex)" explaining that the "extreme" behavior is something to be corrected.

The only "extreme" here is the ideology and bias exhibited in these writings. In another article, Zucker (2012) claims that some patients he had seen confirm suspicions that some trans and gender diverse individuals will falsify being intersex (framed in the article as "physical intersex conditions" and/or "disorders of sexual development") and calling them "intersex posers." His argument was that, perhaps, this might result in their gender dysphoria or trans identity being seen as more valid by themselves or those around them, painting these patients as dishonest and manipulative. This particular assertion is gravely concerning especially when considering the well-documented trope of transgender people as deceitful and deceptive, which often results in violence and even murder that historically has been legally permissible with factors like the "Trans Panic Defense" used in legal arguments to justify killing a trans person (Wodda and Panfil 2015).

Binarizing

A third type of cisgenderist language and framing is binarizing, which Ansara and Hegarty (2014) describe as presenting concepts (in this case, sex and gender) as rigid, binary concepts. This especially proves problematic because neither sex nor gender are binary and to frame it in such a way erases countless experiences of sex and gender diversity (Twist et al. 2021). Examples of binarizing could include listing sex and gender as binary constructs explicitly, using binary pronoun structures like "he/she" or "his/her," framing sex or gender as binary through framing such as "opposite sex" or "the other gender," and research that only included male/female categorization without specific acknowledgement of that structure as a binary limitation and specifying that it was not including experiences outside of sex or gender binary. Of the 29 pieces reviewed, 21 contained binarizing language once again resulting in approximately 72.41% of the collected literature (Bedard et al. 2010; Heylens et al. 2012; Khorashad 2020; Lawrence and Zucker 2013; Pasterski et al. 2015; Singh, Bradley, and Zucker 2011; Singh, McMain, and Zucker 2011; Steensma et al. 2014; VanderLaan et al. 2017; Zucker 2010, 2017a, 2020; Zucker, Bradley, et al. 2012; Zucker et al. 2011; Zucker et al. 2013; Zucker, Lawrence, and Kreukels 2016; Zucker et al. 2017; Zucker and VanderLaan 2018; Zucker, Wood, Singh, and Bradley 2012; Zucker et al. 2019; Zucker, Wood, Wasserman, VanderLaan, and Aitken 2016).

Overall summary of cisgenderist language

It is abundantly clear that the pattern of cisgenderist language in forms of misgendering, pathologizing, and binarizing has continued to be prevalent in Zucker's work. Through this review, only two articles out of the total 29 were not noted to have any explicit instance of misgendering, pathologizing, or binarizing (Zucker 2013; 2018a). Having said that, the referenced articles that did not contain any cisgenderist language were very short corrections on data that was more-so addressing procedural concerns in the research being discussed. One could then argue, perhaps, that there was not much room for cisgenderist language and wonder to ourselves how gender and sex would have been discussed and framed had it been mentioned. Far more serious than how few didn't have any cisgenderist language is how many contained *all three*, which was 16 of the 29 publications, summing up to about 55.17% (Bedard et al. 2010; Heylens et al. 2012; Khorashad et al. 2020; Lawrence and Zucker 2013; Pasterski et al. 2015; Singh, Bradley, and Zucker 2011; Singh, McMain, and Zucker 2011; Steensma et al. 2014; Zucker 2010, 2017a; Zucker, Bradley, Owen-Anderson, Kibblewhite, Wood, Singh, and Choi 2012; Zucker et al. 2011; Zucker et al. 2013; Zucker, Lawrence, and Kreukels 2016; Zucker et al. 2019; Zucker, Wood, Singh, and Bradley 2012). For an overall glance at the body of literature and prevalence of cisgenderist language, refer to Table 1 where each citation is noted along with whether each type of cisgenderist language was present and an example quote and page number with italics emphasizing concerning language.

NON-CISGENDER SEXUALITY & EROTICISM AS DEVIANT AND DISORDERED

Moving now from the general language concerns into ideological themes, the first of several is the pattern in which sexuality and eroticism of transgender and gender diverse people is pathologized as deviant and disordered. This becomes especially concerning when the literature is describing phenomenon as pathological where the same level of pathology is not given to the same phenomenon for cisgender individuals.

As a starting example, Khorashad et al. (2020, 1195) states, "All the transgender males were androphilic, all the transgender females were gynephilic (preferentially at-

Table 1. Cisgenderism via Misgendering, Pathologizing, and Binarizing in the Reviewed Literature

In-text citation	Misgender	Pathologize	Binarize	Example quote (page)
Bedard et al. 2012	x	x	x	"an individual's sense of themselves as being *male or female*… a persistent and intense desire to be *the other sex*" (166)
Heylens et al. 2012	x	x	x	"higher *risk* of being transsexual" (752)
Khorashad et al. 2020	x	x	x	"pregynephillic *girls with gender identity disorder*" (1202)
Lawrence and Zucker 2013	x	x	x	"Nonhomosexual FTM transsexuals, who may be sexually attracted to men or *men and women*…" (2093)
Pasterski et al. 2015	x	x	x	"*girls or women* with CAH have increased *masculine gender identity*" (1364)
Singh, Bradley, and Zucker 2011	x	x	x	"therapeutic approaches that attempt to '*normalize*' the child's *extreme* cross-gender behavior" (151)
Singh, McMain, and Zucker 2011	x	x	x	"Gender identity, a person's sense of self as a *male or a female* … gender identity disorder or *confusion*…" (447)
Steensma et al. 2014	x	x	x	"We would argue that the poor peer relations of gender dysphoric children and adolescents is due, in part, to the social ostracism that *results* from their *marked gender-variant behavior*" (644)
VanderLaan et al. 2017	x		x	"On the basis of clinical information, all transsexuals were *categorized* as sexually attracted towards men. For the comparison group of men, they were *asked to self-report* their sexual orientation identity. All men self-reported a heterosexual sexual orientation identity" (530)
Zucker 2010	x	x	x	"persisters showed significantly more cross-gender behavior and gender identity *confusion* than the desisters" (481)
Zucker 2012	x	x		"There is a curious irony to the *factitious claims* of these *intersex posers*" (98)
Zucker 2013				
Zucker 2015		x		"children and adolescents with *gender identity problems*" (306)
Zucker 2017a	x	x	x	"*Epidemiology* of gender dysphoria and transgender identity" (article title and throughout)
Zucker 2017b		x		"it allows clinicians (and parents) who believe that children *with the condition require therapeutic attention* the freedom to explore the gender dysphoria/gender incongruence" (2522)

In-text citation (cont.)	Misgender	Pathologize	Binarize	Example quote (page)
Zucker 2018b		x		“because some of the children in that study ‘socially transitioned’ from one gender to another prior to puberty, which one can only assume occurred in the context of ‘supportive’ parents. One definition of ‘supportive’ in the *Oxford Dictionary of Current English* (Soares, 2001) is *‘encouraging’*” (233)
Zucker 2019	x	x		“argued for the influence of peers and social media in *inducing* gender dysphoria in these adolescents, but it is far from clear why these adolescents are so *“susceptible”* to such influences” (1987)
Zucker 2020b		x	x	“if one conceptualizes gender social transition as a type of *psychosocial treatment*, it should come as no surprise that the rate of gender dysphoria *persistence* will be much higher… one might ask why would one recommend a first-line treatment that is, in effect, *iatrogenic*” (37)
Zucker, Bradley, et al. 2012	x	x	x	“For some adolescent *boys with GID*, the clinical literature suggests a picture that is parallel to that of early-onset adolescent *girls*” (153)
Zucker et al. 2011	x	x	x	“supportive of *his* desire to live in the female gender role” (74)
Zucker et al. 2013	x	x	x	“some *psychological treatment approaches* may be associated with *“desistance,”* i.e., *reduction of cross-gender behavior and desires* in children” (911)
Zucker and Duschinsky 2016		x		“I do think that people who present with the *‘symptoms’* of Gender Dysphoria do experience stress and suffering. *And it is a syndrome*, it consists of a set of signs and *symptoms*… And I certainly myself feel that if you don’t feel you *need help* then you *don’t need to come see a mental health clinician*” (31–32)
Zucker, Lawrence, and Kreukels 2016	x	x	x	“Perhaps the SOC should reinstate its endorsement, at least in certain cases, of psychotherapy that *aims to increase comfort with assigned sex and gender role and discourages sex reassignment*” (238)
Zucker and VanderLaan 2018			x	“gender-referred children (439 *male*, 95 *female*)” (4038)
Zucker et al. 2019	x	x	x	“If females are more likely to express tomboyish behavior, than [sic] males are to express the *mirror image*” (950)
Zucker, Wood, Singh, and Bradley 2012	x	x	x	“did not express the wish to be a girl; rather *he* insisted that he was a girl” (377)
Zucker, Wood, Wasserman, Vander-Laan, and Aitken 2016			x	“the *male:female* sex ratio” (694)

tracted to members of their own biological sex), and all of the clinical controls were heterosexual (none were transgender or had a diagnosis of gender dysphoria)." What's interesting here is regarding the treatment of sexual orientation: the transgender individuals were described with *-philia* based language, whereas the cisgender controls were described as "heterosexual." One could argue that the clinical language of androphilia or gynephilia can have a pathologizing connotation compared to heterosexual or homosexual. Granted, I don't think "homosexual" would have been the ideal alternative in this case as I'd argue it'd still misgender the transgender participants based on their self-determined gender identities, but it also would not be that difficult to just say "male-attracted" or "female-attracted" as a clear descriptor that is neither pathologizing nor misgendering of the transgender participants.

A similar example appears in VanderLaan et al. (2017), where they are discussing the transgender women (described in the literature as "male-to-female transsexuals") and the comparison group of cisgender men. They write,

> Information regarding the sexual orientation of transsexual patients was obtained during semi-structured interviews with a psychiatrist (patients attended group and/or individual medical appointments on a biweekly basis). On the basis of this clinical information, all transsexuals were categorized as sexually attracted towards men. For the comparison group of men, they were asked to self-report their sexual orientation identity. All men self-reported a heterosexual sexual orientation identity (i.e. gynephilia, sexual attraction towards women). (VanderLaan et al. 2017, 530)

While this passage was a bit more fair in their equal distribution of pathological language (the transgender women are referred to as "androphilic" elsewhere and even in the title), what's interesting is that the cisgender men participants were able to self-report their sexual orientation identity while the transgender women in the research had their sexual orientation identity categorized and imposed upon them. Because the classification was also based on these clinical interviews, one could also infer the tone here that not only did these transgender women have their sexual orientation identity imposed upon them and unable to self-describe, they also had to "prove it," whereas the cisgender men participants were able to self-report heterosexuality and have it taken as fact.

What is most disturbing in this pattern of transgender and gender diverse sexuality and eroticism deemed as pathological is the peddling of concepts like "transvestic fetishism," "autogynephilia," and "autoandrophilia" to describe some of the experiences in the literature. In the large portion of the literature that contains these concepts, transvestic fetishism refers to arousal that forms from dressing in clothing (theoretically) of a different gender, whereas autogynephilia and autoandrophilia are sexual arousals to being perceived as female or male, respectively (Heylens et al. 2012; Lawrence and Zucker 2013; Steensma et al. 2014; Zucker 2010, 2019; Zucker, Bradley, et al. 2012; Zucker et al. 2011; Zucker et al. 2013; Zucker and Duschinsky 2016; Zucker, Lawrence and Kreukels 2016; Zucker et al. 2017).

The issue here is not cisgender people who truly experience these types of attractions and arousals, as that is valid. My concern here is that almost all of the literature mentioned discusses transvestic fetishsim, autogynephilia, or autoandrophilia in the context of "co-occurring" with gender dysphoria (or gender identity disorder, depending on the time of publishing), meaning trans people with these experiences. For example, let's picture what the literature would describe as a "gender dysphoric male with transvestic fetishism and/or autogynephilia." In most cases, I would guess that this person is likely a transgender woman or person of another transfeminine identity. This person is experiencing feelings of attraction and arousal by dressing in clothing of "a different sex," which likely would mean feminine clothing (and is already messy because if this is a feminine-identified person, the fact that considering feminine clothing as "crossdressing" indicates that one is seeing this person as male and a man at the end of the day which is cisgenderist). In addition, this person is aroused by the idea of being perceived as female. Is this transfeminine person a transvestic fetishist with autogynephilia, or are they just aroused by feeling attractive? Even more simply, are they just feeling good in what they're wearing and how they're looking? Plot twist: transgender people are allowed to feel hot. Do we hear our cisgender friends and colleagues talk about an outfit that they feel really good in or maybe a sexy little ensemble they got for date night later and call them a cisvestic fetishist? No! Do we call a cisgender woman who enjoys that she is read as female autogynephilic? No! We don't ascribe these traits to cisgender people because it's to be assumed that one is allowed to feel good and attractive and yes, even sometimes sexy. Not for trans people, however. That's deviant and if they try, it's pathologized.

CONVERSION PRACTICES

Perhaps one of the darkest facets of Zucker's legacy and one that continues to baffle me is the lack of accountability is his endorsement of and association with practices that could be interpreted as conversion efforts. If we look at conversion practices across literature, the overwhelming theme is the attempt to *change* one's sexual orientation or gender identity (Ashley 2020, 2022, 2023; Coleman et al. 2022; Kinitz et al. 2022; Salway et al. 2021; Turban et al. 2018). In 2015, an external review of the Centre for Addiction and Mental Health (CAMH)'s Child, Youth and Family Gender Identity Clinic (CYF GIC) raised concerns that, in tandem with other factors, led to the CAMH to close the clinic and remove Zucker from their employ. In the aftermath, concerns were raised about the process and the dubious reliability of some but not all details, which led to CAMH taking down the external review in favor of an executive summary (Colero 2016) and ultimately reaching a settlement with Zucker although still standing by their decision to cease clinic operations because of the remaining concerns around the clinic's problematic approaches (The Canadian Press 2018). While the external review was taken down and the executive summary from CAMH appears to be lost to time and website redesigns (from reputable sources, anyways), testimony from individuals and families who utilized the CYF GIC confirm that the approaches of Zucker and his clinic were harmful and attempting to change their gender identity and/or expression (Lowthian 2017; Muse 2015, 2020).

Even with testimony and the fact that CAMH nonetheless found issue with clinic operations, the best evidence for Zucker's practices being considered conversion efforts comes in his own admission of the practices, not to mention his continued advocacy for the practice. Zucker et al. (2012) discusses a biopsychosocial model for "treating" gender identity disorder where the discussion on assessment explores all of the possible reasons a child could be experiencing gender dysphoria as something brought on by parents thinking cross-gender behavior is "cute," a product of internalized gender bias, resulting from co-occurring psychopathology, or even projection of a parent's psychopathology onto the child. Interestingly, a child simply determining their gender for themself isn't given nearly the weight or likelihood. Regardless of etiology, conversion efforts are laid out as a very plausible and possibly encouraged approach, stating:

> If the parents are clear in their desire to have their child feel more comfortable in their own skin, that is, they would like to reduce their child's desire to be of the other gender, the therapeutic approach is organized around this goal. (Zucker et al. 2012, 383)

In discussing how to facilitate that process, they suggest interventions of enforcing cisnormative behavior and more same-sex peer relationships in hopes to influence the child to align with the assigned gender identity and expression preferred by the parents and clinicians. They note the following for limiting "cross-gender" behavior:

> In our work, we emphasize that authoritarian limit setting is not the goal (limit setting per se is not the goal of treatment, but part of a series of interventions); rather, the goal is to help the child feel more comfortable in his or her own skin. (Zucker et al. 2012, 388)

Beyond how the child can and cannot express themselves, the recommendations expand to who the child is allowed to have as friends. Describing this, they write "In the naturalistic environment, we typically target the improvement of same-sex peer relations, since peer relationships are often the site of gender identity consolidation (Maccoby, 1998; Meyer-Bahlburg, 2002)" (Zucker et al. 2012, 389). Throughout the discussion of treatment, the discussion of "comfort" is presented, especially noting the idea of the child being comfortable in their own skin. I validate Zucker et al. (2012)'s supposed goal of the child's comfort in their own skin. However, one could also suggest that autonomy over one's expression and identity would be the efficient route to feeling comfortable in one's skin. This begs the question, perhaps this was more about the comfort of the parent(s) and clinician(s)? If the concern is once again about the comfort of others versus the individual's experiences and needs, it denies them the autonomy to self-determine their own experiences and identity (Deci and Ryan 2008; Ryan and Deci 2008).

Last but certainly not least in Zucker et al. (2012)'s endorsement of conversion practices, or at least abetting ambivalence, they respond to questions within the same publication issue around "prevention of adult transsexualism" as a treatment goal, they respond that they "do not have a particular quarrel with the prevention of transsexualism as a treatment goal," only adding that it "should be contextualized" before ending with the statement, "If a child grew up comfortable in their own skin, but was generally miserable otherwise, one could hardly argue with unabashed enthusiasm for the prevention of transsexualism" (Zucker et al. 2012, 391).

In the years since Zucker et al. (2012) and despite the growing criticism of conversion practices no doubt made clearer by increasing legislative actions and the closure of the CAMH FYC GIC in 2015, heels were dug in further. Zucker, Lawrence, and Kreukels (2016) reference changes in the recent Standards of Care that deemed conversion practices unethical. They bemoan their displeasure with the critiques of conversion practices and mourn the chance to engage in them, lamenting:

> It is recognized that GD can remit in some cases (Marks et al. 2000); perhaps psychotherapy could facilitate such remission - or a reduction in GD symptoms, with greater congruence between gender identity and expression and assigned sex - in some subset of the diverse group of adults whose gender problems now qualify for a diagnosis of GD. Unfortunately, these possibilities have not yet been investigated, and such investigations are strongly discouraged in the SOC-7. If a client with GD decided that overt cross-gender expression carried too great a risk of unacceptable consequences and requested a psychotherapist's help in trying to make their gender identity and gender expression more congruent with their assigned sex, would the therapist's participation always be unethical, as the SOC-7 seems to assert? If so, the SOC's position would seem to conflict with the client's right to autonomy and self-determination. (Zucker, Lawrence, and Kreukels 2016, 237)

What is most damning in this passage is the conflation of conversion efforts and helping clients toward a *self-determined* gender identity or expression that would appear more consistent with their sex assigned at birth. Even now, the primary component that defines the unethical practices being referred to is the intent to *change* one's gender identity or expression (Coleman et al. 2022). If a client were to come to the understanding that their gender identity is one that is similar to the one that had originally been assigned to them, they have the right to autonomy over their identity. If a client were to decide that being visibly perceived as gender diverse resulted in oppression or threat of violence that they could not bear, they have that very same right to move with autonomy toward a gender expression that is less visibly gender diverse and perhaps safer, even if their intrinsically-known identity and ideal expression have not changed. In these instances, the client has determined the gender identity or gender expression they want for themselves, rather than have it imposed upon them by the clinician or others. That self-determination rather than imposition is proven to be far more helpful than the harmful impacts of if we were to take that autonomy away (Deci and Ryan 2008). It is so deeply concerning that this nuance is lost on practitioners like Zucker (2020) when they argue for equal consideration of conversion practices because of the possibility of detransition. A troubling question is raised when a practitioner cannot differentiate between someone self-designating a gender aligned with their assigned sex and their own biased imposition that someone moves in that direction. One could argue that it's hard to tell when someone does or does not want something when your assumption is that everyone should want it.

RAPID-ONSET GENDER DYSPHORIA (ROGD)

Another concern has been Zucker's validation and endorsement of rapid-onset gender dysphoria (ROGD) as an emerging clinical phenomenon (Zucker 2019), despite the discussion among researchers and organizations alike that have warned of ROGD's lack of evidence and suspected use of discriminatory fear-mongering tactics (Coalition for the Advancement and Application of Psychological Science 2021; World Professional

Association for Transgender Health 2018). While it is no surprise that this terminology was latched onto given his continued assertion of early-onset and late-onset specifiers of gender dysphoria (Zucker 2018), it is no less concerning.

Critique of the original study that led to the discussion of ROGD noted the immense bias in the way that the research was structured by only recruiting parents from notorious anti-transgender websites (Ashley 2018). He even acknowledges the controversy and the comments he's seen that point out how deeply problematic the sampling was by using members of hate websites for research on marginalized populations. Rather than take a stand for methodological integrity, he sits back and muses on the blatant empirical violence as if it's just any other academic discourse or debate, chiming in with "One could say, therefore, that the paper has indeed had an impact" (Zucker 2019, 1987).

Another example of Zucker's concerning practices around the concept of ROGD is regarding a recent article by Diaz and Bailey (2023) that Zucker approved for publication in his journal, *Archives of Sexual Behavior*. Not only did this article once again utilize incredibly flawed methodology similar to practices previously critiqued by Ashley (2018), but the article also explicitly states that they were denied approval by an institutional review board despite having human subjects and Zucker determined that its publication was "ethically appropriate," despite the significant ethical violation of conducting research like this without that approval or oversight to prevent harm (Diaz and Bailey, 2023).

TREATMENT OF SEXUAL ORIENTATION IN RELATION TO SEX AND GENDER

Another area of concern that has risen from this literature is the ways that sexual orientation, assigned sex, and gender identity and expression have been described in relation to one another. One critique to discuss is the ways that some of the literature conflate sexual orientation and gender identity, a type of criticism that Zucker (2018) has already expressed his disdain for. Nonetheless, I don't think this critique is unfounded. A core of this critique is the amount of literature where Zucker has an apparent fixation (dare I say, "fetish?") with the sexual orientation of transgender and gender diverse people in his research and coercively integrates their sexual orientation as part of their gender identity. Throughout much of the literature, transgender and gender diverse people are categorized by their sexual orientation (and often misgendered in the process with labels of sexual orientation tied to their sex and likely would align with their own self-description of their sexual orientation) in ways that treat the sexual orientation as such an important and differentiating context that "homosexual" versus "nonhomosexual" or "gynephilic" versus "androphilic" are effectively made out to be different gender identities altogether (Khorashad et al. 2020; Lawrence and Zucker 2013; VanderLaan et al. 2017; Zucker, Bradley, et al. 2012; Zucker et al. 2013; Zucker, Lawrence, and Kreukels 2016). Humans are not one single identity and additional context of how people of certain gender identities *and* sexual orientations is a wonderful context to explore, but the way the literature goes about it is not in line with modern understandings of the ways that sexual orientation, gender identity, assigned sex, and other aspects of self are separate and unique facets that create complex and nuanced individuals (Twist et al. 2021; van Anders 2015; van Anders and Schudson 2017).

It's also important to note once again that the specific selection of sexual orientation language in the literature is problematic. The desire to use sex-based terminology in defining sexual orientation is often based on the notion that assigned sex rather than gender identity feels more scientifically grounded (van Anders 2015). However, sexual orientation in day-to-day life and how we form attraction is often based more on gender-based terms, given that we are often more so seeing one's gender expression to determine our attraction rather than their assigned sex - meaning their genitals (with no disrespect to naturalist communities who may be seeing genitals of potential partners just as quickly as their gender expression). Calling a spade a spade, attraction also tends to be sex-based because we have been conditioned to see a certain type of gender expression and *assume* what that person's assigned sex is and, more specifically, what their genitals probably look like. That assumption is the core of cisgenderism (Ansara and Hegarty 2012, 2013, 2014). The use of sex-based language in those ways objectifies these transgender and gender diverse people by reducing them to their genitals and misgendering them in the process.

OVERALL CONCERNS

The core of many of these critiques is the apparent bias and refusal to grant transgender and gender diverse people the autonomy to self-determine their identities and experiences that is vital to appropriate, productive, and beneficial care (Deci and Ryan 2008). This is demonstrated further by the prioritizing and valuing of parental needs and viewpoints over the children's. Zucker, Wood, Singh, and Bradley (2012, 374) note this stance from the very beginning of their approach during the assessment process where the parents are asked what *their* goals are for their child's gender identity and even noted that, while very few, some assessments "were conducted only with parents." What precedent does it set about an individual's right to self-determine their identity and experiences if an entire assessment can be made of them without their ever being in the room? Regarding the notion of waiting to see and having children stay within their assigned gender to see if feelings of dysphoria desist (Zucker 2018), I pose this question: if the idea is to "wait-and-see," why is a cisgender identity viewed as a neutral default space? If the idea is about suppression of undue influence toward a specific identity, wouldn't one suggest no toys at all? No clothes? No friends? Is this about neutral exploration, or an attempt to correct course before it's too late? Is this about helping children be comfortable in their skin, or controlling them so others can be comfortable in their ideology?

Noting the patterns of language and ideology in this literature, it is no stretch to argue that Zucker and his colleagues struggle to view transgender and gender diverse people as having the right to autonomy to self-determine their gender identities and experiences, and simply cannot be bothered to listen to the communities he is claiming to help. Ironically, Zucker (2017 2523) notes that we should be "humble, not dogmatic." It's an interesting choice of words to see come up in a collection of literature with a clear pattern of claiming one knows more about others' own experiences and identities than they do.

The need for more self-determined approaches to gender-related care rather than the imposing nature of Zucker's work is all the clearer when we examine increasing visibility of individuals detransitioning or retransitioning—or "desisting," as Zucker would put it. Detransition and retransition are quite rare experiences among those who receive transition-related care and far more of them are often related to discrimination, pressure, and accessibility reasons barring or discouraging continuation rather than what would be considered traditional regret and deciding that transition or the identity itself was not right for them (James et al. 2016). For many people who do detransition or retransition, a self-determination approach would be far more hopeful both as they navigate their current de/retransition as well as could have been more helpful during their initial transition and possibly avoiding courses of action that would be regretted later had they had that support (Pullen Sansfaçon et al 2023).

CRITICAL REFLECTIONS FOR THE FIELD OF RESEARCH

Now the question is, "where do we go from here?" To that, I offer several thoughts and call for reflections that require some introspection as we move forward.

Research will never be intrinsically apolitical

Many may find a sense of neutral comfort within the "objective" realm of "hard science," but this complacency is flawed. Time and time again, data shows us that the way that research is designed and conducted can have immense impact on the data, and influence and positionality of the researchers themselves can all the more warp what that data will say and how it could be used (Knott-Fayle et al. 2022). Research does not exist in a vacuum and can significantly inform approaches and policy which can be profoundly beneficial or gravely detrimental (Kcomt 2019; Kcomt et al. 2020). Neutrality is a comforting lie we often tell ourselves in research, and that lie is often utilized as a crutch to frame important critiques of discriminatory and unethical research and practices as political matters rather than human ones (Zucker and Duschinsky 2016). It's no doubt easier to write off criticism this way. It's just some activist with a political call-out, not a person who's been harmed or faces harm because of one's actions.

We can continue to embrace the comfort of this false neutrality, absolutely. We can also choose to stand for the things that matter. Just remember, not choosing is still a choice.

What (and who) is given credibility

As humans, we are collections of stories. Stories come to us both from what we are told and also what we come to experience. Iantaffi (2020) prompts us with the important question of whose stories continue to inform us. Research and those who conduct it are their own instances of story and storyteller. As a storyteller, Zucker has clearly shown what stories he finds valuable and credible in how he chooses to retell them in his own stories as seen in this collection of literature. Are those stories, in turn, ones that we value in determining our own understandings of trans and gender diverse communities' needs? Should communities themselves have more credibility and ownership over their stories? The history of who has been given the platform and credibility to tell their (and others') stories is clear, but does it need to be that way?

Enabling continued harm

As we look to these patterns of harm, concern grows more salient when we also recall the context of power. Not only does this body of literature cast a dark shadow of cisgenderism over us, the fact remains that researchers such as (and particularly) Zucker continue to hold and wield immense power and influence in determining approaches to care for transgender and gender diverse communities, including writing the literal definition of their experiences (American Psychiatric Association 2013; 2022). The literature discussed has barely even scratched the surface of Zucker's body of work, and thus makes sense on paper that the power and influence could be interpreted as earned and justified. Nonetheless, barely scratching the surface has still raised so many concerns and calls to question whether that power and influence can be used responsibly? What choice is the research community making in continuing to turn away from these issues and continue to enable cisgenderist power and influence in the study of gender care and fail to seek any accountability or growth?

CONCLUSION

The work to be done is immense, and it will be a long road ahead in advocating for transgender and gender diverse communities. However, the important things are never easy. It is difficult to face and acknowledge the deep-seeded problems within this body of literature. To look at our mistakes and harmful impacts can feel shameful and uncomfortable. It's likely that this has not been pleasant to explore and sit with. Nonetheless, we have a choice with what we want to do knowing these issues and concerns and where we go from here. What can the future of research and care look like when we approach it with a respect for others' autonomy to self-determine their own identities and experiences?

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ACKNOWLEDGMENTS

The author would like to acknowledge that their work would not be possible without the efforts of transgender, gender-nonconforming, and two-spirit scholars and researchers who've come before and/or continue to work alongside them, who continue to pave the way for trans people to tell their own stories and share their own lived experiences. Such scholars include but are not limited to Y. Gavriel Ansara, Florence Ashley, Alex Iantaffi, Meg-John Barker, Roger Kuhn, and countless others not named here.

ORIGINAL ARTICLE

Reflecting on the Rhetoric of Adoption in Trans Youth Care

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Adoption is increasingly being discussed as an alternative to procreation for trans youth given the impact of gender-affirming medical care on fertility. In this article, I caution against idyllic views of adoption and offer a critical perspective on the social, political, and ethical dimensions of adoption. After reviewing adoption's relationship to sexism, racism, imperialism, and cisheteronormativity, I sketch an alternative view of adoption as a complex and multi-valenced form of care in an unjust world.

KEYWORDS transgender youth; adoption; family-building; fertility; reproductive justice
DOI 10.57814/w4m8-4r07

An emerging scholarly literature in trans youth care has elevated adoption as an answer to the conundrum posed by gender-affirming care's impact on fertility (e.g., Chen et al. 2018; Chen et al. 2019; Chiniara et al. 2019; Garborcauskas et al. 2022; Halloran et al. 2023; Harris, Kolaitis, and Frader 2020; Hudson et al. 2018; Stark et al. 2021; see also Clark 2021). These publications, primarily originating in adolescent medicine and fertility counselling, identify adoption as a desirable and desired form of family-building for trans youth. Quantitative and mixed methods studies identify 71% to 93% of trans youth as being open to or interested in adoption (Chen et al. 2018; Chiniara et al. 2019; Halloran et al. 2023; Stark et al. 2021; Walton et al. 2022).

Discussions of adoption in the literature push back against hegemonic understandings of adoption as an inferior form of family-building by highlighting its alignment with the desires of trans youth. Adoption is described in articles as a means of avoiding dysphoria (Chen et al. 2018; Clark 2021) and a solution to infertility for youth who change their mind about not wanting children (Hudson et al. 2018). By far, however, the most salient desirable feature of adoption noted in the publications is its altruism. Quotes from trans youth depict adoption as a way of giving back to society by "saving" one of the "thousands, millions" of children in need of adoption (Chen et al.

2019, 109; see also Chen et al. 2018; Harris, Kolaitis, and Frader 2020; Stark et al. 2021). As one youth explains, "adoption is a really awesome way to go. I don't see any issues with it whatsoever" (Clark 2021, 163).

The centering of adoption in trans youths' reproductive futures arises in the context of rising sociopolitical opposition to gender-affirming care, with concerns over fertility and reproductive potential surfacing as an organizing rhetoric of anti-trans movements (Paxton 2022). By endorsing adoption as a desirable and desired alternative to conception for trans youth, proponents of gender-affirming care offer a counter-rhetoric that legitimates puberty blockers and hormone therapy notwithstanding their impact on fertility. One author also points out that valuing diverse forms of family-building can be beneficial for trans youth in the present given "high rates of family rejection, foster care involvement, and homelessness experienced by [them]" (Clark 2021, 170).

Such narratives offer a rosy picture of adoption that obscures the ethical quandaries invoked by adoption and glosses over the stakes involved in being an adoptive parent. Because they approach adoption as an individual decision, articles by-and-large do not engage in a nuanced or comprehensive discussion of the sociopolitical and ethical considerations raised by the adoption industry. Discrimination against trans youth stands out as the only structural barrier discussed in the articles, yet most articles only mentioned it in passing (Chen et al. 2018; Halloran et al. 2023; Harris, Kolaitis, and Frader 2020; Stark et al. 2021; cf. Garborcauskas et al. 2022). Missing from the articles is any acknowledgement or reflection on the political and moral nuances of adoption—a telling silence given the saviorist narrative deployed by some articles. The fact that much of the adoption industry is predicated on white parents adopting non-white children born to non-white women, often under coercive and exploitative conditions, remains unmentioned. Betraying a lack of rhetorical nuance, an idyllic view of adoption is not far from the literature's surface. Only the cis deal in absolutes.[1]

In this article, I wish to complicate the rhetoric of adoption in trans youth care by introducing critical perspectives on the social, political, and ethical dimensions of adoption. I do not wish to suggest that adopting a child is always unethical or that adoptive relationships are any less authentic or legitimate than other family arrangements. Rather, I argue that adoption is a complex sociopolitical phenomenon that cannot be reduced to a personal choice occurring in a vacuum. To adopt is to become involved in a system that is inextricable from trauma, racism, imperialism, capitalism, sexism, ableism, homophobia, transphobia, and desirability politics. As Kit Myers (2018) explains, "violence is a condition of possibility for adoption." If trans youth care wishes to situate adoption at the epicenter of trans youths' reproductive futures, it must acknowledge adoption as a site of harm as much as love, trauma as much as healing. While I focus on adoption in the United States, my discussion is also relevant to the rest of the Global North.

How trans youth think about adoption does not arise in a vacuum. They are influenced by clinicians, parents, LGBTQI+ spaces, and society at large (e.g., Harris, Kolaitis, and Frader 2020; Stark et al. 2021;). Scholarly publications on adoption in trans

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[1] The quote is more normative or aspirational than descriptive. Just as absolutes were not the sole province of the Sith, some of the authors who deploy a rosy view of adoption are trans.

youth care are part of a broader rhetorical movement that sanitizes and, thus, supports the adoption industry. Injecting nuance into how adoption is discussed in trans youth care is not only important on its own terms but, given their altruistic motives, is likely something that trans youth would want to be aware of. Rather than seeing adoption primarily as a way of "saving" children, avoiding dysphoria, or circumventing infertility, I suggest understanding it as a complex and multi-valenced form of care that cannot be dissociated from the multiple systems of oppression that shape the adoption industry.

This article is divided into four sections. The first section addresses how adoption relates to sexism and anti-abortion movements. The second section discusses how adoption is imbricated with racism and imperialism. The third section explores how adoption interfaces with cisheteronormativity and the ideal of the nuclear family. The fourth section highlights the reality of adoption trauma and suggests re-framing adoption as a form of care for marginalized and vulnerable youths rather than an individual alternative to conception.

My article contributes to the academic literature by synthesizing critical perspectives on adoption for a trans studies audience. By reviewing these perspectives, I hope to foster productive conversations on the rhetorical deployments of adoption in the trans youth care literature and in trans communities more broadly. Despite trans writers like Emi Koyama having long written on the politics and ethics of transracial adoption (Koyama 2004a; 2004b; 2003), these conversations remain rare.

EXPLOITATION, COERCION, AND SEXISM

The industry around adoption gives rise to concerns about gender equality and sexism. Adoption depends on the gestational labor of another. That labor, which is performed principally by women, is unrecognized and un(der)compensated. To the extent that adoption frees people from the burden of childbearing, it does so on the backs of those who give birth. Gestation and childbirth are physically, emotionally, and financially taxing, painful, and risky. Those who perform gestational labor are disproportionately unwed, marginalized women, whereas adoptive parents are disproportionately white, non-disabled, richer people in a socially normative relationship—a stark asymmetry that raises the specter of economic exploitation.

Adoption is associated with limited access to sexual education, birth control, abortion, and support networks as well as poverty, violence, stigma, social pressures, manipulation, coercion, and the exercise of state power (McKee 2018). Structural and individual determinants of relinquishment are not evenly distributed across society and disproportionately impact marginalized groups (Sisson 2022). Adoption is not always chosen by the gestational parent yet even when it is, it often reflects a range of options severely limited by society. The availability of children for adoption is predicated on the constrained autonomy of gestational parents (Ellerby 2018). The adoption industry depends on something "going wrong" in the life of gestational parents. How much of adoption is predicated on poverty and the state's refusal to offer material support to gestational parents? How much of adoption is predicated on the inaccessibility of abortion? How much of adoption is predicated on coercion, manipulation, and pressure? How many have had their children taken away because of their race, political convictions, socioeconomic status, or disability? As stated by critical adoption scholar Margaret Homans (2018), “adoption depends on structural injustice to birth mothers.” Taking a feminist perspective on adoption, trans youth studies must acknowledge the role of reproductive (in)justice in the adoption industry and take note of how the availability of adoption as a form of family-building depends on some people being denied the right to parent (McKee 2018). These injustices are disproportionately borne by women.

Coercion, manipulation, and forced relinquishment have a long and troubling history. During the “Baby Scoop Era,” which began in the postwar period and declined following the legalization of abortion, unwed mothers were systematically pressured to relinquish their infants. Speaking of her experience during the Baby Scoop Era, Janet Mason Ellerby (2018, 10) explains that she “was coerced into believing I was unfit for motherhood, that I had no choice but to surrender the infant whom I loved instantly with a ferocity that still surprises,” describing her encounter with adoption as coercive and exploitive. While it can be tempting to dismiss coercion as the byproduct of a bygone era, the adoption industry remains marred by manipulative and coercive elements. At the domestic level, crisis pregnancy centers not only coerce, manipulate, and pressure women into choosing adoption instead of abortion but also condition support on placing the child for adoption (Joyce 2009; see also Goldstein 2022; McKee 2018). Conservative organizations, especially Christian evangelical ones, often seek to facilitate adoption in parallel to anti-abortion advocacy, at times without basic safeguards (Goldstein 2022). Forced births and pressures to adopt are expected to rise in the wake of *Dobbs v. Jackson Women’s Health Organization* (2022), which rescinded longstanding constitutional protections for abortion. Even outside conservative organizations, many gestational parents who relinquish their children do so because of coercion by a partner or relative, or because they lack the support necessary to raise a child (Wiley and Baden 2005). Moreover, many infants and youths adopted from foster care are forcibly taken from the gestational parent, sometimes as early as birth, often due to poverty, disability, and/or race. Recent years have also seen a surge in migrant children being taken away from their parents and placed into adoption (Briggs 2012; Burke and Mendoza 2018).

Coercion, manipulation, and pressure appear particularly common in intercountry adoption due to the economic incentives created by United States demand for infants (Davies 2011; Graff 2009). Many countries that were or are leading sources of adoptive children for the United States employ coercive and forcible means to increase the supply of adoptable children. Guatemala’s child welfare system housed children forcibly taken from communists, Indigenous families, and impoverished parents (Acevedo 2019; Briggs 2012; Londoño 2021). Gestational parents in China were pervasively coerced into relinquishing their child due to the country’s one-child policy, which imposed severe financial penalties for having more than one child, deceptive and manipulative practices, and governmental abduction (Johnson 2016; Stuy 2014). The demand for transnational adoption creates markets for child abduction and trafficking, which some governments, organizations, and individuals readily participate in (Meier and Zhang 2008; Smolin 2006).

Adoption can be traumatic to gestational parents. Studies have associated relinquishment with unresolved grief, anger, trauma, depression, post-traumatic stress disorder, psychosomatic symptoms, and relationship difficulties (Askren and Bloom 1999; Condon 1986; Deykin, Campbell, and Patti 1984; Wells 1993; Wiley and Baden 2005). Rather than decreasing, dissatisfaction with relinquishment tends to increase over time (Askren and Bloom 1999; Madden et al. 2018). Many gestational parents describe adoption as having had "a protracted negative influence on their lives" (Deykin, Campbell, and Patti 1984). As a gestational parent who relinquished her child, Janet Mason Ellerby (2018) spoke of experiencing "resentment and regret, sentiments that have not substantially subsided in over fifty years." Grief and regret are linked to feelings of being coerced or pressured into placing their child in adoption (De Simone 1996; Kushel et al. 2005), which could also extend to relinquishment motivated by poverty or lack of social support.

Decisions over whether to place a child for adoption are neither atemporal nor independent of sociopolitical context. Adoption decisions are influenced by social conditions and state policies, and adoption in turn shapes state policy and social conditions. The neoliberal erosion of the welfare state and concomitant decrease in support for gestational parents who lack the finances and support for childrearing contributes significantly to the feeling of "having to" choose adoption for the sake of the baby (McKee 2018, 82). According to the United Nations Special Rapporteur on Extreme Poverty and Human Rights, 18.5 million people in the United States live in extreme poverty and 5.3 million live in absolute poverty (Alston 2018). While the United States is wealthy as a country, inequality has long been rising (Piketty 2014). We know that poverty is one of the leading motivations for abortion, which is in close relationship to relinquishment (Biggs, Gould, and Foster 2013; Finer et al. 2005). It is likely that a large proportion of gestational parents placing their child in adoption would want to raise a child but cannot do so due to poverty, itself a result of unrestrained capitalism and the dismantling of welfare programs.

The relationship between adoption and the erosion of social support is not accidental. On the contrary, religious conservative groups have mobilized in favor of adoption as "a strategic alternative to federal and state governments subsidizing (disproportionately minority) children in the foster care system or their families on welfare" (Perry 2016, 1844). Adoption facilitates the abolition of social welfare programs, which in turn increases the supply of children available for adoption due to poverty and lack of support. Not only is this cyclical dynamic unjust, but it cannot account for the much larger and rising number of youths in foster care who cannot or will not be adopted, and who must survive in a withering child welfare system (Johnston 2017).

Conservatives' promotion of adoption is also intertwined with anti-abortion movements. Presenting adoption as an ethical alternative to abortion, religious conservative movements encourage parents to adopt and deploy the demand for adoption as a reason to discourage or ban abortion (Joyce 2013a). In striking down the constitutional right to abortion, the majority opinion in *Dobbs v. Jackson Women's Health Organization* (2022) emphasized that "a woman who puts her newborn up for adoption today has little reason to fear that the baby will not find a suitable home."[2] In a footnote, Justice Alito quoted the Center for Disease Control and Prevention, reporting that "the domestic supply of infants relinquished at birth or within the first month of life and

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[2] Dobbs v. Jackson Women's Health Organization, 142 S. Ct. 2228, 213 L. Ed. 2d 545 (2022).

available to be adopted has become virtually nonexistent." In this political context, the decision to adopt becomes part and parcel of the justification for violating bodily autonomy and gender equality, weaponizing adoption against the rights that feminists have fought for. Forced births and pressures to adopt are expected to rise in the wake of the court decision.

SAVIORISM, RACISM, AND IMPERIALISM

Adoption also involves severe concerns around racism and imperialism. Children of color form the majority of adopted children and are predominantly adopted by parents of a different racial background than them, with white parents accounting for over three-fourths of legal adoptions (McKee 2018; Zill 2017). The exploitation, coercion, and violence involved in adoption primarily burden women of color, to the benefit of white parents. This is especially true in transnational adoptions, where 84% of adoptions are transracial (McKee 2018). In light of the ongoing disenfranchisement of children and their historical treatment of children as their parents' property, the commodification and exoticization of non-white infants in domestic and international adoption markets carry racial significance, as do concerns over exploitation of gestational labor, coercion, and lack of social support for non-white parents (Hart 1991; Hübinette 2005; Rollo 2018; Smolin 2004). Some authors have described transnational adoption as a form of forced migration, abduction, and child trafficking (Hübinette 2007; Moyo 2008; Smolin 2004).

Domestically, adoption is intertwined with the child welfare systems known for their ongoing role in racism. Foster care is one of the main avenues through which children are adopted (Kalisher, Gosciak, and Spielfogel 2020). As a result of structural racism embedded in child welfare systems, children of color and particularly Black children are overrepresented in foster care. The child welfare system has long served as a tool of anti-Blackness and settler colonialism, disrupting Black and Indigenous communities and furthering governmental agendas of population surveillance and territorial dispossession (Crofoot and Harris 2012; Dettlaff and Boyd 2020; McKee 2018; Stephens 2022). The government historically pursued the adoption of Indigenous children by non-Indigenous families in an effort to assimilate Indigenous communities and extinguish their claims to sovereignty (Thibeault and Spencer 2019). The 1978 *Indian Child Welfare Act* was later adopted to end the large-scale removal of Indigenous children from their families. A white evangelical family recently challenged the statute's constitutionality before the Supreme Court, threatening to undermine tribal sovereignty and reinstate widespread adoption of Indigenous children by white settlers (Asgarian 2022). The statute was thankfully upheld by the Supreme Court in June 2023, but remains unevenly enforced by states (Lussenhop 2023; Lussenhop and Philip 2023).

For their part, child welfare policies targeting Black children were steeped into fears of Black reproduction and intertwined with anti-poverty and sterilization programs that also sought to discourage pregnancy among unwed Black women (Briggs 2012). Governments and conservative groups trafficked in racist stereotypes such as the "welfare queen" and "crack baby" to justify racist social and child welfare policies (Briggs 2012; Nadasen 2007). As Leora Neal of the National Association of Black Social Workers explained in 1996,

> the child welfare system … has systematically separated Black children from their birth families. Child welfare workers have historically undertaken little effort to rehabilitate African-American parents, to work with extended families, or to reunite children in foster care with their families. (Briggs 2012, 28)

The adoption of Black children as part of white family-building further implicates adoption in a long history of white families exploiting Black reproductive labor. White women, who were unwilling or unable to breastfeed, often forced enslaved Black women to nurse white children, which often meant that they were unable to nurse their own children (Jones-Rogers 2017; West and Knight 2017). The commodification of Black bodies is reproduced in adoptive practices, where white women who are unable or unwilling to bear a child rely on the gestational labor of Black women and other women of color to fulfil their own family-building goals.

Recent years have seen a rise in reports of migrant children being taken away from their families by government agents and placed into adoption (Briggs 2012, 269ff; Burke and Mendoza 2018; Joyce 2018). Government agents have also used the threat of adoption to discourage people from pursuing asylum in the United States (Joyce 2018). The weaponization of adoption against migrant families came in the midst of a conservative panic around a so-called "invasion by illegal immigrants" and involved the mass detention of children and adults crossing the US–Mexico border. Given the rise of demographic anxieties and fear of immigration among white conservatives, it is likely that migrant children will continue to be separated from their families and placed into adoption.

The decrease of children available for adoption in the domestic market following the legalization of abortion has led to the growth of transnational adoption (Moriguchi 2012). While domestic adoption remains more common than transnational adoption, many children continue to be adopted from countries of the Global South. Transnational adoption occurs in a context of stark disparity not only between gestational and adoptive parents but also between countries. Interest in transnational adoption is fueled by white savior narratives whereas the availability of children for adoption is inextricable from imperialist foreign policy. Evangelical churches in the United States have played a critical role in popularizing transnational adoption as a form of saviorism, reframing it as a form of missionary work (Joyce 2013b). Transnational adoption positions the United States as a savior and altruistic force for good while obscuring the injustices that lie behind adoption and the country's complicity in creating children in need of adoption (Davies 2011; see also Wyver 2021a).

Guatemala offers a tragic example of how United States' foreign policy interfaces with transnational adoption. Until it reformed intercountry adoption in 2008, Guatemala was one of the leading sources of adoption for the United States (Schuster Institute 2012). Children adopted from Guatemala were routinely taken from their families on account of supporting communism, being Indigenous, or being impoverished (Briggs 2012). Both groups of children were molded by US foreign policy. In 1954, the United States government backed a *coup d'état* that overthrew the democratically elected leftist president Jacobo Arbenz Guzmán and installed an authoritarian military regime that was more favorable to the interest of US multinationals (Taylor-Robinson and Redd 2003). Popular welfarist reforms were abandoned and reversed by the new government. A few years later, a civil war began between the US-backed government and leftist groups who opposed the government's totalitarian and anti-egalitarian policies. The civil war continued until 1996 and involved widespread human rights abuses by government forces, including forced disappearances and genocide of Mayan communities (Comisión para el Esclarecimiento Histórico 1999). It is in this context that Guatemala found itself with immense numbers of children available for adoption, having not only taken away the children of individuals accused of being communists but also taking away children of those who were Indigenous or impoverished by the abandoned reforms and decades-long civil war. The United States was far from an innocent party in Guatemala's pattern of child abduction, trafficking, and adoption corruption that occurred. On the contrary, the United States' imperialist foreign policy played an integral role in manufacturing the humanitarian crisis that set the stage for large-scale transnational adoption from the country. The Guatemalan experience was not an exception and is echoed in many other countries such as Chile, Vietnam, and the Philippines (Bergquist 2009; Briscoe 2000; Hincks 2016; Londoño 2021; Promchertchoo 2020; see also Human Rights Watch 2010; Joyce 2011).

Transnational adoption frequently involves abduction and child trafficking by governments and private organizations (Leifsen 2010; Makinde 2016; Mezmur 2010; Stuy 2014). The demand for transnational adoption creates significant financial incentives for trafficking (Dickens 2002; Makinde 2016). In Nigeria, transnational adoption has notably fostered neo-slavery and the creation of baby factories (Makinde 2016). It is often impossible for adoptive parents to ascertain whether an adoption involves abduction, trafficking, and slavery due to the participation of government agents and orphanages, who also stand to benefit financially. The scope of coercion, violence, abduction, and trafficking in transnational adoption is often revealed after the fact, decades later.

Foreign policy also plays a central role in the number of children who are voluntarily relinquished by their parents. Lacking the financial and social means of raising a child is one of the most common reasons for placing a child for adoption. In some countries, widespread poverty has led to the phenomenon of "poverty orphans," youths who are nominally considered orphans but who were relinquished and placed in an orphanage by their gestational parent due to poverty (Batha 2018; Fry 2020; Joyce 2013a; LFBS 2021). Poverty in the Global South results from centuries of colonialism followed by political and economic policies that established a global capitalist system of resource extraction and labor exploitation for the benefit of the United States and other countries of the Global North (Brand, Dietz, and Lang 2016; Gindin and Panitch 2012; Lenin 2022; Selwyn 2019). Far from accidental, the transfer of wealth from the Global South to the Global North was meticulously structured by the US through trade and tax treaties, international organizations, monetary policy, foreign aid, global investments, and military intervention (Gindin and Panitch 2012; Parmar 2015; Weaver 2011).

To the United States, other countries are little more than a pool of labor and natural resources to exploit. US hegemony not only creates the market for transnational adoption but is replicated in it—transnational adoption exploits the labor of birth parents and treats children as commodities for the taking (Yngvesson 2000). Children are an export like any other. Mirroring its foreign policy emphasis on free trade, the

US played an active role in ensuring the continued possibility of private transnational adoptions during the negotiations leading up to the Hague Convention on the Civil Aspects of International Child Abduction, despite known patterns of coercion, abductions, and trafficking (Dickens 2002, 80; Pfund 1994; see also Winslow 2012). Preserving the ability to adopt children from other countries was more important than protecting children and gestational parents from grave violations, refuting the claim that transnational adoption is first and foremost a matter of altruism.

Beyond economic exploitation and commodification, transnational adoption also participates in the formation of national identity by situating the United States as a benevolent force on the global scene and situating white adoptive parents as superior to non-white parents from other countries (Davies 2011; Winslow 2012). By reifying hierarchies of parenthood that are intertwined with race, transnational adoption participates in the US racial imaginary and reinforces white supremacy. As historian Rachel E. Winslow (2012, 5) explains, the US "used international adoption as one way to tell a story about their nation as a benevolent power that used its authority to throw off colonial structures of racism and hegemony." US involvement in the transnational adoption market is predicated on an ideology that sees non-white parents as inadequate and white parents as saints, an ideology reimagined as colorblind under the auspices of global capitalism.

Adoptive parents are typically unaware of the oppressive systems they are participating in (Wall 2012). Clinicians and parents' uncritical gesture towards adoption as an avenue of family-building for transgender youth reveals the whiteness of trans youth studies, rhetorically recruiting trans youth in a morally complex institution that is intertwined with racial oppression and imperialism. The rhetoric of adoption in trans youth studies mirrors the implication of queer people in transnational adoption in the 1990s, during which time gay and lesbian families were disproportionately like to adopt babies from Guatemala since the country didn't prohibit them from adopting (Briggs 2012). In so doing, they provided sustenance to anti-welfarist and imperialist movements that live off forced births, coercion violence, abductions, and trafficking. As Laura Briggs (2012, 264) observes:

> White queers (or those rhetorically imagined as white in policy debate) disproportionately served as the safety valve in this system, unburdening child welfare agencies of their "hard-to-place" children, either as foster parents or as adoptive parents.

Given the saviorist elements found in the trans youth care literature, trans youth are likely to serve a similar safety-valve function in the child welfare system.

Racial disparities in access to gender-affirming care and adoption only further enhance this concern. Since white trans youths have greater access to gender-affirming medical interventions before puberty and greater access to the adoption industry (Tordoff et al. 2023; Zill 2017), the racial dynamics prevailing in adoption likely extend to future adoption by trans youths. By failing to mention the racism and imperialism involved in the adoption industry, the trans youth care literature makes it possible for white trans youths and their families to adopt a colorblind politic that obscures their complicity in systems of racial oppression (Bonilla-Silva 2022). This, in turn, facilitates a post-racial mythology wherein race is no longer a defining factor in the allocation of life chances, negating the need to fight the ongoing operations of racism and anti-Blackness in society (Gines 2014). Acknowledging the saviorism, racism, and imperialism of the adoption industry is critical—as is fighting them.

QUEER PARENTHOOD, NUCLEAR FAMILIES & CISHETERONORMATIVITY

The imagined role of adoption in trans youth lives is predicated on the belief that adoption will be accessible to trans youth upon reaching adulthood. Yet adoption is expensive, putting it out of reach for many trans youths given widespread poverty in trans communities and especially Black and Indigenous trans communities (Carpenter, Lee, and Nettuno 2022; Dodge 2020; Goldberg et al. 2020; Goodwin 2006). Even without financial barriers, the persistence of transphobia, homophobia, and religious conservatism in domestic and transnational adoption casts doubts on the feasibility of adoption as a form of family-building for most trans youth.

Countless countries prohibit transnational adoption by queer, trans, and/or unmarried people, whether as a matter of policy or practice (Briggs 2012). Domestically, religious organizations play an outsized role in facilitating adoption—organizations that would simply not let trans people adopt since they do not conform to their conservative image of the family. The legal standing of LGBTQI+ adoption is uncertain. A 2017 decision by the Supreme Court of the United States struck down an Arkansas law that effectively prohibited same-sex adoption (DeMillo 2017). However, the decision was based on the court's defense of same-sex marriage in *Obergefell v. Hodges* (2015), which is under threat following *Dobbs v Jackson Women's Health Organization* (2022). It is unlikely that same-sex adoption will remain constitutionally protected in years to come. Federally, the Every Child Deserves a Family Act prohibits discrimination against LGBTQI+ people in adoption by organizations that receive federal funding, but it does not apply to organizations that do not receive federal funding and some states have been granted an exemption from the application of the law (Tatum and Flaherty 2019). Stateside, some legislatures have enacted bans on discrimination in adoption, whereas others expressly allow it (Warbelow, Avant, and Kutney 2020).

Law is a poor proxy for practice, however, and many organizations are likely to discriminate against LGBTQI+ parents regardless of anti-discrimination statutes. Furthermore, there are some indicators that the availability of adoption is decreasing for LGBTQI+ people. In 2006, Catholic Charities requested an exemption from Massachusetts's anti-discrimination statute after nearly two decades of permitting adoption by queer couples (Briggs 2012). The sharp rise in anti-LGBTQI+ legislation and public discourse in the last few years also suggests that adoption will become ever more unavailable to trans youths. Rising accusations that LGBTQI+ people are "groomers" are particularly telling, since bans on same-sex adoption are often predicated on the view that queer adults are inherently or disproportionately sexual predators (Ciesemier 2022; Lin 1999; Paz 2022; Tenbarge 2022). The legal persecution of trans communities by conservative state governments also raises concerns about the risk of trans parents being targeted by child protection agencies—an ongoing threat of family separation even among trans youths who overcome barriers to adoption (Goldberg et al. 2020). Access to adoption does not entail protection from discrimination and trans parents often face significant discrimination (Cohen 2017; Stotzer, Herman, and Hasenbush 2014). Asking the adoption and child protection industry to cease and de-cis is more easily said than done.

Beyond the feasibility of trans adoption, queer theory also proffers critiques of its desirability. Queer critiques of the family are particularly salient in a context where adoption is often being elevated as a goal *for* trans youths more than *by* them. To the extent that trans youths locate adoption in a reproductive future, it is often at the encouragement and/or under the influence of clinicians and parents. Harry Benjamin, often considered the father of trans medicine in the United States, saw "[m]arriage with the adoption of children" as the goal of most trans women, evincing the normative ideals that underpinned his understanding of gender transition (Benjamin 1966). The fact that many trans women used his book as a roadmap to secure gender-affirming care highlights the prescriptive role of such statements. They do not only describe desire but shape it. Given the role of clinicians and parents in shaping reproductive futures (Harris, Kolaitis, and Frader 2020; Stark et al. 2021), we must ask whether adoption should maintain the place it currently holds in trans youth studies. In the words of Jasbir K. Puar (2013, 31), "we must not only be critical of familial homophobia but also of the model of family itself—even queer family." Who benefits from the family?

The exaltation of parenting is possessed by the ideal of the nuclear family. The purported natural order of things is for children to be born from a marriage between a father who is the primary earner for the family and a mother who gives birth and raises the child without compensation. Lying at the heart of patriarchal oppression, the division of labor between mother and father aligns with the capitalist need for both production and reproduction (Federici 2014; Oyèwùmí 2002). The nuclear family also ensures the ongoing concentration of wealth and property by establishing lines of inheritance (Engels 2021; Jaggar 1983). Invested in patrilineality, the nuclear family maintains inequality along race and class lines, erases different family arrangements, and idealizes "fighting for our children," an idea uncomfortably reminiscent of the white supremacist slogan: "We must secure the existence of our people and a future for white children" (Ashley and Buchanan 2023; see also Edelman 2004; Oyèwùmí 2002; 2000). It is no accident that those praising reproduction as the ultimate purpose of life are often the most hateful, and that "save our children" has served as a slogan for some of the vilest movements in history. As queer theorist Lee Edelman (2004, 2–3) points out, reproductive futurism is fundamentally conservative "insofar as it works to affirm a structure, to authenticate social order, which it then intends to transmit to the future in the form of its inner child." White supremacy, imperialism, and patriarchy all rely on the nuclear family.

From a queer standpoint, trans youth studies' normalization of parenting as a natural desire through adoption is cispicious because it re-centers the nuclear family so valued by racial capitalism and fails to question its role as an instrument for the oppression of queer and trans communities (Gleeson, O'Rourke, and Rosenberg 2021; O'Brien 2019; Puar 2013). Adoption, especially, requires families to approximate conservative ideals of the family—those who are further away from monogamous marriage between two cisgender and heterosexual adults risk being denied adoption. To the extent that same-sex adoption is permitted, it requires same-sex couples to uphold dominant norms except for their sexual orientation. Polyamory and communal childrearing are out of the question. In the words of historian Rachel E. Winslow (2012, 421): "While the family might have been symbolically universal, the nuclear family with explicit gender roles was still promoted as the only true home for an orphan." Adoption must subscribe to dominant norms due to the role in plays in shaping national identity—a fertile ground for (re)inscribing the gendered division of labor and the subjugation of youth into trans lives. And yet, trans adoptive parenthood will always be considered a travesty[3] of cisheteronormative procreation because of its limits in reproducing whiteness and racial capitalism (Ashley and Buchanan 2023; Myers 2013).

From this vantage point, trans youth studies' appeal to adoption invites trans youth into a respectability politics that unquestioningly submits to hegemonic conceptions of the good life and empties transitude of its revolutionary potential. The rhetoric of adoption doesn't merely rebut anti-trans critics; it also participates in the recuperation and inclusion of trans childhoods that least diverge from oppressive, hegemonic norms (Puar 2013; Tsfati and Ben-Ari 2019). Instead of questioning anti-trans appeals to fertility, clinicians and parents produce a new picture of the trans child as domesticated, palatable, respectable. This transnormative picture sanitizes trans childhood, depicting trans youths as "good citizens" that can be enlisted into the projects of dominant society such as racial capitalism (Bradford and Syed 2019; Tsfati and Ben-Ari 2019). A neoliberal society in which adoption collaborates in the privatization of child welfare and eventual abolition of the welfare state is to the detriment of marginalized communities (Briggs 2012; McKee 2018). Who benefits from the family? Not trans youth.

FROM ADOPTION AS REPRODUCTION TO ADOPTION AS CARE

A critical perspective on adoption does not entail that adopting is always or necessarily wrong. Adoptees often have nuanced perspectives on adoption and many report being open to becoming adoptive parents themselves (Koyama 2004b; Parkhurst 2022; Stark et al. 2021; cf. Garborcauskas et al. 2022). Recognizing the injustice of the adoption industry does not stop children from being relinquished or taken away. By the time of adoption, many of the harms and injustices of the adoption industry have already occurred. Deciding not to adopt does not undo those injustices nor meaningfully challenge the oppressive forces that generate them.

Calling for the abolition of the adoption industry does not necessarily mean that no one should adopt in the present, even if it is an eventual goal. However, ethical engagement with adoption cannot proceed from viewing it as a replacement for procreation, as a means of fulfilling trans youths' family-building desires. Trans youth studies must make space for the realization that adoption "may simultaneously be an act of violence and an act of love, an excruciating rupture and a generous incorporation, an appropriation of valued resources and a constitution of personal ties" (Turner Strong 2001, 471).

Recognizing the injustices that make adoption possible is a necessity for those hoping to care for adopted children. As Kimberly McKee (2018, 80) observes, the elision of reproductive injustice "results in the myth that adoptees are a blank slate upon their adoption" and "reflect the social death they experience upon the severing of ties to their birth families." Cutting off adoptees from their gestational parent and birth culture is often deeply traumatic, and adoptees disproportionately live with trauma,

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[3] Pun intended (Oxford English Dictionary 2009, s.v. travesty; see also Hübinette 2007, 143).

mental illness, attachment problems, and difficulties in identity formation. As therapist and adoptee Theodora Blanchfield (2022) explains: “Growing up hashtag blessed doesn’t erase the trauma of being removed from my birthmother almost immediately after birth.” To many, adoption trauma translates into feeling flawed: “But you always, always live with the idea that [you’re] never, never good enough—no matter what you do, what success you have, there’s always a little bit that holds back” (Dalton, McLaughlin, and Cassidy 2022, 78).

In a study of siblings, adopted children were around four times as likely to have attempted suicide (Keyes et al. 2013). Among adoptees who had a history of child welfare involvement, a study found that over 93% had experienced mistreatment (Murray et al. 2022). Adoptees often struggle to form healthy emotional bonds with their adoptive parents and may display trauma responses such as hoarding food, stealing, and aggressiveness towards others (Vasquez and Stensland 2016). Attempts to “treat” these behaviors as disorders rather than understandable responses to trauma can aggravate trauma, further harming adopted youths (Chaffin et al. 2006).

Many adoptees express a disrupted sense of identity, describing their sense of self as a “fragmented and chaotic mess,” “fractured,” “unsettled,” or lost (Merritt 2022, 9; see also Dunbar and Grotevant 2004; Grotevant 1997; Hoopes 1993; Merritt 2020). Identity development is a lifelong process, and it is not uncommon for adoptees to (re)discover latent trauma and experience identity crises later in life (Dunbar and Grotevant 2004; Grotevant 1997; Merritt 2022). Preventing youths from learning about or being in contact with their gestational parents can further inhibit the development of a healthy and integrated personal identity (Grotevant et al. 2013; Von Korff and Grotevant 2011). Despite the potential harms of confidential adoption records, few states allow unrestricted access to records by adoptees (Baffer 2020). Transracial and transnational adoptions create additional barriers to identity development because they interfere with racial and cultural bonds, resulting in adoptees feeling alienated from both their adoptive and birth communities (Davies 2011; Wyver 2021b). Reflecting on her youth, Sara Jones (2022), who was adopted from Korea by white parents, explains that “there were many moments growing up where I wished that I was white like the other kids around me.”

Adopted children are disproportionately likely to experience marginalization due to race, disability, sexual orientation, and gender modality. This is especially true for trans adoptive parents due to their expected role as caregivers for children considered “hard-to-place” (Briggs 2012, 264). Because of the normative underpinnings of the adoption system, adoptive parents are often ill-equipped to understand and help their child avoid, heal, and deal with experiences of marginalization. Trans youths who become adoptive parents are more likely to be white and socioeconomically privileged and may contribute to the racial marginalization of their children due to ignorance and unexamined prejudice. Adoptees often report racial microaggressions from their parents and speak of their parents failing to give them the tools necessary to handle racist interactions (Davies 2011; Tigervall and Hübinette 2010; Wyver 2021b). Speaking of her experience as a Black woman adopted in a white family, writer Laura Fish (2006, 203) explains that:

> My parents believe that everyone is equal and that colour doesn’t matter. This was the rule at home but the moment I stepped outside the

> warmth of my family, colour seemed to matter horribly. In fact, to my great surprise, it was the first thing that everyone noticed about me.

Like Fish, many adoptees not only live with white parents but live in areas where their racial background is rare—further othering them and impeding if not preventing the development of community bonds with other people of color (Tigervall and Hübinette 2010).

Adoptive parents' tendency towards saviorism clashes with the needs of adoptees (McKee 2018). As adoptee Alé Cardinalle explains, "Adoptees are told to just be grateful that we were chosen. … And yet so many of us are struggling" (Sasani 2022). Trans youths' unique experiences with identity formation, belonging, and marginalization can be both beneficial or harmful to adoptees' process of learning and (re)constructing their sense of self. On the one hand, it can make them more understanding and equipped to support their child's identity development and resilience (Hübinette 2011). On the other hand, their own experiences surrounding attachment, identity, and trauma can create relational difficulties and get in the way of supporting others' identity development especially if their adopted child does not or struggles to see them as their "real parent." Will trans youths turned parents be able to decenter themselves as their child strives to develop an integrated identity? Will they be able to decenter themselves during their child's search for their gestational parents? Will they have the emotional resilience to interact and maintain contact with birth parents? Will they have the socioeconomic means to pursue therapy for themselves and their child? Will they educate themselves on adoption trauma, racism, and how to best care for adoptees? Will white trans youth be able to unlearn racial bias to meet the needs of non-white adoptive children? Will they have the emotional maturity to acknowledge and accept "being perceived as the worst kind of colonizer" (Watkins 2006, 269)? Will they have the knowledge and social resources required to foster the child's racial and cultural community ties? Will they be able to do all those things without making their child feel like a burden? An affirmative answer to each of those is not a given, yet is necessary for adoptive parenthood. While trans youths are as deserving of parenthood as others, nobody is entitled to a child—especially if they have not done the work of deconstructing their attitudes, prejudices, ignorance, and trauma. As educator and adoptee Mia Thaicha (2022) has pointed out, the ability to procreate is irrelevant to whether someone should adopt. What matters is whether they have the capacity to support and nurture their adoptive child. Education is critical (Forkey et al. 2015; Hartinger-Saunders, Jones, and Rittner 2019).

Dislocating reproductive futurism, I tentatively propose seeing adoption not as a form of family-building but instead as a complex and multi-valenced form of care in an unjust world. It is, in a sense, unjust care insofar as demand for adoption participates in and sustains the injustices that enable the adoption industrial complex. Alternatives exist in the form of kinship care and legal guardianship, which hold space for forms of caregiving that do not permanently sever youths' relationship with their birth parents (Barra 2020). These options should be considered before turning to adoption. And yet, considered individually, the decision to adopt may nevertheless offer forms of care, love, and happiness that would be impossible in orphanages and foster care systems grievously underfunded by the confluence of global capitalism and neoliberal privatization. The ethics of adoption are inescapably ambivalent, as family and kinship so often are. Adopting a child can be wonderful, but it is also hard.

The approach I am sketching sees critical adoption studies, Indigenous studies, Black feminist studies, and trans theory as rich sources of guidance, suggesting a more expansive view of family and kinship that decenters the nuclear family and displaces the right to parent with the right to care, love, and support. While offering a praxis of trans adoptive parenthood is beyond the scope of this article and perhaps beyond my knowledge and ability, the following ideas may offer a starting point for such work. Critical adoption studies scholar Kit Myers (2018, 19) speaks of "adoptive kinship (rather than family) as a descriptor and analytic might be more capacious for adoption praxis," rooted in a "mutuality of being." Indigenous studies scholars Sandra de Finney and Lara di Tomasso (2021) stress the value and centrality of Indigenous caring practices and communal caregiving in supporting youths' cultural permanency and sense of identity. Black feminist scholars Rhonda Wells-Wilbon and Gaynell Marie Simpson (2009) draw on African diasporic practices to propose a new model of caregiving outside of the strictures of the Euro-American nuclear family. In their work on gender affirmation, trans philosopher E. M. Hernandez (2021) deploys the notion of loving attention and caring for people on their own terms to challenge processes of marginalization and epistemic domination. Trans philosopher Amy Marvin (2019) draws on the caregiving practices of Sylvia Rivera and Marsha P. Johnson to offer a theory of caregiving that emphasizes the simultaneity of dependency and solidarity, the mutuality of caregiving, and the necessity of care practices outside the family. And lastly, trans studies scholar Hil Malatino's (2019) work helps us understand caregiving in a mode of survival, speaking to the "creative and caring acts of trans intimacy" that makes life "not only livable but also, sometimes, joyous." Each of their work is replete with teachings for trans adoptive parenthood, teachings that trans youth studies should foreground if wishes to approach adoption critical, from a place of care rather than commodification.

CONCLUSION

It is critical for trans youth studies to take seriously adoption's potential for harm and ongoing role in oppression and injustice. Adoption, both past and present, is inextricable from regimes of coercion, violence, sexism, homophobia, transphobia, racism, and imperialism. Often, adoption means adopting a child who was unjustly taken away from Black, Indigenous, Latine, or Asian parents pursuant to racist policies that strive to exploit, destabilize, and disenfranchise communities of color and cast the United States as an altruistic and benevolent ruler of the international community. Adoption as an industry cannot be distanced from the white supremacist belief that racialized parents are inadequate and that white parents are superior. The pervasiveness of trauma and marginalization among adoptees alters the stakes of parenting, complexifies it. Beyond their inherent moral valence, these injustices are fundamentally at odds with trans youth studies' emphasis on autonomy, self-determination, and equality. Trans youth studies should also avoid overstating the feasibility of adoption in an industry plagued by cisheteronormativity, ableism, and racism. By articulating trans youths' reproductive futures around adoption, clinicians and parents may be planting the seeds of disappointment.

This is not to say that adoption is necessarily bad or that trans youths should not become adoptive parents.[4] Adoption can be a site of love as much as harm, healing as much as trauma. Yet adopting does not make one a saint, and should not be approached cavalierly, without a developed understanding of its social, political, and ethical dimensions and of how to approach it with care. Often, trans youths' desire or adoption is less an informed and naturally emerging desire than one that was shaped by clinicians and parents, by social norms around the family, and by the rhetoric of adoption in trans youth studies and advocacy. While stressing the possibility of adoption may be personally and politically valuable to trans youths, trans communities and their loved ones are duty-bound to approach discussions with thoughtfulness and critical reflection. We must not let ourselves get cistracted by opponents of gender-affirming care. Adoptive children and gestational parents are not rhetorical pawns nor commodities.

In embracing a rhetoric of adoption, trans youth studies risks becoming a collaborator in the violence and exploitation of the adoption industrial complex. Instead of depicting adoption as a 'solution' to infertility, trans youth studies should militate against the injustices that make adoption possible and strive to ensure that trans youths are adequately prepared for the complexities and difficulties of adoptive parenthood. Those who adopt or promote adoption have an individual and collective duty to push back against reproductive injustice and oppression, to resist the sociopolitical forces that make the adoption industry possible. As scholars, clinicians, relatives, and potential parents, we must push back against closed adoptions, neoliberal erosion, racist child welfare policies, the foster-care-to-prison pipeline, anti-abortion movements, imperialism, and global capitalism. Doing so is a bare minimum. Because silence is acquiescence—or worse, support.

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[4] Perspectives among adoptees and scholars differ between domestic and transnational adoption, with more sharing the view that transnational adoption causes more evil than good and should not be practised in any country. Many adoptees and gestational parents support abolishing adoption in favor of kinship care and legal guardianship (Barra 2020; DelBalzo 2012; Drennan ElAwar 2012). In this article, I do not take a firm stance on whether and when adoption should be permissible.

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ACKNOWLEDGEMENTS

I would like to thank Xtine Milrod, Allyn Walker, and the two anonymous peer reviewers for their helpful feedback. Xtine Milrod deserves additional thanks for their guidance and encouragement. My paper owes an immense debt to the adopted people in my life, including my sister Béatrice Paré, who have privately shared their perspectives with me, guided me towards readings, and continue to shape my thinking on adoption.