

TRANSGENDER COMMUNITY, INDIVIDUAL AGENCY, AND THE NEGOTIATION  
OF MEDICAL AUTHORITY

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by

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## CHAPTER 1

### INTRODUCTION

Transgender people, an umbrella term describing individuals who do not identify with the sex category they were assigned at birth, are a rapidly growing population in the United States. Recent estimates suggest that transgender people currently make up .6 percent of the U.S. adult population or approximately 1.4 million people nationwide (Flores et al. 2016). As the transgender community becomes more visible, healthcare institutions and medical professionals must wrestle with how to conceptualize and adequately serve gender diverse people. In 1980, the American Psychiatric Association laid claim to the conceptualization of transgender experience by including it in its third edition of the *Diagnostic and Statistical Manual for Mental Disorders* (APA 1980). In May 2013, the American Psychiatric Association released *DSM-5* (APA 2013) and reiterated their claim to the framing of transgender experience, changing the gender diverse diagnosis from gender identity disorder to gender dysphoria.

Much has been written debating the presence of a transgender diagnosis in the varied versions of DSM as well as the benefits and detriments of medical classification, diagnosis, and treatment of gender diversity. Scholars, activists, and community members hold competing perspectives on the medical model of gender diversity, at once rejecting it as a pathologizing form of social control while clinging to its power in the self-actualization of transgender and gender diverse people (Burke 2011). This dissertation engages these debates at the individual and community levels, focusing here on an exploration of transgender and



gender diverse people's engagement with medical authority and the effects of that authority on their interpersonal and healthcare interactions.

To frame the dissertation, I offer an overview of the format and a summary of each of the three stand-alone, article-length empirical chapters that comprise the body of the dissertation. Each of the chapters contributes to the literature on medical authority, transgender experience, and gender accountability; therefore I offer brief descriptions of these areas in this introductory chapter. Following this introductory chapter, I provide a chapter on methodology, Chapter II, that offers i) an explanation of my methodological and analytical approach to the dissertation and ii) a description of Trans South, the site of my data collection. Starting with transgender and gender diverse people's experience of medical authority over their mental health care, the three empirical chapters are presented in the following order: Chapter III, "You Are Not Sick, You Are Not Broken: Peer-to-Peer Support and Transgender Mental Health;" Chapter IV, "I Can't Be Not Trans Enough: Medical Hegemony, Conformity Pressure, and Transnormative Accountability;" and Chapter V, "Rejecting, Reframing, and Strategically Introducing: Trans People's Engagement with the Medicalization of Gender Dysphoria." Following these three chapters, Chapter VI concludes the dissertation with a summary of the findings, their implications, and a discussion of limitations and suggestions for future research.

## Medicalization

This dissertation contributes to the literature on transgender and gender diverse experiences of medical authority and medicalization. Medicalization, as defined by Conrad (2007) is the process by which benign human variations of experience or identity become classified as conditions to be diagnosed, treated, or cured by medical authority. Conrad writes, "the key to medicalization is definition" (2007:5). That is, in order for an experience or identity to be medicalized, it must be "defined in medical terms, described using medical

language, understood through the adoption of a medical framework, or “treated” with medical intervention” (2007:5). Both biological and psychological experiences are subject to medicalization; however this dissertation engages medicalization primarily as it focuses on the transformation of psychological experiences into treatable psychiatric conditions. The American Psychiatric Association currently uses the 5<sup>th</sup> edition of its *Diagnostic and Statistical Manual of Mental Disorders* (2013) to define over thirty categories of psychiatric disorder that contain over two hundred psychiatric conditions and sub-conditions including restless leg syndrome, skin picking or excoriation disorder, pain occurring as a result of sexual penetration or genito-pelvic pain disorder, and gender dysphoria (APA 2013).

Medicalization operates as both an empowering and constraining force. For individuals with stigmatized experiences (Goffman 1963), medicalization lends credibility to their experiences and offers clinically supported avenues to care or relief from suffering. Medical professionals (e.g., physicians, pharmaceutical companies) often initiate processes of medicalization. However, there have been instances when effected groups such as those living with the effects of trauma (Stein et al. 2006), autism (Jordan 2009), and chronic fatigue (Broom and Woodward 1996) have argued for the recognition of their experience as illness. In these instances, groups recognize that sanctioning by medical science has the potential to grant legitimacy to their claims to healthcare, social support, and validation (Brown and Zavestoski 2004; Dumit 2006).

Medicalization may also operate as a form of social control, positioned as a basis of stigmatization when the medicalization is psychiatric in nature. Research has drawn attention to the ways that medical authority coopts deviant or non-normative behavior as something to be controlled, treated, and cured (Conrad 1992; Conrad and Schneider 1980). When a psychiatric state or human variation is framed as a medical disorder, it becomes subject to control from healthcare professionals as well as non-medical social institutions such as

education in the case of child and adolescent attention deficit disorders (Malacrida 2004) or the church and family in the case of disorders of sexuality and gender identity (Conrad 2007). Here, I offer an abbreviated overview of the medicalization of transgender and gender diverse experience.

### Medical Authority & Transgender Experience

Transgender identity and experience has been formally claimed and defined by medical authority since the introduction of a psychiatric diagnosis for gender diversity in *DSM-III* (1980). In May 2013, the American Psychiatric Association released *DSM-5*, which included a new description and diagnosis for gender diversity that discontinued the use of ‘disorder’ in the diagnostic label. Listed as *gender identity disorder* in *DSM-IV-TR*, the text-revised fourth edition of *DSM-IV*, the new diagnosis is termed *gender dysphoria* in *DSM-5*. This change is largely symbolic, however, and the continued presence of a psychiatric diagnosis for gender diversity undermines the new terminology. Further, the new diagnosis does little to combat the assumption of gender diversity as medical condition, specifically a psychiatric illness, which in turn leads to a variety of medical interventions for transgender and gender diverse people. The three empirical articles that comprise the body of this dissertation examine how medical authority’s claim on gender diversity influences the identity, interaction, and healthcare experiences of transgender and gender diverse people.

Medical authority over gender diversity by way of psychiatric diagnoses has led to the development of a hegemonic medical model for understanding transgender people’s experiences of gender over the life course (Johnson 2013, 2015, 2016). The medical model of transgender identity should be understood as the APA’s framing of gender diversity as “a psychological condition [...] that requires medical treatment, including gender affirming surgery or hormone therapy” (Koenig 2011, p. 619). Positioning transgender experience and identity within the medical model creates the following three-step process of becoming

transgender: (i) experiencing discomfort and distress surrounding gender throughout life; (ii) acquiring a psychiatric diagnosis for gender variance; and (iii) accessing gender-affirming medical interventions. While the content of the diagnosis, in terms of language used and descriptions given, has shifted over time to be less damning of transgender and gender diverse people, I have argued elsewhere (Johnson 2015) that the form of the diagnosis has continued to sustain this narrowly defined process of transgender identity. This dissertation explores how this narrow definition of gender diversity influences not only the medical experiences of transgender and gender diverse people but also how their social interactions and experiences are shaped by the medical model.

The medical model of gender diversity offers a clinically supported avenue for gender-affirming healthcare and does well to legitimize the discomfort that transgender and gender diverse people experience. However, the medical model's pervasive influence positions it as an accountability structure for transgender and gender diverse people's experiences in multiple arenas of social life including healthcare interactions, familial interactions, and transgender community interactions. To best explain how medical authority operates in the lives of transgender and gender diverse people, I employ doing gender theory (West and Zimmerman 1987) throughout the dissertation with special focus on social accountability (Hollander 2013; Lucal 1999). Here, I offer an abbreviated explanation of West and Zimmerman's (1987) interactional model of gender as it applies to my analysis of transgender and gender diverse experiences.

### Gender Accountability

An interactional model, based on West and Zimmerman's (1987) theory of doing gender, places the development and meaning of gender in the social rather than individual domain. Doing gender theory positions gender as an accomplishment of social interaction rather than an essential characteristic of individuals. For West and Zimmerman, individuals'

sex and sex category are separate entities with the former determined via “biological criteria,” such as sex organs and chromosomes, and the later through “identificatory displays” or social representations of sex (1987:127). Both of these classifications are based on others’ evaluations, be it doctors in the case of sex or interaction partners in the case of sex category. Gender, however, is defined as “the activity of managing situated conduct in light of normative conceptions of attitudes and activities appropriate for one’s sex category” (1987:127). Gender is thus a social accomplishment, conceptually separate from, albeit normatively linked to, sex and sex category.

The social accomplishment of gender relies on continued accountability to normative situated standards for gender presentations that are coherent with assigned sex categories: that is, masculinity with perceived maleness and femininity with perceived femaleness. As West and Zimmerman explain it, accountability is the crux of doing gender. While doing gender does not assume purposive attempts to meet specific standards, individuals are said to always already be doing gender, as “accountability is a feature of social relationships” (1987:137). As Hollander (2013) explains, accountability is ubiquitous and ongoing regardless of individual acknowledgement or investment. To do gender, then, is to “engage in behavior at the risk of gender assessment” (West and Zimmerman 1987:136).

Raewyn Connell’s (2009) reflection on doing gender theory highlights transgender people’s unique experiences of gender and sex category by focusing on embodiment. It is here where the medical model becomes most visibly influential in the interactional experiences of transgender and gender diverse people. Connell argues that gender, as a social accomplishment, is embodied in ways that are impossible to ignore. Part of doing gender is signaling embodiments, in addition to practices, that cohere with assigned sex categories. Transgender people who cannot or do not wish to access gender-affirming medical interventions experience what Connell terms *contradictory embodiment* (R. Connell 2009,

2012). Connell argues that transgender experiences of doing gender would be better understood through a lens that “centers on recognition and the relationship of embodiment to recognition” (2009:109). For Connell, to do gender is to engage in interaction while being recognized as gendered in particular ways. Embodiment, Connell argues, is central to that recognition.

To better capture transgender and gender diverse people’s embodied experiences of gender recognition and accountability, Catherine Connell (2010) coined the concept “doing transgender.” Connell defines doing transgender as “transpeople’s [sic] unique management of situated conduct as they, with others, attempt to make gendered sense of their discordance between sex and sex category” (2010:50). To better understand the interactional model of gender, we must account for the experiences of transgender people who socially signal secondary sex characteristics (e.g., facial hair, breasts, and vocal pitches) that do not align with their gender presentation or sex category. Against the backdrop of our normative sex/gender system, accountability to medical authority is often required for transgender people to access embodiment and thus social recognition that coheres with their gender identity. The medicalization of transgender experience reinforces the relationship between embodiment and gender identity, levying medical authority and prescribing clinical pathways to individual experiences of *doing transgender*. For example, in order for transgender and gender diverse people to “do transgender,” they may feel the need to rely on medical authority and procedures to align their bodily presentations with the sex category in which they identify.

## Overview of Dissertation

This dissertation is organized into three separate, stand-alone, journal-length articles. Beginning with transgender and gender diverse people’s engagement with medical authority over their mental health experiences, Chapter III, “You Are Not Sick; You Are Not Broken:

Peer-to-Peer Support and Transgender Mental Health,” explores how participants use peer-to-peer support to overcome socioeconomic barriers to mental health care. This chapter builds on existing research in transgender health that suggests that community involvement and peer-to-peer support among transgender people may enhance mental health experiences and moderate the effects of stigma and discrimination on health outcomes. Using both ethnographic and interview data, Chapter III identifies three key processes through which peer-to-peer support enhances the mental health of transgender and gender diverse people: i) the normalization of gender diversity, ii) the formalization of a social support network, and iii) the empowerment of transgender and gender diverse people.

Chapter IV, “I Can’t Be Not Trans Enough:” Medical Hegemony, Conformity Pressure, and Transnormative Accountability,” explores how transgender and gender diverse people experience transnormative accountability, which I define as accountability to a hegemonic medical model of gender diversity. This chapter builds on existing research suggesting that the medical model of gender diversity operates as a normative accountability structure for transgender and gender diverse people (Johnson 2013, 2015, 2016). Prior research on transgender community groups suggests that transgender people police each other’s identities and experiences according to a medical model of gender diversity (Gagne and Tewksbury 1998, 1999; Gagne et al. 1997; Schrock 1996; Schwalbe and Schrock 1996). Through inductive qualitative analysis of 158 hours of participant observation and 33 in-depth interviews with members of Trans South, a transgender community organization in the U.S. Southeast, this article departs from prior research on transgender community groups, as findings show participants do not experience transnormative accountability within their primary transgender community group. Participants do however experience transnormative accountability in their interactions with cisgender friends, family members, and medical professionals.

Chapter V, “Rejecting, Reframing, and Strategically Reintroducing: Trans People’s Engagement with the Medicalization of Gender Dysphoria,” explores how transgender people engage the medicalization of transgender experience under the purview of the American Psychiatric Association. Building on sociological literature related to medicalization, this paper argues that the lived experience of medicalization is a non-linear, complex process whereby individual engagement with medical authority differs according to social context. Using both ethnographic and interview data, findings reveal that participants i) reject a medical frame in their own understandings of transgender identity, ii) embrace and stress the importance of gender affirming medical technologies for individual identity development and social interaction, and iii) strategically introduce medical logics and embrace medical authority in order to facilitate medical and social recognition, validation, and acceptance.

This dissertation, as a whole, attempts to understand transgender and gender diverse people’s engagement with and accountability to medical authority. The results advance our understanding of the ways that transgender and gender diverse identities, embodiments, and interactions are held accountable to medical models of and pathways to gender identity. Medical authority has both positive and negative effects for transgender and gender diverse people. As a scientific, and at times moral, authority (Wilkerson 1998), medicine legitimizes gender diverse experience and offers avenues for the actualization of identity via medical intervention; however, as an enterprise of social control, medicine restricts the definitions, pathways, and experiences available to transgender and gender diverse people (Conrad 2007; Conrad and Schneider 1980). This dissertation, examining transgender and gender diverse people’s engagement with medical authority in terms of mental health care, psychiatric diagnosis, and social interaction extends our understanding of the nuanced ways in which medical authority impacts the lived experiences of transgender and gender diverse people.



## CHAPTER 2

### METHODOLOGY

In December of 2012, I attended a transgender community event in a city adjacent to where I earned my undergraduate degree. At that meeting, I introduced myself to the group leaders and voiced interest in learning more about their organization, Trans South. I was immediately added to their very active closed Facebook community. Over the next six months, as the American Psychiatric Association was deliberating the treatment of transgender identity in the *DSM-5*, I became increasingly interested in the medicalization of transgender identity. While transgender academics, activists, and advocates were publishing opinion pieces and editorials debating continued authority over gender variance, members of the community group I was following seemed to be oblivious to or uninterested in the potential and eventual changes in medical discourse. I wanted to understand more about how medical authority impacts transgender community groups and the individuals within them. Specifically, I was interested in how transgender people relate to medical discourse surrounding transgender experience, how transgender people push back against medical authority, and how their ties to transgender community impact both of these things.

#### *Overview of Research*

I began my research on transgender people, community, and health in June of 2014 (Kent State University IRB Log Number 14-235). My purpose was to gain a better understanding of how transgender community groups facilitate knowledge of medical authority and the role of medical discourse in structuring group dynamics. Additionally, I was interested in how transgender people relate to medicalized explanations of their identities and

experience and how they negotiate medical authority. To answer my research questions, I designed an ethnographic study that would allow me to experience group dynamics in real time through field observations while also exploring the experiences of specific group members through in-depth qualitative interviews.

### *The Community Group: Trans South*

Trans South is a pseudonym for a community-based organization for transgender and gender non-conforming individuals in a coastal southeastern state. Starting in 2011 as a group of four friends talking about their gender experiences over coffee, the group has grown to nearly 350 members. The group's mission statement describes the goal of Trans South as "connecting folks through friendships, providing support through resources, and initiating trans-inclusive community change through social action." This mission is carried out via monthly discussion meetings surrounding specific topics related to transgender experience and identity; workshops related to legal, social, and medical transition; activism activities related to transgender, gay, and lesbian identities; social events aimed at building friendship and community ties; and an annual summer camp where members learn healthy coping skills for dealing with stigma and discrimination, coming out strategies, and community building. The group was granted regular meeting space through the local Unitarian Universalist Church in 2013 but often holds events at the 80-acre family estate of the group leader. The group is predominantly white, male-identifying, working class, between the ages of 18-30, with most members having some college education.

### *Field Observations*

I conducted field observations at Trans South group events from June 7, 2014 until August 5, 2014. I also returned to the group for follow up field observations on January 3, 2015, for the group's annual holiday gathering, and August 16-18, 2015, for the annual summer retreat. I secured consent from Trans South's leadership team prior to attending my

first field-observation. Only the group leader was required to give written consent for the field-observations, but I reminded all attendees of my study at the start of each event and offered field observation informed consent documents to participants who wanted more information. I also informed group members of my field observations through the group's closed Facebook community. During my fieldwork, I conducted nearly 158 hours of field-observations at the various activities of the group, keeping jotted and audio notes of all field observations. I later expanded the jotted and audio notes into full fieldnotes. In order to gather as much data as possible, I attended and took fieldnotes at every event that was offered during the dates of my fieldwork. Over the course of fieldwork, there were five types of events held: Planning, Social, Activism, Skill-Building, and Community-Building.

Planning and social events were much less formal than other types. While planning events are open to the entire membership, members of the leadership team informed me that only the core membership typically attends these meetings. The first planning meeting that I attended was focused on the group's spinoff youth chapter. This meeting was held at a local Starbucks café with seven members in attendance. While the group targets the young adult gender nonconforming community, they have recently branched out to include high school aged gender nonconforming people and their parents. The group has held sensitivity training sessions at local high schools as well as foster parent training sessions in an effort to better educate organizations about gender variance and the proper treatment by those charged with their care. The youth chapter is the group's attempt to build community for, in addition to awareness of and education surrounding, transgender and gender variant young people.

The second planning event that I attended was a leadership strategizing session at the residence of a leadership team member. This interaction included three members of the leadership team and was predominately focused on processing and implementing a policy to deal with a conflict among group members. Over the course of my fieldwork, two additional

LGBTQ community groups were created and began recruiting. One of these groups is focused specifically on trans-masculine community, with leadership consisting predominately of former Trans South members. The planning meeting that I attended was focused on how to manage sexist and anti-genderqueer rhetoric taking place within the trans-masculine group and spilling over into the membership of Trans South. This issue was never resolved and the conflict-heavy members were eventually removed from Trans South.

I attended two Trans South social events as part of my ethnographic fieldwork. The first social event that I attended was the birthday party of Trans South's group leader. The party was held at the member's family estate, also the site of the group's annual summer retreat. Of those in attendance, ten were members of Trans South and much of the conversation revolved around plans for Trans South activism activities, membership drives, and programming. The party was my introduction to the group's core membership and through those connections' recommendations I was able to secure interview participants quickly. The second social event that I observed was Trans South's annual winter holiday gathering, New Thanksmas. Many of the group members are estranged from or have strained relationships their family members due their gender identity. New Thanksmas offers a traditional family gathering, including a potluck followed by gift exchange and holiday games for those who do not get to experience Thanksgiving, Christmas, or New Year with their family of origin. This event was also held at the family estate of the group leader with twenty-five members in attendance.

I attended two of the group's activism events as part of my fieldwork. The first activism event I attended was the Unity Rally Against Hatred, an event co-sponsored by the trans community group that was aimed at offsetting a Ku Klux Klan recruitment rally happening the same day. Over the course of the summer that I completed fieldwork, the local chapter of the Ku Klux Klan was staging a marketing campaign to increase awareness of and

membership in their organization. I, along with several members of the group, received zip-locked packets of information regarding Klan values and an upcoming rally along with Jolly Ranchers and Smarties candies. The Unity Rally Against Hatred, held at the local public library, brought together several groups, including several local religious leaders and organizations, to stand in contrast to the public displays of hate by the local Ku Klux Klan leaders and to call for constant vigilance against the threat to equality and fairness in the community.

The second activism event that I attended was a “We Do! Action,” in collaboration with the Campaign for Southern Equality (CSE), to demand equal marriage rights for LGBT people in the U.S. Southeast. The group has worked in conjunction with CSE since the start of its “We Do! Campaign.” Members of the group who had been denied access to marriage rights due to their birth assigned sex category, accompanied by nearly one hundred supporters and several local news media, took part in this campaign by marching to the local probate office, applying for and being denied marriage licenses. These events were regular activism opportunities for group members, who could attend as applicants or supporters. Members of the group regularly take part in these local activism opportunities and have travelled with Campaign for Southern Equality throughout the U.S. Southeast to stand in support of gay, lesbian, and trans-inclusive partnerships. The “We Do! Action” that I attended during my fieldwork included five applicant couples, two of which were active members of the group, with several group members among the nearly one hundred supporters in attendance.

The group held one skill-building workshop during my fieldwork, an improv theater workshop focused on improving coping skills. The improv theater event was facilitated by two actors from a local art house theater and consisted of role-playing scenarios surrounding interpersonal conflict management. This workshop was held at the local Unitarian

Universalist Church, where the local pastor has allotted a regular meeting space for the group's events. Thirty members of the group attended this meeting, taking turns acting out agreed upon scenarios that are most likely to arise in the daily lives of gender non-conforming people. These scenarios included encountering hostility from strangers in a public restroom, law enforcement when identity documentation does not match presentation of self, and friends and family members who use religious doctrine as grounds for condemnation. The improv scenarios gave group members opportunities to practice composure and boundary maintenance while simultaneously serving as tools to construct the group's agreed upon responses to these types of scenarios.

The group held two community-building events during the course of my fieldwork, their second- and third-annual summer overnight retreat in the summers of 2014 and 2015 respectively. The second-annual summer retreat, in summer 2014, lasted four days and three nights and took place at the group leader's 80-acre family estate along the Saluda River. There were fifty-five members in attendance and those who stayed overnight either camped in tents outside or slept on air mattresses inside the makeshift dorms in the finished basement of the main house. The third-annual summer retreat, in summer 2015, lasted three days and two nights. There were sixty members in attendance. The group outgrew the donated space from prior years and relocated to a retreat facility in Toccoa, GA in 2015. Each summer retreat consists of team-building exercises, meditation meetings, and workshops. The team-building exercises included a variety of events including group games, camp songs, talent shows, nature walks, and spirit walks. The workshops consisted of one-hour sessions related to transgender experiences and activism; romantic relationships; faith reconciliation; familial reconciliation; legal transition and power of attorney; improving coping skills; local politics; being a good ally; transition anxieties; and community building.

## *Qualitative Interviews*

Between June 3, 2014 and August 6, 2014, I conducted in-depth interviews with thirty-three members of Trans South. Interview participants included seven transgender women, twenty-two transgender men, and four individuals who identified as genderqueer. Most interview participants identified their race as white (n=29), two of which identified as white Hispanic, with the remaining two participants identifying as black and multiracial. The majority of participants had either attended some college (n=15) or graduated from college (n=13). Participants ranged in age from 18 to 44 years with the majority falling in the 18-24 (n=14) or 25-34 (n=16) age brackets. These demographic ratios are representative of the larger group membership.

Table 1: *Demographics (age, race, education, income), Interview Participants*

	<u>TRANS MEN</u>	<u>TRANS WOMEN</u>	<u>NON-BINARY</u>
<u>AGE</u>			
18-24	12	2	0
25-34	9	4	4
35-44	1	1	0
<u>RACE</u>			
White (Non-Hispanic)	20	6	3
White (Hispanic)	1	1	0
Black	0	0	1
Multiracial	1	0	0
<u>EDUCATION</u>			
High School	0	2	0
Trade School	1	0	0
Some College	13	1	1
College Graduate	7	3	3
Some Graduate School	1	1	0
<u>INCOME</u>			
Below 30k	17	6	3
30-50k	4	0	1
50-75k	0	0	0
75-100k	1	0	0
100-150k	0	0	0
Above 150k	0	1	0

As I was interested in the relationships between transgender people, transgender community, and medical authority, I limited the criteria of inclusion to people within Trans South who did not identify with the sex they were assigned at birth. This included transgender men, transgender women, and individuals who identified outside of the male/female gender binary. Participants were not required to have undergone medical intervention of any kind to participate nor were they required to have legal documentation to substantiate their gender identities. The individuals I interviewed had differing amounts of group involvement, with the majority being deeply integrated into Trans South while the rest were only engaged online with other Trans South members.

All interview participants were recruited via convenience sampling. I recruited interview participants from the group's closed Facebook community as well as from in-person encounters at field-observation events. The group's Facebook community ranged between 300 and 350 members during my fieldwork. To recruit within the Facebook community, I posted a call for participants to the group with directions for those interested to contact me personally and privately through Facebook message or by email. Additionally, I sent personalized emails to group members who were active within the online group. I also recruited interview participants at field-observations by making announcements before group dismissal. The majority of interviews took place either in a private study room at a local public library or at the participant's home. Three interviews took place at local Starbucks coffee shops, one at a frozen yogurt shop, one at a local restaurant, one on a blanket in the grass outside the public library, and one at my home.

### *Interview Content*

Interviews were structured around five topical clusters: 1) transgender identification, 2) transgender community interactions, 3) transgender medicalization, 4) transgender healthcare experiences, and 5) impact of intersecting identities. Each cluster contained



several prompts that included several follow-ups or probes for further information. The first cluster, transgender identification, consists of four primary prompts aimed at gathering information about the participants' personal identity and their perspective on transgender as an identity category and gender transition as a process. The second cluster, transgender community interactions, consists of questions aimed at the participants' engagement with the transgender social, support, and outreach group. These prompts encouraged participants to reflect on their interaction with group members and their connection to the transgender community. The third cluster, transgender medicalization, consists of questions aimed at participants' exposure to, understanding of, and identification with a medical model of transgender identity as well as their perspective on the recent DSM shift from Gender Identity Disorder to Gender Dysphoria. The fourth cluster, transgender healthcare experiences, consists of prompts aimed at understanding participants' comfort interacting with healthcare professionals. The final cluster, intersecting identities, consists of two prompts related to the effects of participants' race and class on their experiences and one prompt encouraging the participants' to reflect on what they would like to see in the future for transgender health. While structured around specific topical prompts, the interviews were flexible enough to allow the participants to tell their own story and describe their experiences. That is, while an interview guide was used, I adapted to the answers of the participants as new themes unfolded. Interviews ranged in length from 32 minutes to 126 minutes, and averaged approximately 71 minutes in length. Written consent was secured prior to every interview.

### *Analysis*

Drawing on sociological and interdisciplinary research on transgender people and medicalization, I had three central research questions going into the project: (1) How does the work of transgender community groups relate to medical discourse surrounding transgender

identity and experience? (2) How do transgender people relate to medical discourse surrounding transgender experience? (3) What roles does medical authority play in the individual and community experiences of transgender people? While my own transgender identification, my prior exposure to transgender studies scholarship, and my working knowledge of Trans South allowed me some anticipation of specific themes in the data related to these guiding research questions, I did not restrict my analysis to a predefined coding scheme. Instead, I used an inductive coding method that allowed themes to arise independent of my expectations. I audio-recorded all interviews and paid a professional transcriptionist to transcribe them. Once transcription was complete, I initiated open or line-by-line coding using NVivo for Mac (Version 10.1.2), tagging every topic that arose in the interviews. After open or line-by-line coding, I used refined coding (or axial coding) to integrate the codes into thematic categories or schema. Once the coding schema was developed, I went back and recoded all interviews based on the new schema. I paid particular attention to accounting for negative cases, or those that seemed to be outliers among the participants. I created a set of memos that pulled together the disparate pieces of data from each of the codes. Using these memos as guides, I began to construct my analysis.

#### *Researcher Positionality and Its Effects*

My social location as a southern, white, educated, transgender man was certainly a factor in my interactions with members of Trans South. Being transgender and raised in the rural south gave me comfortable entrée to the community and members of the group identified me, first, as a member of their community and, second, as a researcher. In general, participants were very open about their experiences and feelings related to their identities, their communities, and their attitudes towards medical authority. While Trans South has a very active social media and local community where members often discuss their experiences, my participants seemed eager to have someone listen to their story with an

affirming and supportive ear. Several participants expressed gratitude for allowing them to tell their stories. Many interviews involved emotional moments. Participants revealed to me that the interviews gave them a chance to talk through things they had never before put into words. While my gender identity made me a comfortable audience for members of Trans South, it also operated as a barrier in some instances. In the data analysis phase of the research, I realized that there were many moments during data collection where participants did not elaborate or explain things fully because they relied on my experience as a transgender person to bridge the gaps in their explanations. Participants would often stop short of an in-depth explanation and insert comments such as “you know what I’m talking about,” or “I’m sure you understand what I mean.”

In addition to its impact on the research process, being a transgender researcher positioned me to contribute to the group in ways I did not foresee. Many times throughout the interviews and field observations, members of Trans South would ask me questions about my transition-related experiences and at times would ask my advice related to seeking medical-intervention, interacting with healthcare professionals, or community debates or conversations to which they felt my sociological training would contribute. I was asked by the leadership team to weigh in on planning and organizing events, working through member conflicts, and formulating social justice goals for the group. I led a workshop, Transgender Studies 101, at the annual summer retreat to familiarize the membership with academic study of their lives, experiences, and communities. I also volunteered my research skills and time to write a Needs Assessment for the group based on my interviews and field-observations. These things contributed to my establishing rapport with membership and also served as a way to give back to Trans South for allowing me to conduct research.

## CHAPTER 3

### YOU ARE NOT SICK; YOU ARE NOT BROKEN:

#### PEER-TO-PEER SUPPORT AND TRANSGENDER MENTAL HEALTH

Transgender people, individuals whose gender identities do not match the sex categories they were assigned at birth, face staggering obstacles to full social integration including disproportionately high rates of discrimination, violence, homelessness, unemployment, poor mental health, and suicidality (Grant et al. 2011). While trans people may be more culturally visible than ever before, 1 in 5 trans people are estimated to be homeless or in unstable housing (National Health Care for the Homeless Council 2014), trans women of color are being murdered in record numbers (Anti-Violence Project 2015), and so far in 2016, 16 states have filed 44 bills aimed at denying trans people access to medical care, public facilities such as bathrooms and locker rooms, and limiting workplace protections and accurate identity documentation such as birth certificates and drivers licenses (Human Rights Campaign 2016).

The lived realities of transgender marginalization and oppression contribute to the growing mental health needs of the trans community where it is estimated that 40 percent experience clinical levels of depression and anxiety (Budge et al. 2013) and 41 percent have attempted suicide (Grant et al. 2011). The health consequences, both physical and mental, of stigma and discrimination have led scholars to call for the World Health Organization to designate gender identity a social determinant of health (Pega et al. 2015). According to Pega and colleagues, “prejudice, stigma, transphobia, discrimination, and violence targeted at transgender people produce differential levels of social exclusion for populations defined by

gender identity, including in health care settings” (2015:e59). These social exclusions, both socioeconomic and sociocultural, limit trans people’s access to care and lead to poorer health outcomes for trans people.

This paper uses ethnographic methods to explore how trans people in a community group overcome both socioeconomic and sociocultural barriers to traditional mental health care by turning to the peer-to-peer support offered in a local transgender community group. This paper builds on existing research on trans health experiences that suggests that trans community involvement and peer-to-peer support among trans people may enhance trans mental health and moderate the effects of stigma and discrimination on health outcomes. Specifically, this study uses qualitative methods to explore the processes through which involvement and peer-to-peer support enhance the mental health experiences of trans people.

#### Transgender People and Barriers to Care

Within the current U.S. healthcare system, access to specialized, newly developing, and controversial medical technology is often dependent on individuals’ socioeconomic status. Interventions specifically designed for trans people are no exception. Gender-affirming medical interventions—including psychotherapeutic interventions aimed at alleviating the mental health consequences of stigma and discrimination—are not equally accessible to all trans people. A 2010 survey of trans people nationwide revealed that members of the trans community experience unemployment at twice the rate of the general population, with trans people of color experiencing unemployment at up to four times that rate (Grant et al., 2011). Transgender people who wish to access medical intervention are most often required to pay for these services, including mental health services, out-of-pocket, despite statements from multiple professional medical associations encouraging insurance companies, both public and private, to provide coverage for medical services and procedures related to gender transition (Stroumsa 2014). Transgender people’s experiences of under- and

unemployment combined with insurance exclusions create the conditions under which access to gender affirming care becomes cost-prohibitive for many trans people.

In addition to socioeconomic barriers, trans people also face sociocultural barriers to both gender-affirming and routine care. While socioeconomic barriers may affect trans people's access to care, sociocultural barriers affect trans people's desire to seek care, comfort in a care setting, and physicians' ability to offer care. Among the reasons that trans people postpone treatment seeking include past experiences of stigma and discrimination in healthcare settings (Cruz 2014; Poteat et al. 2013), perceptions of a lack of provider knowledge regarding trans health and experience (Bauer et al. 2009), and trans insensitivity in intake forms, health insurance, and office environment (Redfern et al. 2014). In addition to trans people's own sociocultural barriers to seeking care, the lack of attention to trans health in medical school curriculum (Sequeira et al. 2012; Stoddard et al. 2011) contributes to physician-side barriers to offering care including lack of training, questions of ethics in providing gender-affirming interventions, and provider perceptions' of diagnosis versus pathologization (Snelgrove et al. 2012).

### Alternative Avenues to Health

Trans people who have socioeconomic and/or sociocultural barriers to care may rely on alternative or community based practices to promote health and well-being. Alternative avenues to health have been studied among other groups who also experience barriers to care. For example, Becker and colleagues found that African Americans facing socioeconomic and sociocultural barriers to care relied on extended kin networks, spiritual philosophies, and nonbiomedical healing traditions to promote health and well being (2004:2069). Similarly, in their review of research related to rural communities and health practices, Wardle and colleagues found that alternatives to traditional health care, such as home remedies and

spiritual healing, are “a significant part of the de facto rural health system” for “populations in remote or geographically isolated locations” (2010:108).

Alternatives to traditional care have been studied in a variety of disciplines and referred to using terms such as ethnomedicine, lay health care, or self-care. O’Connor subsumes this collection of terms under the conceptual construct of “vernacular health belief (or healing) systems” (1995:6). “In matters of health and illness,” O’Connor writes, “‘vernacular’ refers not to what people supposedly do or ‘ought’ to do according to an official set of standards, but to what they *actually* do when they are sick, when they wish to prevent sickness, or when they are responsible for others who are ailing” (1995:6). This refers not only to physical health practices but also emotional, spiritual and psychological practices aimed at promoting health and well-being. McLaughlin politicizes the use of “vernacular,” stating “it refers to practices of those who lack cultural power and who speak in a critical language grounded in local concerns” (1996:5-6).

For trans people, who as a community are in a mental health epidemic with limited access to traditional mental health care, alternative, community-based, or vernacular health practices may operate as a stand-in or stop-gap. Research on the health experiences of transgender people reveal that trans community involvement and trans peer-to-peer contact enhances trans mental health and moderates the effects of stigma and discrimination on health outcomes (Bariola et al., 2015; Bockting et al., 2013; Bradford et al., 2013; Testa et al., 2014). However, these studies do little to show *how* involvement and peer-to-peer contact support the mental health of transgender people. Using ethnographic data from a transgender community group in the rural southeast United States, this study explores the processes through which involvement and peer-to-peer contact affects trans people’s perceptions of their mental health.

## Data and Methods

This analysis is based on field observations and qualitative interview data collected from a study on transgender, community, and health. Between June 2014 and August 2015, I conducted approximately 158 hours of participatory field-observations and 33 in-depth qualitative interviews within Trans South, a community-based organization for transgender and gender non-conforming people in a coastal southeastern state. I attended and took fieldnotes at every group event held during the dates of my fieldwork. Over the course of fieldwork, there were five types of events held: Planning (2), Social (2), Activism (2), Skill-Building (1), and Community-Building (2). I kept jotted and audio notes of all field observations, later expanding the jotted and audio notes into full fieldnotes. I secured consent from Trans South's leadership team prior to attending my first field-observation. Only the group leader was required to give written consent for the field-observations, but I reminded all attendees of my study at the start of each event and offered field observation informed consent documents to participants who wanted more information. I also informed group members of my field observations through the group's closed Facebook community. Interviews followed a semi-structured guide with five topical clusters: 1) transgender identification, 2) transgender community interactions, 3) transgender medicalization, 4) transgender healthcare experiences, and 5) impact of intersecting identities. Each cluster contained several prompts that included several follow-ups or probes for further information. Interviews ranged in length from 32 minutes to 126 minutes, and averaged 71 minutes in length. Written consent was secured prior to the start of every interview. All interviews were audio recorded and transcribed by a professional transcriptionist.

Inclusion was limited to people within Trans South who did not identify with the sex they were assigned at birth. Participants were not required to have undergone medical intervention of any kind to participate nor were they required to have legal documentation to



substantiate their gender identities. Participants were recruited at field-observation events and via the group's closed Facebook group. Of the 33 interview participants, there were seven transgender women, twenty-two transgender men, and four genderqueer people. Most interview participants identified their race as white (n=29), two identified as white Hispanic, with the remaining two participants identifying as black and multiracial. The majority of participants had attended some college (n=15) or graduated from college (n=13). Participants ranged in age from 18 to 44 years with the majority falling in the 18-24 (n=14) or 25-34 (n=16) age brackets. These demographic ratios are representative of the larger group membership.

In line with my call for reflexivity within transfeminist methodology (Johnson 2015b), it is necessary to reflect here on my subject position as a researcher. My social location as a southern, white, educated, transgender man was certainly a factor in my interactions with members of Trans South. Being transgender and raised in the rural south gave me comfortable entrée to the community and members of the group identified me, first, as a member of their community and, second, as a researcher. I believe my social location put participants at ease when confiding in me. While my personal connection to and experience with the transgender community gave me a preview of themes that arose in the data, my analysis is based on a thorough review of literature in the sociology of gender, transgender studies, and medical sociology.

While my own transgender identification, my prior exposure to transgender studies scholarship, and my working knowledge of Trans South allowed me some anticipation of specific themes in the data, I did not restrict my analysis to a predefined coding scheme. Instead, I used an inductive coding method that allowed themes to arise independent of my expectations. I audio-recorded all interviews and paid a professional transcriptionist to transcribe them. Once transcription was complete, I initiated open or line-by-line coding

using NVivo for Mac (Version 10.1.2), tagging every topic that arose in the interviews. After open or line-by-line coding, I used refined coding (or axial coding) to integrate the codes into thematic categories or schema. Once the coding schema was developed, I went back and recoded all interviews based on the new schema. I paid particular attention to accounting for negative cases, or those that seemed to be outliers among the participants. I created a set of memos that pulled together the disparate pieces of data from each of the codes. Using these memos as guides, I began to construct my analysis.

## Findings

Using Trans South as an empirical example, this article shows how peer-to-peer interaction among trans people in a transgender community group enhances emotional and psychological well-being by normalizing trans identities and experiences, creating a social support network, and empowering trans people. The latest version of the Standards of Care for treating trans patients, put forth by the World Professional Association for Transgender Health (WPATH), states that treatment options for transgender people include psychotherapeutic counseling...

“for purposes such as exploring gender identity, role, and expression; addressing the negative impact of gender dysphoria and stigma on mental health; alleviating internalized transphobia; enhancing social and peer support; improving body image; or promoting resilience” (Coleman et al. 2012:171).

Participants in my study, however, relied on the peer-to-peer interaction of Trans South to meet these needs. Members sought traditional mental health services largely to receive a written recommendation from a licensed therapist for gender affirming medical interventions and often discontinued care once this recommendation was secured. Given the mental health outcomes associated with transphobic stigma and discrimination, trans people are positioned to benefit greatly from focused and individualized mental health care. In absence of this care,

the unattended mental health needs of trans people who cannot or do not wish to seek traditional mental health services are not being met. In what follows, I explore participants' stance toward traditional mental health services, showing that they prefer to rely on the peer-to-peer interaction facilitated by Trans South for their emotional and psychological needs that related to trans identity and experience. I then explore the ways in which Trans South enhances participants' perception of their emotional and psychological well being through peer-to-peer interaction that normalizes trans experience, cultivates a social support network, and empowers trans people.

### *Mental Health Professionals as Gatekeepers*

Every year, at the beginning of January, Trans South holds its annual holiday gathering where members come together to share a potluck meal, exchange gifts, and engage in fellowship. Many of Trans South's members are misgendered by or have been alienated from their families as a result of their gender identities. New Thanksmas—meant to celebrate Thanksgiving, Christmas, and the New Year—gives members an opportunity to experience a large holiday gathering in an environment of validation and support. When I arrived at the group's second annual New Thanksmas event, a few members had already arrived and were setting up the buffet where a turkey, ham and many casseroles were to be served. I dropped off the bags of ice and cases of bottled water, my contribution to the feast, and made my way to the den where members were watching the local NFL team win their playoff game. It felt like a southern holiday. By halftime, the number of people had more than doubled and the house was buzzing. I walked out onto the porch to enjoy the unseasonably warm weather and chat with a few guys about the game. Smoking a few feet from me on the edge of the porch, Chet tells Jesús that he is getting things in order to start the process of medical transition. Jesús asks if Chet has his letter yet. Among trans people, "the letter" is an iconic document. Referring to therapist's written recommendation for gender-affirming medical intervention,

“the letter” was a motivating factor in many participants’ utilization of traditional mental health services. While “the letter” is an archaic requirement that was replaced by an informed consent clause in the 2012 standards of care, it is still enforced by many healthcare providers caring for transgender and gender diverse people. Not all participants in my study were interested in medical intervention. However, those that were relied on a limited number of trans-affirming health professionals in their area, many of whom required therapist recommendation for services.

After Jesús asks Chet about the letter, Chet shakes his head and tells Jesús, “I’m going to Charlotte.” Among group members, Charlotte is shorthand for a physician two hours away who does not require therapist recommendation for the administration of hormone replacement therapy but costs more and requires medical tests more often than other physicians in the area. Jesús responds, “Hey, if you can afford it...” Chet tells Jesús that he has been saving a little bit each week from the paycheck he earns as an electrician, “I can either save for six months and go to Charlotte, or I can pay a therapist for six months just to tell me what I already know.” Most of my participants either avoided traditional mental health services or discontinued them after receiving recommendation for gender-affirming care. Like Chet, many members of Trans South see mental health providers as unnecessary in their identity development and as gatekeepers whose role is primarily to provide access to medical interventions.

Seeking mental health services largely to receive written recommendation for gender affirming care, many participants held a view of mental health professionals as uneducated and thus unhelpful when it comes to transgender experience. These members take comfort in the community and shared experience that Trans South provides and find frustration in health care interactions where they feel misunderstood or as if they have to fill in gaps in the understanding of those charged with, and charging them for, their care. Reid, a 26-year old

genderqueer trade worker, had been a member of Trans South for a year at the time of our interview. Alienated from familial support due to homophobia and transphobia, Reid leans on the group a lot for support and prefers reaching out to group members over traditional mental health care providers:

Generally, therapists haven't gone through the experiences themselves. They are trying to relate everything to a theory or, you know, some stuff that they read. Whereas, the [group members], they all, they are all at different stages of the transition. They know, you know, what happened, what was supposed to happen, what didn't happen, and what they expected to happen. So, you have a whole lot more, you get a better understanding, and they understand you better when you come to them with your problems versus just a sympathetic ear from a random person.

Reid's comments reveal a common sentiment among group members that mental health professionals are ill-equipped to meet their needs. While some members of the group do seek out the services of mental health professionals, it was more common among my participants to dismiss psychotherapeutic intervention as unhelpful or as a source of continued misunderstanding.

For people who seek psychological intervention as a means of healing and processing, continued misunderstanding may be more harmful than helpful, especially for trans people who are just beginning to explore their identities. Spencer, a 25-year old genderqueer college student, felt frustrated with their therapist's lack of understanding and ultimately decided to discontinue care:

I went to a therapist at first when I was kind of exploring these feelings and she just did not get it. So, on top of my already being hesitant to explain it to myself, I'm having to be hesitant because of this. It was just very frustrating. [...] She just was very ignorant. And, she was very cool. Like, she was very sweet. She wanted me to

feel better and to come into my identity but at the same time there was just such this level of like, ‘I don’t understand, will you explain it to me?’

The understanding gap referenced by Spencer and Reid as a barrier to seeking mental health care is not limited to transgender people. Patient perceptions of provider misunderstanding or lack of support are common barriers to treatment seeking within traditional mental health services, especially for individuals with newly recognized or stigmatized experiences of mental health (Pietrzak et al., 2015). Seeing therapists as gatekeepers to affirming care who are largely uneducated on trans issues, members turn to Trans South to fill the gap.

### *Normalizing Trans Experience*

The first time that I attended Trans South’s annual summer camp was in its second year. I arrived at camp on Thursday afternoon around five o’clock on a sweltering July day and parked my car in a large green field next to the main house where camp activities are held. Located in the middle of 80-acres of wooded land, the main house is a brick house with a sprawling front porch anchored on either end by large wooden swings where members of Trans South were sitting when I arrived. Everyone was smiling, laughing, and catching up on the events in each others’ lives. I checked in at the entry way and received a swag bag filled with information about the group and other local trans-affirming organizations, a camp schedule, a camp t-shirt, and a laminated nametag that read: “Austin. He/Him/His.” The conversations on the porch were warm and friendly as campers, new and veteran, were getting to know each other. The excitement was palpable. Jack, a trans man who later helped me set up my tent in the back field, turned to me and said: “You’re really gonna love this. Last year was the best weekend of my life!” Other members chimed in with similar sentiments. I sat on a porch swing next to two other group members, trans men who were veteran camp goers. When I asked them what made camp so great, the response was unanimous: at camp, trans people are just people. One of the group members on the opposite

end of the porch added, “We’re the normal ones here. It’s everybody else who are the weirdos!” Everyone on the porch laughed as they continued their conversations. Jim, an older group member in his fifties who was standing on the edge of the porch near me, chain smoking cigarettes and drinking coffee, joined in, “It’s nice to be in a bubble for a few days where we’re not gawked at like circus freaks or zoo animals.” He smiled and lit another cigarette. Other camp members began crowding the porch and I excused myself to the air conditioned house.

As I walked into the downstairs restroom, I immediately noticed a sign hanging on the mirror. The sign read: “You are not wrong. You are not sick. You are not broken. You are not alone.” Wrong, sick, broken, and alone are common sociocultural narratives related to transgender identity and experience. From medical discourse that positions gender nonconformity as psychiatric illness to media depictions of transgender social isolation; transgender people, in the popular imaginary, are suffering and suffered. This sociocultural narrative surrounding transgender experience has lived consequences as transgender is positioned as something to be avoided, rejected, and eradicated. These lived consequences manifest in transgender people’s increased risk of suicide, homelessness, unemployment, and violence (Grant et al., 2011). The transgender people who participated in my study were intimately familiar with these consequences, with many being rejected from their families, pushed out of their homes, and fired from their jobs after coming out.

Tim, a 20 year old trans man and call center agent, came to Trans South seeking community after being harrassed and rejected by cisgender friends and family members. In our interview, Tim spoke of Trans South’s work to normalize trans experience in the face a culture that marginalizes trans people:

I think the main thing that most people get out of the [group] is the feeling of normalcy, of not being alone. You never have to be alone. There is always someone

who, even if no one knows exactly how you feel, they will have similar experiences. We deal with gender dysphoria. We deal with people in Wal-Mart coming up and screaming at us and our partners. We deal with, you know, not being considered, always being an “other,” or, you know, alienated or someone who is, you know, not normal.

Through its annual summer camp and other initiatives, Trans South creates a space where transgender experience is normalized as benign human variation, aiming to alleviate the burden of marginalization and oppression that trans people face in everyday life. Instead of suffering and suffered, within Trans South, trans people are celebrated, welcomed, and validated in their identities. As the members told me: at camp, trans people are just people. This is not to say that being trans is forgotten or erased, but to explain that camp offers the opportunity for members to operate outside of the cis gaze where they are held to normative narratives of gender identity and experience or subjected to the interactional violence and microaggressions of a ciscentric society.

Gandolf, a 23 year old trans man and college student, had been a member of Trans South for over a year at the time of our interview. When we met, he was making arrangements to return to school after taking a year off due to transphobic bullying from classmates and professors. For Gandolf, Trans South’s efforts at reframing transgender identity helped him cope with this psychological distress and changed not only the way he saw himself but how he viewed transgender people as a group:

Before, I always kinda thought being trans was a negative thing, that it was a thing that should be looked down on. I mean, not that I would go around looking down on trans people, but it was just like it was something that you don’t do and that’s not normal. And, I mean, it, it still kind of isn’t normal in the sense of the word, but,



when you go there, you feel normal. And, they definitely reinforce the positivity.

Like, own the label transgender, don't have it be a shameful thing.

Leslie, a 25 year old trans woman and graphic designer, had a similar experience in the group:

It was kind of a scary step for me to go in there with all these strangers, these other trans people. It helped me build a lot more confidence in just myself... a lot more, a lot more confident, a lot more outgoing. I think I have a lot less fear of letting others know that I am trans. It is something that, I don't know, I just feel better about the whole experience of myself.

Over the course of my field work, the group gained almost 150 additional members and I was able to witness many of these transformations in real time. Like many other member of the group, Tim, Gandolf and Leslie experienced Trans South as a space to break down the dominant, sociocultural meanings of transgender identity and replace them with characterizations of transgender experience as normal and as one of many types of benign human variation. In turn, this reframing alleviated some of the internalized transphobia that members experienced leaving them feeling more connected, more confident, and, in the words of my participants, more normal. Another result of this reframing is that trans becomes a characteristic of members rather than a central and salient marker. Claire, a 28 year old trans woman and doctoral candidate in computer science, describes how her experience was transformed by being in the group:

When I first went to [the group] I was so, felt so vulnerable and fragile and like in need... And now, now, like... And, I was so distressed! I had so much dysphoria and now, like, trans is like... being trans is just not a thing anymore. Like it's so, like it's not... It is something I still like identify with. I'm proud to be part of the community and I still identify that way, but it's not like it used to be, like something I thought

about everyday and it was like a big deal and now it's like just who I am. It's something about me, it's not a big thing. So, it's changed not just how I view myself, but how I see [other trans people] and everything else.

### *Cultivating Social Support Networks*

The private Facebook group for Trans South is an active virtual space where members have easy access to social support. The group encourages members to post personal updates, pose questions to the group, and share in each other's celebrations and setbacks. In an effort to keep group members informed and engaged in current trans community events and stories, leadership often posts links in the group to current news items related to the trans community. One such post was a call for messages of support for a local trans woman with a link to a news story about her ongoing civil suit against the state's Department of Motor Vehicles. The DMV refused to photograph Candice for her driver's license because, in the words of the DMV representative, she did not look the way a boy should. The first time I met Candice was almost a year after her story was posted in the group. I was checking people in at Trans South's third annual summer camp, handing out nametags, swag bags, and t-shirts when Candice arrived with her mother, Pamela. Immediately a camp favorite, Candice walked in with beachy waves in her long blonde hair, a big smile spread across her face, and large dark sunglasses covering her eyes. She owned the room. Her make-up, the same make-up the SCDMV insisted she remove before taking her photograph, was subtle: mascara, a thin layer of eye-shadow, light foundation, and maybe some lip gloss. Her mother, Pamela, tells me over a breakfast of scrambled eggs, toast, and grits in the dining hall the next morning that other students are becoming a problem for Candice. Candice is regularly harassed for being trans and prohibited from using the girls' restroom at her high school; boys are attracted to Candice but can't reconcile this attraction with cissexist understandings of trans bodies and sexualities. Pamela says she worries about Candice's safety, as these young boys are

becoming young men in a culture that restricts masculinity to the point of violence. As we're talking about Candice's experiences, Pamela tells me that she spends a lot of time thinking through how to make Candice's life as normal as possible. Connecting with Trans South was part of that effort.

The Night Owl House is the camp dormitory for campers who like to stay up late sharing stories, playing card games, and strumming guitars in preparation for the annual camp talent night. Every night after the last camp song has been sung, I drop off my nametag and notepad at Early Bird House and hike up the hill to Night Owl House to visit, talk, or play cards until I'm ready for bed. Sitting on the steps outside Night Owl House, Candice tells Sammie, a member of the leadership team, that she feels overwhelmed. I sit down next to her on the top step as she tells us both that the pressure of being the perfect trans girl is weighing on her. She speaks to us with the wisdom and worry of a twenty-something, all calculated self-confidence and uncertainty rolled into one. She is only eighteen and she is about to start her senior year of high school. With her shower-wet hair wrapped up in a towel that sits lop-sided on her head, tears stream down her bare face. She speaks to us of the pressure of being the perfect girl, of fitting in at her rural southern high school, of being held to impossible standards of femininity and respectability, of having to explain herself to people while at the same time figuring out who she is. Sammie, a trans man in his early twenties, sits with his back against the dark grey wood siding of Night Owl House, a few steps down from Candice and me, nodding in solidarity. In an attempt to demonstrate his understanding to Candice, Sammie tells us that he is also overwhelmed and afraid of not being the man he thinks he is or wants to be. Other campers from Night Owl House join us outside and the conversation trails off. Instead of talking, we sit and listen to the songs of cicadas shedding their skins.

Centered on the development of a support system of people with shared experiences, Trans South assists members like Candice and Sammie in coping with hardships related to, but not exclusively based on, being transgender. This shared understanding creates social ties within the group that serve as a support system for members who lack support in their everyday lives. Chet, a 23-year old trans man, had been a member of the group for two months at the time of our interview. A multiracial electrician who lives stealth, a term used in trans communities to denote someone who does not disclose their trans status in their daily life, Chet spoke directly to the community support he received within Trans South:

It was awesome just cause there's other guys that were like me. So, you know, being the oddball, feeling so outside all the time in the real world... I'm just one of the guys you know? But, to have somebody that knows what's going on in my head is like... we know the same problems and stuff. That made a big difference. You know, having friends that I could relate to that were going through the same situation I'm going through.

Over the course of my observation, Chet became a strong member of the group. He attended most meetings and events, was one of the most active in the online group, and was quick to speak candidly, with admired vulnerability, of his lifelong struggle for self-acceptance.

According to the 2010 National Transgender Discrimination Survey, 41 percent of respondents attempted suicide compared with 1.6 percent of the general population (Grant et al., 2011). Alongside these staggering statistics related to suicidality, transgender people also experience increased rejection from friends and family (Grant et al., 2011). As these studies show, the stress and uncertainty experienced by members like Candice, Sammie, and Chet are not unique within the larger transgender community, nor are they unique within Trans South. In an interview with Brian, a 25 year-old line worker at an auto parts manufacturing plant, he described his feelings of isolation and aimlessness before joining the group:

I think if I wouldn't have been connected with [the group] then I probably still would be looking or probably still just would be like I don't know where to start and probably wouldn't have went anywhere...I didn't kill myself by now and I told them all that.

Brian's feelings of isolation and aimlessness were common among members of Trans South before joining and many members of the group cited Trans South as an avenue for them to reach a more positive mental health state. Wendyl, a 25 year old Black trans man who works in retail management, describes Trans South's effects in a similar way:

Definitely more empowered to bring more of my extrovertedness out. Because before even thinking about how I identified, before I even knew any of that stuff existed, it was just, you know, I could just see myself like very outgoing, energetic. You know, when those words started popping into my head, it was just kind of like I backed, would start backing off from people and things. Just when I started to understand a lot more about how, you know, the cruelty of some people. And now, it's just, it's coming...I'm, I guess I will say I'm coming back in the limelight. You know, I don't feel afraid or as scared as I used to feel and it's because of them.

Experiences of members like Brian and Wendyl are common in Trans South. During the course of my field observations, at least three members of the group attempted suicide and three more were admitted for treatment to a local in-patient mental health facility. Trans South members often voice suicidal thoughts in the closed Facebook group. These posts are not calls for attention, but rather are panic buttons for community support or what I refer to as *crowdsourced social support*. When members post their feelings of loneliness and anxiety, or in more extreme cases desperation and hopelessness, in the group, the responses often include real-time responses from other members through private message or by phone.

## *Empowering Trans People*

One of the key features of Trans South's summer camp is the diversity in workshops and facilitators that the group organizes. From sessions on faith reconciliation to a collaborative art project, leadership draws on the strengths of the membership to put together a diverse line-up of trans-led and trans-centered activities. Many of these workshops are led by members of the group who have no past leadership experience but who possess an expertise or talent in some area. The collaborative art workshop was one of the highlights of year three. After the last dinner tray had been stored in the dining hall, campers made their way down a wooded path to a cabin by the creek. In one half of the large meeting space was a ring of tables covered in art supplies with a canvas at each seat. Over the course of the next hour, Xander led the group in a collaborative project that resulted in every person contributing to each canvas in the room. Xander, a 31 year old trans man and artist who works in automobile manufacturing, came to the group looking for a way to contribute to the local trans community and Trans South welcomed his creative talents.

Trans South developed from the leadership team's own experiences of isolation and frustration with a lack of support resources and the leadership teams works diligently to cultivate a network where members may enhance their social and peer support, explore their identities, and build resilience. The cultivation of local trans support network is not simply a top-down endeavor from Trans South leadership. Existing members of the group are encouraged to reach out to new members as they become involved, create and develop events or educational campaigns, and take on responsibility by leading topical discussions or facilitating workshops in their areas of expertise. Empowering members to take responsibility for their community is a cornerstone Trans South's success. When asked what he gained from being in the group, Andrew, a 31 year-old trans man and trans advocacy consultant, spoke directly to the opportunity to contribute:

I got a lot of hope, community wise. So, I went from a place of feeling completely alone to a place of being like, *holy shit, there's a lot of trans people here!* And, I think it gave me a chance to give back. Like even though I thought that I needed this, I don't know, larger amount of help from people who have gone before. Like, it actually gave me a chance to just, well, I've gone this far so I can give this much back.

The social support network that Trans South cultivates arises from the community building efforts of the group and is sustained through mutual investment. As Andrew's comments illustrate, members often come to Trans South looking for resources or support and find that support in the context of the group is a mutual exchange. Dustin, a 30-year old emergency medical technician and member of the group for two years, also spoke of this mutual investment:

They give me the support that I need to keep going and be the person that I am. Without them, I probably never would have started transition and I would be miserable. I like helping other people with transition if that's what they wanna do. Or, if that's not what they wanna do, answer questions, you know? I haven't got my name changed yet but if they ask about T, you know, I'm right there with, this is my experience, maybe it can help you.

Members of Trans South are treated as experts of their own experiences and are empowered to tell their stories, support their community members, and take responsibility for the maintenance of the network of social support that the group cultivates. Trans South's network of social support is maintained through monthly discussion meetings related to issues that arise for members such as sexual health and self-acceptance, workshops related to anxiety management and coping skills, and group activities such as improv theater sessions that allow

members to roleplay instances of discrimination, prejudice, and confrontation while developing interactional scripts for facing these social challenges.

## Discussion and Conclusion

The transgender community has a complex relationship to mental health care. While not all trans people desire medical intervention, trans people that do wish to access gender affirming surgeries or hormone therapies are often required to obtain a formal recommendation from a licensed mental health provider. Further, trans people experience mental health disparities at disproportionate rates, positioning them to benefit from trained and focused care that a professional mental health practitioner could provide. However, socioeconomic and sociocultural barriers limit their access to and desire to seek this care. Participants largely saw mental health professionals as costly gatekeepers to medical intervention who were ill-equipped to meet their needs. I suggest here, alongside and at times in place of traditional mental health services, trans people's involvement in trans organizations that promote and facilitate peer-to-peer contact may enhance their experiences of mental health and improve their psychological well-being. Participants' peer-to-peer contact was facilitated by their involvement in Trans South, a transgender community organization in the rural U.S. southeast. Peer-to-peer contact benefitted Trans South members in a variety of ways: normalizing trans experience; cultivating a social support network; and empowering trans people. While the World Professional Association of Transgender Health suggests psychotherapy addresses these concerns, the participants in my study preferred getting their needs met through their involvement in a transgender community group and among other trans people.

Findings support recent claims in transgender health research that peer-to-peer contact moderates the effects of stigma and discrimination and enhances mental health for trans people (Bariola et al., 2015; Bockting et al., 2013; Bradford et al., 2013; Testa et al., 2014).



This research goes beyond these recent claims to examine the processes through which peer-to-peer contact comes to benefit trans people emotionally and psychologically. Feelings of normalcy are central to the mental health of trans people, a factor that is often ignored in transgender studies scholarship. To be sure, the implications of striving for normalcy in trans experience is not always beneficial to all trans people in all contexts. As I have written elsewhere (Johnson 2015), the concept of a normalized trans experience tends to gather around medicalized definitions and causalities, privileging a white, middle-class, American trans experience. In fact, because trans people's mental health is enhanced through the feelings of normalcy that peer-to-peer contact provides, traditional mental health providers—who are implicated in a system that is founded on white, middle-class American experience—are inadequate, in their current form, in the facilitation of positive mental health outcomes for trans people. Rather, it is important that, alongside traditional mental health services, trans mental health care include efforts at building peer-to-peer trans community networks that look like the people they serve.

This research contributes to our understanding of how marginalized populations experience mental illness. Scholars have argued that stigma is a fundamental cause of disease (Hatzenbuehler et al. 2013) in that it delays treatment seeking in stigmatized patients and inhibits provision from practitioners who lack training or cultural sensitivity. To that end, many scholars have written about the ways that stigma affects illness experiences according to gender identity (Pega et al. 2015), sexual orientation (Cochran 2001; Coker et al. 2010; Meyer 2003), disability (Jacoby et al. 2005; MacLeod et al. 2003), race and ethnicity (Clark et al. 1999; Paradies 2006; Williams 1999; Williams et al. 2008), and weight (Puhl et al. 2001; Puhl et al. 2007; Puhl et al. 2009). Here, we see that peer-to-peer interaction may alleviate some of the detrimental effects of stigma on mental health outcomes by operating as a stand-in or stop-gap for traditional mental health services. Future research must explore how

peer-to-peer interaction affects the mental health experiences of other stigmatized groups, with attention to the ways that non-medicalized support may offset pathologization of nonnormative experiences.

## CHAPTER 4

### I CAN'T BE NOT TRANS ENOUGH: MEDICAL HEGEMONY, CONFORMITY PRESSURE, AND TRANSNORMATIVE ACCOUNTABILITY

Transgender people, individuals who do not identify with the sex category they were assigned at birth, are a rapidly growing population in the United States. Data released from the Williams Institute at UCLA in 2011 estimated that .3 percent of the U.S. adult population, or approximately 700,000 people identified as transgender (Gates 2011). Updated data in 2016, from the same organization, estimates that transgender people make up .6 percent of the U.S. adult population or approximately 1.4 million people (Flores et al 2016). The rapid expansion of transgender identification has stirred much debate related to gender diversity from lawmakers, faith communities, scholars and activists, and health care providers. Central to many of the debates surrounding transgender experience is the question of how we should frame gender diversity – as sin, as sickness, or as social identity? In the U.S., medical authority has largely won the day in the framing of gender diversity. Since 1980, when it was first introduced in *DSM-III* (APA 1980), transgender experience has been framed as a medical condition—specifically a mental illness—that requires physical medical intervention for its management. From medical interactions, to legal contexts, to community group membership, research has shown that the medical model of transgender experience operates as a normative accountability structure for transgender and gender diverse people (Johnson 2015). Given the rapid expansion of transgender identification evidenced by data from the

Williams Institute, it is vital that we understand the consequences of medical authority in the lived experiences of transgender and gender diverse people.

Qualitative interviews with 33 transgender and gender diverse people and direct observations of a transgender community organization suggest that transgender people are held accountable to a medical model of transgender experience by cisgender people both within and outside of medical settings. This accountability, which I interpret as conformity pressure, takes place when transgender or gender diverse people are assumed or encouraged to receive gender-confirming medical interventions that produce normative coherence between gender and sex category. While prior research, reviewed later in this paper, suggests that transgender community groups are sites of conformity pressure for transgender and gender diverse people, findings here do not support those prior claims. Rather, my participants experienced their transgender community group as a safe space wherein individuality was valued over conformity. Predictably, however, transgender and gender diverse people are constrained by medical authority in their healthcare interactions. Specifically, participants were pressured to conform to a medical model of gender diversity when their healthcare providers assumed or encouraged gender-confirming medical interventions that participants were not comfortable with. While many would expect medical providers to encourage their patients to adhere to a medical model, participants' also reported experiencing pressure from cisgender friends and family members outside of a medical context. Pressure from friends and family members manifested for participants in persistent questions or assumptions about their plans to pursue gender-confirming medical intervention. I interpret this pressure as transnormative accountability, a key mechanism through which transgender and gender-diverse people experience transnormativity.

Transnormativity is the ideological hegemony that results from the dominance of the medical model of gender diversity (Johnson 2013; 2016). Many transgender and gender

diverse people need medical intervention to live healthy lives. However, not all transgender or gender diverse people need or want medical intervention and those that do have unique surgical and endocrinological pathways and/or limits to their experiences of medical transition. The overreliance on a medical model of gender diversity thus limits the identity development, social and legal recognition, and healthcare experiences of transgender people by defining a standard, narrow process for gender actualization. The findings in this study support recent evidence within transgender studies and the sociology of gender and sexualities suggesting that transgender people are influenced by the medical model of gender diversity regardless of their adherence to it (Johnson 2015; 2016). The persistence of the hegemony of the medical frame for understanding gender diversity in everyday life is important to note as transgender and gender diverse communities are growing at such a rapid rate. In a cultural context that privileges medical authority above most other explanatory frames (Budrys 2011; Szasz 2007), it is important to understand the ways that medicalization of gender diversity affects lived experience both within and beyond medical settings.

#### The Medical Model and Transnormativity

The medicalization of gender diversity under the purview of the American Psychiatric Association (APA) has led to the development of a hegemonic medical model for framing transgender people's experiences of gender across multiple social contexts and institutions (Johnson 2015). Starting with its inclusion in *DSM-III* (APA 1980), gender diversity has been framed as a medical condition, specifically a mental illness, requiring hormonal and surgical intervention for its management (Koenig 2011). Trans scholars, activists, and advocates have had an ambivalent relationship to the medicalization of trans experience from the time it was first introduced in *DSM-III* (1980). Some argue that inclusion in *DSM* legitimizes gender transition as a medically necessary endeavor while others firmly reject medicalization,

arguing that the negative effects of pathologization outweigh the benefits (Burke 2011; Butler 2006; Koenig 2011; Romeo 2004; Spade 2003, 2008; Valentine 2007).

Following sustained critiques from transgender advocacy groups, the APA shifted the terminology for its diagnosis of gender diversity in the latest iteration of *DSM*, changing *gender identity disorder* in *DSM-IV-TR* (2000) to *gender dysphoria* in *DSM-5* (2013). While replacing “identity disorder” with “dysphoria” makes a symbolic gesture away from the pathologization of transgender people, it does little to combat the prominence of a medical model for framing gender diversity in everyday life. The APA’s continued claim on transgender experience and identity through the psychopathological framework of the *DSM* has created a normative three-step process for becoming transgender: 1) experiencing discomfort and distress surrounding gender throughout life, 2) acquiring a psychiatric diagnosis for gender diversity, and 3) accessing gender affirming medical interventions to counteract discomfort and distress. While the content of the diagnosis, in terms of language used and descriptions given, has shifted over time to accommodate critiques from transgender advocacy groups, the presence and form of the diagnosis has continued to sustain a rather narrow frame for understanding transgender experience.

Transnormativity, as I define it, is the ideological hegemony that results from the medical model of gender diversity (Johnson 2013; 2016). As a regulatory normative ideology, transnormativity should be understood alongside heteronormativity (Berlant and Warner 1998; Ingraham 1994; Warner 1991) and homonormativity (Duggan 2003; Seidman 2002) as both empowering and constraining, deeming some transgender identifications, characteristics, and behaviors as legitimate and prescriptive (e.g., those that adhere to the medical model) while others are marginalized, subordinated, or rendered invisible (e.g., those that do not adhere to the medical model). For individuals who do adhere to a medical model of transgender identity, transnormativity simultaneously affirms the legitimacy of their

gender identity while enforcing a narrow margin of error regarding their access to gender-affirming social interaction, legal recognition, and medical care. For individuals who do not adhere to a medical model of transgender identity, characterized by the rejection of binary gender embodiments, identification, and medical interventions, transnormativity marginalizes and at times eclipses their experiences, limiting their access to gender-affirmation in interactions with both transgender and cisgender people and institutions.

It is important to note that the dichotomy of adherence/rejection with regard to a medical model is false. Medical transition is an individualized process for each transgender person and the available interventions are extensive. Therefore, most transgender and gender diverse people accept some dimensions of a medicalized gender experience while rejecting others. The variability of pathways for medical transition thus amplifies accountability to a medical model of gender diversity as transnormativity creates a “trans enough” hierarchy with those engaging in more interventions granted higher status, recognition, and support than others (Bornstein 1995; Mog and Swarr 2008).

### Gender Accountability

West and Zimmerman’s (1987) theory of *doing gender*, the dominant sociological frame for understanding experiences related to gender, positions gender as a social accomplishment rather than an innate component of individuals. According to doing gender theory, the social accomplishment of gender relies on continued accountability to normative situated standards for gender presentations that adhere to normative understandings of sex category; that is, masculinity with perceived maleness and femininity with perceived femaleness. As West and Zimmerman explain it, accountability is the crux of doing gender. While individuals may not make purposive, rational attempts to meet specific standards for gender presentation, individuals are said to always already be *doing gender* in social interaction, as “accountability is a feature of social relationships” (1987:137). As Hollander

(2013) explains, accountability is ubiquitous and ongoing regardless of individual acknowledgement or investment. To do gender, then, is to “engage in behavior *at the risk of gender assessment*” (West and Zimmerman 1987:136). Lucal writes, “[g]ender is pervasive in our society” and individuals “cannot choose not to participate in it” (1999:791). Put another way, “even if people choose not to meet gender expectations, they can hardly help responding to them” (Hollander 2013:7).

For transgender people, who are held accountable to a medical model of gender diversity, responding to transnormative accountability is a necessary part of daily life (Johnson 2015). In interactions with friends and family members, healthcare providers, and the legal system, transgender people must respond to and operate within a medical framework. Transnormative accountability takes place across social institutions and contexts as transgender and gender diverse people are expected and/or pressured to undergo gender affirming medical interventions, develop a narrative of gender dysphoria over the life course, and adhere to binary models of gender, sex, and sex category. This accountability is ubiquitous, operates outside of individual acknowledgement, and applies to transgender and gender diverse people regardless of the extent to which they engage in a medicalized transition process.

### Transnormative Accountability

In the late 1990s, two groups of sociologists published several articles focused on the identity work that occurs in transgender community groups (Gagne and Tewksbury 1998, 1999; Gagne et al. 1997; Schrock 1996; Schwalbe and Schrock 1996). This body of work, taken together, argues that transgender community organizations engage in accountability practices that are deeply reliant on a medical model of transgender identity and experience. These accountability practices, which I conceptualize as transnormativity (Johnson 2013; 2016), require transgender community members to engage in “acts of self-observation and



self-reporting” (Schleifer 2006:58) that reaffirm medical authority. This body of research suggests that transgender people’s understandings of their identities, narratives of self, and relationships to their embodiments are constructed according to a medical model and transgender people are sanctioned, ostracized, or pushed out of transgender community groups when they fail to conform.

In the studies cited above, accountability to a medical model is most visible in the collective creation of a normative transgender narrative “equally invested in a proper early trace of transgendered [sic] consciousness as much as in a future gendered arrival” (Chen 2010:202). While community narratives that align with a medical model may in fact be accurate accounts of some transgender people’s experiences, not all transgender people identify with the medical model or require medical interventions. Thus, reliance on a medical model at the expense of others when framing transgender experience—by scholars, community members, or social institutions—is argued to be a disservice to transgender community in that it creates “an unspoken hierarchy” (Bornstein 1995:67) that positions transgender people who do not align with a medical model as “not ‘trans’ enough because of lack of surgeries or hormones” (Mog and Swarr 2008:np).

Scholars within the field of transgender studies have complicated the research on transgender community accountability (Califia 2003; Namaste 2000; Serano 2013; Spade 2003). Spade argues that transgender people’s relationship to medical discourse and authority is “fraught with difficulty” (2003:29). Due to the medical model’s codified definition of transgender experiences in *DSM*, access to medical intervention often requires “narratives of struggle around [transgender] identities that mirror the diagnostic criteria” (Spade 2003:29). Thus, as Califia (2003) and Namaste (2000) suggest, accountability within transgender communities surrounding medicalized narratives may at times be described as utilitarian. That is, rather than regulating personal experiences or identifications, transgender people

accumulate and pass on formulae for narratives that are deemed acceptable by cisgender people, including medical professionals, in order to assist transgender people in navigating social and medical interactions.

It is worth noting that data on transgender community dynamics has by and large been missing from the sociological literature since the late 1990s and the research on transgender community accountability from that era may not necessarily represent the dynamics within transgender community groups in the 21<sup>st</sup> century. This paper offers a timely update to the sociological literature on transgender community groups. Using ethnographic research methods, this paper explores how transgender and gender diverse people in a community group in the U.S. southeast experience transnormative accountability. As I show in the findings, the transgender people in my study do not experience transnormative accountability within their primary transgender community group. Participants did however experience transnormative accountability in their interactions with cisgender friends, family members, and medical professionals.

## Data and Methods

This analysis is based on field observations and qualitative interview data collected from a study on transgender, community, and health. Between June 2014 and August 2015, I conducted approximately 158 hours of participatory field-observations and 33 in-depth qualitative interviews within Trans South, a community-based organization for transgender and gender non-conforming people in a coastal southeastern state. I attended and took fieldnotes at every group event held during the dates of my fieldwork. Over the course of fieldwork, there were five types of events held: Planning (2), Social (2), Activism (2), Skill-Building (1), and Community-Building (2). I kept jotted and audio notes of all field observations, later expanding the jotted and audio notes into full fieldnotes. I secured consent from Trans South's leadership team prior to attending my first field-observation. Only the

group leader was required to give written consent for the field-observations, but I reminded all attendees of my study at the start of each event and offered field observation informed consent documents to participants who wanted more information. I also informed group members of my field observations through the group's closed Facebook community.

Interviews followed a semi-structured guide with five topical clusters: 1) transgender identification, 2) transgender community interactions, 3) transgender medicalization, 4) transgender healthcare experiences, and 5) impact of intersecting identities. Each cluster contained several prompts that included several follow-ups or probes for further information. Interviews ranged in length from 32 minutes to 126 minutes, and averaged approximately 71 minutes in length. Written consent was secured prior to the start of every interview. All interviews were audio recorded and transcribed by a professional transcriptionist.

Inclusion was limited to people within Trans South who did not identify with the sex they were assigned at birth. Participants were not required to have undergone medical intervention of any kind to participate nor were they required to have legal documentation to substantiate their gender identities. Participants were recruited at field-observation events and via the group's closed Facebook group. Of the 33 interview participants, there were seven transgender women, twenty-two transgender men, and four genderqueer people. Most interview participants identified their race as white (n=29), two identified as white Hispanic, with the remaining two participants identifying as black and multiracial. The majority of participants had attended some college (n=15) or graduated from college (n=13). Participants ranged in age from 18 to 44 years with the majority falling in the 18-24 (n=14) or 25-34 (n=16) age brackets. These demographic ratios are representative of the larger group membership.

In line with my call for reflexivity within transfeminist methodology (Johnson 2015b), it is necessary to reflect here on my subject position as a researcher. My social

location as a southern, white, educated, transgender man was certainly a factor in my interactions with members of Trans South. Being transgender and raised in the rural south gave me comfortable entrée to the community and members of the group identified me, first, as a member of their community and, second, as a researcher. I believe my social location put participants at ease when confiding in me. While my personal connection to and experience with the transgender community gave me a preview of themes that arose in the data, my analysis is based on a thorough review of literature in the sociology of gender, transgender studies, and medical sociology.

While my own transgender identification, my prior exposure to transgender studies scholarship, and my working knowledge of Trans South allowed me some anticipation of specific themes in the data, I did not restrict my analysis to a predefined coding scheme. Instead, I used an inductive coding method that allowed themes to arise independent of my expectations. I audio-recorded all interviews and paid a professional transcriptionist to transcribe them. Once transcription was complete, I initiated open or line-by-line coding using NVivo for Mac (Version 10.1.2), tagging every topic that arose in the interviews. After open or line-by-line coding, I used refined coding (or axial coding) to integrate the codes into thematic categories or schema. Once the coding schema was developed, I went back and recoded all interviews based on the new schema. I paid particular attention to accounting for negative cases, or those that seemed to be outliers among the participants. I created a set of memos that pulled together the disparate pieces of data from each of the codes. Using these memos as guides, I constructed my analysis.

## Findings

Using Trans South as an empirical example, this paper examines transgender people's experience of transnormative accountability. As stated above, transnormativity should be understood as the privileging of a medical model of transgender experience that requires

gender-affirming medical intervention in the quest for normative coherence between body and gender identity. Transnormative accountability is the social pressure placed on trans people to conform to this medical model by individuals and institutions. Prior research, discussed earlier, has suggested that transgender community groups are conduits of transnormativity and that their members are vehicles of transnormative accountability. However, while participants in my study acknowledge the social presence of transnormative accountability, they locate the source of conformity pressure in their experiences with cisgender people, including friends, family members, and health professionals. In contrast to the existing and mostly outdated research on transgender community dynamics, my participants revealed that the community group in my study rejects transnormative accountability and works to create an environment free of conformity pressures for its members.

#### *Transnormative Accountability from Cisgender Friends and Family Members*

At Camp Trans South, the days start early with morning meditation at sunrise and a breakfast bell that echoes through the mountains at 8 a.m sharp. As I made my way to the meeting space after finishing my oatmeal and sausage breakfast, many members collected on the porch to enjoy their coffee and the view of the Appalachian foothills before the day started. Others were already gathered in the meeting space chatting and catching up on recent events in their lives. I sat down on the couch beside Jason. Jackie sat across from us in the chair. Without much small talk, Jackie asked Jason, “Did you tell your sister?” Jason took a deep breath and then let out a hard sigh, “I told her last week. It was fine, I guess. She didn’t disown me.” Jackie and I waited silently for more information, giving Jason time to determine how much he wanted to share about his coming out experience. With frustration in his voice, Jason continued, “She was cool about stuff. I’m still family, she still loves me. She’ll try to use my name and pronouns.” Jackie shifted in her seat and asked the question

before I could, “Do you feel supported?” Jason pulled nervously at the hem of his shorts, “As much as she can I guess. She just doesn’t get it. She asked me about surgeries and kept asking when I’m getting a penis.” We all laughed uncomfortably as Jason said what we were all thinking, “It’s all about the junk to cis people. Unless you have a dick, you’re not a man.” Jackie leaned her head back on the couch and responded as if she were talking to someone on the ceiling, “I’m so sick of talking to cis people about penises every time I try to get them to call me the right name or pronoun.” Jason responded, “Cis people are obsessed with penises, and we’re the perverts?” The group laughed uncomfortably again as we each made our way to other groups and conversations.

Many members of Trans South reported experiencing conformity pressures from their cisgender friends and family members. For participants, this pressure comes in the form of persistent questions or assumptions about the status of their genitalia or their intentions to undergo gender affirming medical interventions. Gandolf, a 23-year old trans man and college student, experiences conformity pressures from cisgender friends and family who make verbal assumptions about his intentions to pursue gender affirming surgery:

I feel like there are times where I do feel slight pressure in terms of people who are like, ‘Oh, so you’re gonna start hormones and you’re gonna have top surgery and then you’re gonna have bottom surgery and it’s gonna be great!’ And I’m like, ‘No, I’m not having bottom surgery.’ Mostly cis people...most of the trans people I know realize that it’s an individualized process and not everybody is the same or is gonna go through all this. Most of the time when I get that pressure, it’s from cis people.

Gandolf’s experience is not unique and many members of the group voice feeling similar pressures from their cisgender friends and family members to commit to body altering medical interventions with which they are not comfortable.

Elijah, a 30-year old trans man and stay at home father, experienced pressure as a result of his cisgender friends' expectations that he would conform to a normative male embodiment after publicly identifying as male. In our interview, he spoke of this pressure and the resulting struggle to find comfort in his own embodiment:

Either I can do that same thing that I was doing to myself when I identified as female, which is I can try and fit myself into this box that I'm never, ever, ever going to fit into or I can just be comfortable with who I am [...] I think most people, I mean I don't know that they were necessarily aware that they were doing it [pressuring] at all and I don't think it was something that was, you know, hateful or insensitive or whatever. I think it was just, people kind of expect things from you when you transition [...] and they kind of expect that your body is going to go through changes.

The expectations of bodily changes that both Elijah and Gandolf reference stem in part from the ideological and rhetorical hegemony of the medical model of transgender experience wherein medical intervention is prescriptive and ubiquitous. While it is easy to locate the source of this pressure in ill-informed individuals, Elijah notes that people who hold these expectations are not necessarily hateful or insensitive. Expectations are borne from ideology that privileges the medical model of transgender experience and eclipses all other pathways to or experiences of transition. An integral component of the medical model of transgender experience is adherence to a normative binary system of gender wherein the identities man and woman represent two unique bodily experiences. When transgender or gender diverse people fail to conform, they not only reject transnormativity but they fail to *do gender*. Regardless of individual intent, conformity pressures stemming from transnormative ideology specifically, and gender ideology more broadly, result in trans people like Elijah and Gandolf feeling pressured to adhere to a narrow understanding of what it means to be transgender.

Bobby, a 21-year old trans man and college student, told me during our interview that he often feels pressure from cisgender people in his life to alter his body and does not feel comfortable voicing his disinterest in the current options for genital reconstruction or bottom surgery. In our interview, Bobby voiced anger and frustration with cis people's expectations of what his body is supposed to look like and which surgeries he should pursue:

It is such bullshit and I hate it so much. It's like cis people don't have to deal with this shit. It's like, 'well I have a dick so I am [a man]' or 'I have boobs so I am [a woman]'. Like with me, I'm really feminine and I don't want bottom surgery right now because there are so many kinks with it and they haven't got out all the bugs quite yet. So, if someone out of context heard me say that, they are like, 'oh then you are not trans because you don't want bottom surgery.' Well no! That don't mean shit!

While potentially interested in medical interventions, Bobby felt that his lack of commitment to surgical intervention discounted his identity to the cisgender people in his life. To cis people, Bobby noted, having bodies that normatively match gender identity is a qualifying standard for recognition.

#### *Transnormative Accountability From Medical Professionals*

Over the course of my field observations in Trans South, members began to see me as a knowledgeable source for their questions or concerns about gender related healthcare. While attending group events, I often found myself in side conversations about pathways to medical transition, the effects of hormones over the life course, and the availability of trans-affirming practitioners in the area. One of these side conversations took place at an activism event at the local public library, cosponsored by Trans South and other social justice organizations, aimed at countering a spur of Ku Klux Klan activity in the area. The event drew a large crowd and when I arrived there was standing room only in the meeting space. I caught the eye of a couple of Trans South members and made my way around the room to



join them. As we all sat down next to each other and leaned our backs against the wall, Jackson turned to me, “I’m glad I ran into you, I had a couple questions for you.” I nodded and said, “What’s up?” Jackson seemed nervous as he began to speak, “You know how some guys get top surgery but not hormones?” I nodded. “My therapist says that if I’m going to get top surgery, I need to go on hormones too. If not, she said it won’t matter much.” I took a deep breath and waited for Jackson to continue. We sat silently for a few minutes. Jackson pulled on his fingers and continued, “I guess my question is, do I need to take hormones?” I let the conversation pause and, before I could answer, Avery asked another question, “Do you want to take hormones, Jackson?” This question lingered until Jackson shook his head no and Avery responded, “You have to find a doctor that knows what she’s talking about, who understands trans people. Otherwise, she’s only making you feel worse.” I stated to both of them that I agreed and Avery offered Jackson some suggestions for other mental health practitioners in the area.

Several members of Trans South had similar experiences with their medical providers and felt pressured by them to pursue medical interventions that they either were not interested in or were not ready for. Coral, a 24-year old trans woman and human resources associate at a major medical center, described being pressured by physicians in her local healthcare system to undergo medical interventions:

I’ve been pressured. I can’t say I succumbed to it but yeah. I’ve had people tell me, especially medical professionals tell me, ‘This should be your next step, this should be what you need to do to do this.’ [...] I think there is some sort of predisposition that people are supposed to take hormones and get surgeries and it’s not necessarily the case. I know trans people who identify as the other gender or some alternative of that. They don’t take hormones and they’re fine.

The predisposition that trans people undergo medical intervention, that Coral refers to, is the transnormative accountability that trans people face from friends and family members as well as their healthcare providers to adhere to a predetermined medical model of transgender experience. However, as Coral notes, not all trans people wish to pursue medical intervention and, as members of Trans South can attest, those that do wish to medically transition do not all desire the same types of medical interventions.

Andrew, a 31-year old trans man who works in the service industry, also experienced pressure from his medical provider to undergo more medical interventions than he desired. In our interview he described an experience he had with a health professional at a trans health clinic:

I had an experience with a doctor in Atlanta, which is one of the reasons that I moved to Asheville. I was asking about hysterectomy and whether I needed to get one or not and he was like, ‘Well, you’ll get one whenever you have bottom surgery.’ I’m like, ‘Yea, I’m not gonna get that.’ He was like, ‘You’re not gonna get bottom surgery? You’re not gonna do the full transition?’ I’m like, ‘I’m all set. I’m done. And, I’m done with you.’

While Coral experienced transnormative accountability from her local general healthcare providers, Andrew’s experiences occurred in a trans health clinic from a physician who specializes in trans health care. Not only did his physician make assumptions that he would undergo additional medical procedures, Andrew’s tone in our interview suggested he felt shamed by this provider. The question, “You’re not gonna do the full transition?,” is a loaded one with implications that the rejection of genital reconstruction and the absence of normative male genitalia positions Andrew as not fully male. This experience affected Andrew so much that he chose to change providers. However, not all trans people have the resources, either socioeconomic or sociocultural, to make this decision. For many

participants, the provider who facilitated their medical intervention was the only available option.

Reid, a 26-year old skilled trade worker and genderqueer person, felt the effects of transnormative ideology in their interaction with therapists. Reid's identification as genderqueer rather than within a binary model of gender caused therapists to discount Reid's transgender experience:

If I go to a therapist and say, 'I'm not happy being female. I identify as genderqueer, gender non-binary,' whatever I will choose to use. They'll go, 'Well, do you want to have surgery or hormones?' And I would go, 'No, that's not what I'm looking for.' And they will say I don't have [gender dysphoria]. It's like I can't be taken seriously until I go and have my breasts cut off or unless I start hormones and grow a beard.

For Reid, and other members of the group who identify outside of a gender binary, transnormative accountability creates an unwelcoming and invalidating healthcare environment. Genderqueer is a gender identity category that does not align with a binary model of gender. That is, genderqueer people identify with neither, both, or a combination of masculine and feminine gender identities and often use gender neutral pronouns such as the singular form of they, them, and their or the gender neutral pronouns ze, hir, and hers.

Genderqueer people, like other trans people, may or may not choose to undergo medical intervention and each genderqueer person has a unique relationship to their gendered body parts, presentations, and senses of self. Genderqueer should not be confused with intersex, which is the congenital "presence of both male and female sex traits (genital, gonadal, and/or chromosomal)" (Davis et al. 2015:2). For the genderqueer participants in my study, transnormative accountability most often manifested in relation to a binary model of gender wherein they were expected to identify as either male or female and without such

identification, their healthcare providers either refused treatment or offered treatment that was invalidating to their experiences of gender.

### *Community Rejection of a “Trans Enough” Hierarchy*

One of my field observations took place at an improvisational theater workshop where members were led by a group of actors from the local community theater in roleplaying scenarios of discrimination and confrontation related to their gender identities or presentations. This meeting was aimed at developing scripts for members to deescalate confrontations and maintain their safety during hostile and at times violent encounters. As members gathered into the meeting space, a room donated to the group by a local faith organization, chairs were already outlining the perimeter of the space. I made my way to a chair by the back wall in time for the program director of Trans South to call the room to attention and to start the group introductions. When the introductions reached Bobby, a 20 year old trans man, his introduction to the group included a transition update. He had decided to stop his testosterone injections. As he explained it:

When I first started transitioning, I thought that I had to be on hormones to be a man. People said that my depression would go away with T and that I would be more comfortable. After a few months on T, I just dont know anymore and I think I need to take a break from the hormones and figure out what I want and what’s right for me and my body. I’m still Bobby. I’m still he and him. I’m still a guy. I just dont know that I need a beard or all that.

Bobby’s update was immediately met with applause and many members in the room thanked him for sharing this update. Bobby responded with tears forming in his eyes, “I was afraid you guys would be disappointed in me.” The program director of Trans South stood up and walked over to Bobby. With their hand on Bobby’s shoulder, Ivan spoke both to Bobby and the membership in attendance:

You have to do what makes you feel comfortable bud. Every person in this room is on their own journey to be who they truly are. What that looks like for me is going to be different than what that looks like for Bobby. We love you and we're proud of you.

Ivan's comment was met with more applause as the introductions continued around the room.

As a group, Trans South rejects the transnormative accountability that is described by previous research on transgender community groups and reviewed earlier in this paper. That is, rather than holding members accountable to the medical model of transgender experience and policing individual pathways to transition, Trans South sets out to offer an environment that respects all members' trans experience and works to create a space where all members' gender identities are validated regardless of their adherence to a particular model of trans experience or pathway to transition.

Ivan, the program director for the group, is a 28-year old genderqueer person and co-founder of Trans South. During our interview, I asked Ivan if there are divisions between group members related to pathways of transition or history of trans experience that would have led Bobby to feel anxious about disclosing to the group his decision to stop hormones:

I don't think that's something that comes up often. If it has come up, then I think it's countered with another voice of 'but you don't have to medically transition.' I think we do a good job at that 'trans enough' stuff [...] Not everyone wants to change their body and your body doesn't have anything to do with your gender. I mean, wanting to change your body or not makes you no more or less man or woman or genderqueer.

So, to tie the two together in that way is really problematic.

Claire, a 26-year old trans woman, doctoral student, and another member of Trans South leadership team, also characterized this kind of transnormative accountability as problematic:

You end up stigmatizing people based on their ability to transition or the ability to pass or these sorts of things, which is deeply, deeply problematic. It just exacerbates

the problem that many trans people face [...] And, so, to say that trans, that being trans or that transitioning, is all about this process of looking a certain way only benefits the people who have the ability to do it. And, for people that don't, it just makes their problems all that much worse. It just throws them under the bus, so to speak.

As members of the leadership team, Ivan and Claire occupy influential positions in Trans South. Each has a voice and perspective that often sets the tone for the group at large and their characterizations of tying medical transition to gender identity as problematic filtered into the group dynamics. Members of the group rejected the ranking of trans authenticity according to level of medical transition or history of trans experience, what Ivan referred to above as “that ‘trans enough’ stuff.” The group’s rejection of transnormative accountability and a trans enough hierarchy was a key component of the group and many members credited leadership with creating a welcoming and affirming environment for all trans people.

Andrew, mentioned above, felt that group dynamics of acceptance and recognition of diverse trans experience were a direct result of the tone set by leadership. When asked if he had ever experienced dividing lines in the group according to level of trans experience or pathway to transition, he replied:

That’s one thing the leadership does well, is communicate and really believe that if you identify as trans, then you are trans. It doesn’t matter what you do or don’t do, how you identify, binary or not binary.

The leadership’s mission of respecting and accepting the diversity of trans experience is not lip service. As Andrew notes, the leadership team believes in this mission of accepting diverse trans experience and that was visible during group events and member interactions. In discussion meetings, at summer camp, and during activism activities, the leadership team made a point to talk about trans experience as a wide range of possible gender presentations

and identifications including both binary and non-binary, with medical transition and without medical transition.

Chet, a 23-year old trans man and trade worker, echoed Andrew's comments in his characterization of the leadership team and stressed one of the group's philosophies that individual trans people are experts of their own experience:

I think they understand that everybody's got their own sense of being. It's very mellowed out like that. They're all about being yourself and not letting other people judge who you are. You know, when it comes down to it, you're the only person that can make you that person.

As Chet notes, the group stresses that each trans person's experience is unique and the defining factor of trans experience is personal transgender identification rather than medical procedures. Rather than dividing people based on their adherence to a particular model, history, or pathway of trans experience, Trans South celebrates the diversity within the group and does not define trans as a set of steps toward transition or as a list of biographical markers of a trans history. Rather, in Trans South, individuals are trans because they understand themselves to be. Sammie, a 23-year old trans man and service industry worker, described the lived experience of Trans South's rejection of conformity pressures:

I feel more secure in my identity. I feel like I can't be not trans enough. Whatever way I am, I'm still man enough. Even though I haven't had surgery, I haven't started T, none of that really matters. Consistent usage of pronouns every time, they would look at me and, still, it's 'he' every time.

Sammie's comments reveal the effects of the rejection of transnormative accountability within Trans South. The validation of being recognized as a man, regardless of medical history, is a powerful experience for trans people. As a group, Trans South rejects the transnormative accountability of a trans enough hierarchy that is based on medical

intervention rather than personal transgender identification. Members of the group experience this as a positive affirmation of individual trans identities and unique trans experiences.

## Discussion and Conclusion

The Williams Institute at UCLA estimates that .6 percent of the U.S. adult population, or approximately 1.4 million people, identify as transgender (Flores et al 2016). This estimate has doubled since the 2011 estimates were released from the same organization (Gates et al 2011). Given that the medical model is currently the dominant frame for understanding gender diversity, it is important to understand how this medical frame operates in the lives of the rapidly increasing population of transgender people. Prior research has shown that the medical model is both an empowering and constraining component of transgender people's experiences of gender diversity, enabling access to identity validation and transition-related medical care while simultaneously limiting transgender people to a narrowly defined process of becoming transgender. I argue here that the medical model of gender diversity should be understood as an organizing force for the social framing of transgender experience. I identify the privilege of this medically based, social framing as transnormativity, a regulatory normative ideology that deems some transgender identifications, characteristics, and behaviors as legitimate and prescriptive while others are marginalized, subordinated, or rendered invisible. Transnormativity is maintained and enforced through transnormative accountability when transgender and gender diverse people are held to medical standards wherein they are expected and/or pressured to undergo gender affirming medical interventions, develop a narrative of gender dysphoria over the life course, and adhere to binary models of gender, sex, and sex category.

I focus here on transgender and gender diverse people's experiences of transnormativity in the form of pressure to conform to a medical model of transgender experience. While existing research, reviewed earlier in this paper, cast transgender



community groups as conduits of transnormative accountability participants in the current study describe Trans South as actively working against the use of a medical model to influence members' identity experiences. Individuality and personal autonomy are central to the experience of community that the organization in this study cultivates. While these findings are limited to participants in one specific transgender community group, the departure from existing research suggests more work is needed to understand the persistence of transnormative accountability within transgender community groups today. While participants' experiences within Trans South do not include transnormative accountability, their experiences with cisgender (i.e., non-transgender) friends, family members, and medical professionals do. Participants reported experiencing conformity pressures in these experiences through persistent assumptions or questions related to their intention to pursue transition-related medical interventions such as hormone replacement therapy or gender-confirming surgeries. This pressure resulted in participants feeling unsupported, misunderstood, and further marginalized in their personal lives as well as in their healthcare interactions.

This research contributes to our understanding of the medicalization of social deviance and how diversity comes under the constraint of medical ideology in both medical and non-medical settings. When a psychiatric, emotional, or mental state or human variation is coopted by medical authority and named a medical disorder, it is subject to social control from doctors and other healthcare professionals but is also highly susceptible to regulation by individuals in non-medical social institutions such as education in the case of child and adolescent attention deficit disorders (Malacrida 2004), or the church and the family such as in the cases of masturbation and disorders of sexuality (Conrad 2007). The persistence of the hegemony of the medical frame for understanding gender diversity in everyday life is important to note as transgender and gender diverse communities are growing at such a rapid

rate. In a cultural context that privileges medical authority above most other explanatory frames, future research is vital to understand the ways that medicalization of gender diversity affects lived experience both within and beyond medical settings.

## CHAPTER 5

### REJECTING, REFRAMING, AND STRATEGICALLY REINTRODUCING: TRANS PEOPLE’S ENGAGEMENT WITH THE MEDICALIZATION OF GENDER DYSPHORIA

Transgender experience has been designated a medical condition, more specifically a mental illness, since its introduction in *DSM-III*, the third edition of the *Diagnostic and Statistical Manual for Mental Disorders* (APA 1980). In the iterations of *DSM* that followed, the diagnosis has taken on many names and symptomologies. The latest iteration, *DSM-5* (2013), includes a new description and diagnosis that discontinues the use of ‘disorder’ in the diagnostic category, shifting from Gender Identity Disorder in *DSM-IV-TR* to Gender Dysphoria in *DSM-5*. This change, largely a symbolic gesture away from the pathologization of trans people as disordered, sparked debate among trans scholars and activists during *DSM-5*’s revision process and after its publication regarding the ongoing project of trans medicalization (DeCuypere et al. 2010; Serano 2013).

The debates surrounding the medicalization of diverse genders under the purview of the APA are not new. Trans scholars, activists, and advocates have had an ambivalent relationship to the medicalization of trans experience from the time it was first introduced in *DSM-III* (1980). Some argue that inclusion in *DSM* legitimizes gender transition as a medically necessary endeavor while others firmly reject medicalization, arguing that the negative effects of pathologization outweigh the benefits (Burke 2011; Butler 2006; Koenig 2011; Romeo 2004; Spade 2003, 2008; Valentine 2007). The debates surrounding trans inclusion in *DSM* hinge on the rejection or acceptance of a medical model of trans identities.

The medical model of trans identity should be understood as the APA's framing of gender diversity as "a psychological condition [...] that requires medical treatment, including gender affirming surgery or hormone therapy" (Koenig 2011:619). While the language of disorder changed in the new iteration, the inclusion of trans experience in *DSM*, by its very nature, continues the project of pathologization and reinforces a narrow medical model of trans experience.

This paper uses ethnographic methods to explore how trans people engage with the medicalization of trans experience. This paper is unique in that it explores trans people's stance toward and engagement with medicalization post-*DSM-5*, under the new diagnosis of *Gender Dysphoria*. Further, unlike other scholarship on trans medicalization, this paper focuses on trans people in a community group rather than trans activists or practitioners of trans healthcare. In shifting focus to trans people in a community group, this paper explores how those less versed in scholarly and activist debates regarding medicalization experience and engage medical authority over their gender identities and experiences.

## Medicalization

Medicalization, or the process by which benign human variation becomes classified as something to be diagnosed, treated, or cured by medical authority (Conrad 2007), has gained much attention in recent years with the 2013 revision of *DSM*. Conrad writes, "the key to medicalization is definition" (2007:5). That is, in order for phenomena to be medicalized, they must be "defined in medical terms, described using medical language, understood through the adoption of a medical framework, or "treated" with medical intervention" (2007:5). First published in 1952, *DSM-I* spanned a short 152 pages (APA 1952). The latest iteration of the manual, *DSM-5*, is nearly six and a half times the length of the original and currently uses medical language to define over thirty categories of psychiatric disorder that contain over two hundred psychiatric conditions and sub-conditions including restless leg

syndrome, skin picking or excoriation disorder, and pain occurring as a result of sexual penetration or genito-pelvic pain disorder (APA 2013).

Medicalization may be used as a form of social control, often positioned as a basis of stigmatization when the medicalization is of a psychiatric nature. Sociologists interested in the process of medicalization have drawn attention to the ways in which medical authority coopts deviant or non-normative behavior as something to be controlled or treated (Conrad 1992; Conrad and Schneider 1980). While physical human conditions may be subject to medicalization and social control, this process is most visible in the case of psychiatric conditions. When a psychiatric state or human variation is deemed a medical disorder, it is not only subject to control from doctors and other healthcare professionals but is highly susceptible to regulation by individuals in non-medical social institutions such as education in the case of child and adolescent attention deficit disorders (Malacrida 2004), or the church and the family such as in the cases of masturbation and disorders of sexuality (Conrad 2007).

Understanding medicalization as a form of social control highlights the constraining and often negative effects of diagnosis and treatment for individuals with the conditions under evaluation. For example, individuals labeled with medical conditions often report experiences of social stigmatization associated with diagnosis and medical problems, such as women diagnosed with disorders of infertility (Whiteford and Gonzalez 1995) and individuals diagnosed with schizophrenia (Harrison and Gill 2010). Hatzenbuehler, Phelan, and Link (2013) have further argued that stigma itself may be considered a fundamental cause of disease. That is, as medicalization of human conditions increases stigmatization of individuals, it subsequently creates the conditions under which differently situated individuals are 1) susceptible to multiple risk factors, and, 2) limited in their access to health resources such as social support and power.

Adversely, medicalization may also lend credibility to illness experiences with less social acceptability. Medical professionals such as doctors and pharmaceutical companies often initiate processes of medicalization but there have been instances when effected groups have initiated the process, arguing for a condition to be listed as a medical disorder for the improvement of their lives (Brown and Zavestoski 2004; Dumit 2006). As with trauma (Stein et al. 2006), autism (Jordan 2009), and chronic fatigue (Broom and Woodward 1996), sanctioning by medical science has the potential to grant legitimacy to individuals' illness claims as well as access to healthcare, treatment, social support, and validation.

### Medicalization and Trans Experience

Trans people's gender dysphoria is one experience that has been claimed and defined by medical authority as something to be diagnosed, treated, and cured. While recently coopted by the American Psychiatric Association, gender dysphoria is not a new concept for the transgender community. Referring to the discomfort that trans people feel in relation to their birth-assigned sex category or the reaction that their perceived sex category elicits from others, gender dysphoria has been in circulation as a term for decades among trans people (e.g., Cromwell 1999; Devor 1996). Framing trans people's discomfort as mental illness, the American Psychiatric Association (2013) defines gender dysphoria in the following way:

*Gender dysphoria* refers to the distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender. Although not all individuals will experience distress as a result of such incongruence, many are distressed if the desired physical interventions by means of hormones and/or surgery are not available. The current term is more descriptive than the previous *DSM-IV* term *gender identity disorder* and focuses on dysphoria as the clinical problem, not identity per se (emphases in original, APA 2013:451).

As the definition points out, *gender dysphoria* as a psychiatric diagnosis has shifted focus to psychological consequences of transgender experience rather than transgender identity itself being symptomatic of mental illness. However, the distress that *DSM's gender dysphoria* highlights surrounds individual experiences of body, gender, and sex category incongruence. In doing so, *DSM* fails to account for dysphoria as a mental health consequence of gender ideology, transphobia, and cissexism for trans and gender diverse people. Further, the current definition continues the work of medicalization, marking medical intervention as the next logical and necessary step in dealing with dysphoria. Intervention may indeed be a next step for many trans people. However, *DSM* overemphasizes the importance of intervention and eclipses both the social causes of and social action needed to combat dysphoria in the lives of trans people.

The medicalization of transgender experience may have both positive and negative effects. For trans people, diagnosis may operate as a form of social control in its gatekeeping effects that regulate who has access to gender affirming medical care, social support, and legal recognition (Johnson 2015). Additionally, diagnosis may further stigmatize an already disproportionately disadvantaged community (Hatzenbuehler et al. 2013). While the medical model of transgender experience may operate as a form of social control or increase stigma for trans people, the medicalization of transgender experience also has the potential to legitimize trans experience and provide access to healthcare resources. Medicalization has positioned transgender identification and experience as a scientifically supported phenomenon. Like with other socially controversial diagnoses, medicalization may serve as validation for trans people whose experiences are often discounted in daily life.

Given the conflicting effects of medicalization, scholars, activists, and advocates working in the areas of transgender studies and transgender rights have documented ambivalent perspectives on the medical model, acknowledging its usefulness as a

legitimizing force while also underscoring its pathologizing effects (Burke 2011; Butler 2006; Koenig 2011; Romeo 2004, Spade 2003, 2008). As Burke (2011) writes, this debate centers on the distinction between medicalization and pathologization. Medicalization supports an avenue to gender affirming healthcare for trans people and legitimizes the discomfort that trans people experience surrounding gender identity. Pathologization labels trans people as mentally ill and positions gender variance as in need of correction under medical authority. Dewey and Gesbeck's (2015) work, however, reveals this distinction as semantic and as having little bearing on the control that diagnostic categories, whether they are perceived as medicalizing or pathologizing, have on the lived experiences of trans people.

Using ethnographic methods, this paper explores how trans people in a community group in the U.S. southeast respond to and engage the medicalization of trans experience. This paper is unique in that it explores trans people's stance toward and engagement with medicalization post-*DSM-5*, under the new diagnosis of *Gender Dysphoria*. Further, unlike other scholarship on trans medicalization, this paper focuses on trans people in a community group rather than trans activists or practitioners of trans healthcare. In shifting focus to trans people in a community group, this paper explores how those less versed in scholarly and activist debates regarding medicalization experience and engage medical authority over their gender identities and experiences. As I will show, trans people in this study reject a medical frame of trans experience, reframe medical intervention as a social pursuit, and strategically reintroduce a medical frame in order to facilitate medical and social validation.

## Data and Method

This analysis is based on field observations and qualitative interview data collected from a study on transgender, community, and health. Between June 2014 and August 2015, I conducted approximately 158 hours of participatory field-observations and 33 in-depth qualitative interviews within Trans South, a community-based organization for transgender



and gender diverse people in a coastal southeastern state. I attended and took fieldnotes at every group event held during the dates of my fieldwork. Over the course of fieldwork, there were five types of events held: Planning (2), Social (2), Activism (2), Skill-Building (1), and Community-Building (2). I kept jotted and audio notes of all field observations, later expanding the jotted and audio notes into full fieldnotes. I secured consent from Trans South's leadership team prior to attending my first field-observation. Only the group leader was required to give written consent for the field-observations, but I reminded all attendees of my study at the start of each event and offered field observation informed consent documents to participants who wanted more information. I also informed group members of my field observations through the group's closed Facebook community. Interviews followed a semi-structured guide with five topical clusters: 1) transgender identification, 2) transgender community interactions, 3) transgender medicalization, 4) transgender healthcare experiences, and 5) impact of intersecting identities. Each cluster contained several prompts that included several follow-ups or probes for further information. Interviews ranged in length from 32 minutes to 126 minutes, and averaged 71 minutes in length. Written consent was secured prior to the start of every interview. All interviews were audio recorded and transcribed by a professional transcriptionist.

Inclusion was limited to people within Trans South who did not identify with the sex they were assigned at birth. Participants were not required to have undergone medical intervention of any kind to participate nor were they required to have legal documentation to substantiate their gender identities. Participants were recruited at field-observation events and via the group's closed Facebook group. Of the 33 interview participants, there were seven transgender women, twenty-two transgender men, and four genderqueer people. Most interview participants identified their race as white (n=29), two identified as white Hispanic, with the remaining two participants identifying as black and multiracial. The majority of

participants had attended some college (n=15) or graduated from college (n=13). Participants ranged in age from 18 to 44 years with the majority falling in the 18-24 (n=14) or 25-34 (n=16) age brackets. These demographic ratios are representative of the larger group membership.

In line with my call for reflexivity within transfeminist methodology (Johnson 2015b), it is necessary to reflect here on my subject position as a researcher. My social location as a southern, white, educated, transgender man was certainly a factor in my interactions with members of Trans South. Being transgender and raised in the rural south gave me comfortable entrée to the community and members of the group identified me, first, as a member of their community and, second, as a researcher. I believe my social location put participants at ease when confiding in me. While my personal connection to and experience with the transgender community gave me a preview of themes that arose in the data, my analysis is based on a thorough review of literature in the sociology of gender, transgender studies, and medical sociology.

While my own transgender identification, my prior exposure to transgender studies scholarship, and my working knowledge of Trans South allowed me some anticipation of specific themes in the data, I did not restrict my analysis to a predefined coding scheme. Instead, I used an inductive coding method that allowed themes to arise independent of my expectations. I audio-recorded all interviews and paid a professional transcriptionist to transcribe them. Once transcription was complete, I initiated open or line-by-line coding using NVivo for Mac (Version 10.1.2), tagging every topic that arose in the interviews. After open or line-by-line coding, I used refined coding (or axial coding) to integrate the codes into thematic categories or schema. Once the coding schema was developed, I went back and recoded all interviews based on the new schema. I paid particular attention to accounting for negative cases, or those that seemed to be outliers among the participants. I created a set of

memos that pulled together the disparate pieces of data from each of the codes. Using these memos as guides, I constructed my analysis.

## Findings

Using Trans South as an empirical example, this paper examines trans people's engagement with the medicalization of transgender experience post-*DSM-5*. The shift to gender dysphoria in *DSM-5*, hailed by many as a step away from the pathologization of trans people as disordered, has yet to be examined in terms of community engagement and response. Participants in my study rejected the medical frame for understanding transgender experience, arguing that trans experience was not a medical condition. Yet, participants also stressed the importance of access to gender affirming medical interventions, which they characterized as facilitating social interaction more than individual identity development. Finally, while they rejected the medical frame in their own understandings of their identities and experiences, participants strategically reintroduced a medical frame in order to facilitate medical and social recognition and validation.

### *Rejecting a Medical Frame*

Every year, Trans South holds its annual summer camp where members come together over several days to build community, learn positive coping skills, and celebrate trans experiences. In its second year, camp was held at the private family home of the group leader. Over four days and three nights, members of Trans South came together to explore their identities and experiences among other trans people, attend workshops focused on building coping skills and processing the emotional consequences of familial rejection or transphobia, and engage in team building activities such as the Trans South Olympics and the Spirit Walk.

Closed to cisgender members of the group, one of the breakout sessions was organized as a safe space where trans members could ask questions, get advice, or process

encounters they had experienced as a result of their trans status. I walked in late to the session and sat on the floor in front of the couch. Nathan, a 20-year old trans man who had been a member of the group for less than two months, was crying as he recalled a conversation with his mother about a trans person on a television show. Not yet out to his mother, Nathan did not know how to respond when his mother referred to Laverne Cox's character on *Orange is the New Black* as "sick" and "psychologically disturbed." Wiping tears on his shirt's sleeve, Nathan opened up to the room, "I guess, in a way, we are sick, right? I mean, we have to get this diagnosis from a therapist. I guess I just never thought about it that way." Garrett, a member of the group for three years, walked over and handed Nathan a box of tissues. Before sitting back down, Garrett squeezed Nathan's shoulder and said, "You're not sick. There's not a thing that's wrong with you. If your mama can't see that, she is the one who is sick in the head." Others around the room joined the conversation, echoing Garrett's remarks. Jim, a trans man in his fifties, added, "If we're sick in the head, why don't they fix our brains and not our bodies? We're not crazy, our bodies are sometimes just a bit off-kilter."

Throughout the weekend, the topic of trans people having a disorder came up repeatedly. Members of Trans South largely dismissed the classification of gender dysphoria as a medical condition, specifically a psychological disorder. AJ, a 34-year old trans man who works in retail management, felt that medical classification implied that there is a treatment plan and a cure for gender dysphoria. When asked if he considered his experiences of gender dysphoria to be a medical condition, he answered definitively:

Not at all, it's not a medical condition. It's not like that. It's not something that you can just take medicine for and it's going to go away. It's how you've felt, how you identify yourself, and how you have felt all of your life. Medicine doesn't take that away.

For AJ, medical conditions are those for which you get treatment in the service of a cure. As AJ mentions, “it’s not something that you can just take medicine for and it’s going to go away.” Indeed, this is not the goal of medical intervention for transgender people. According to the World Professional Association for Transgender Health’s (WPATH) Standards of Care (SOC) for trans and gender diverse patients, the goal of gender affirming medical intervention is not to eradicate or cure gender dysphoria but to facilitate coping and resilience among people who are marginalized and misunderstood as a result of their gender identity (Coleman et al. 2012). At times this calls for psychotherapeutic intervention to develop positive coping skills or reframe thinking about transgender experience. At other times this calls for hormonal or surgical intervention to assist transgender people in feeling at ease in their bodies. According to WPATH’s Standards of Care (Coleman et al. 2012), neither psychotherapeutic nor biomedical interventions are aimed at curing trans people.

Coral, a 24-year old trans woman and human resources associate in a major medical center, felt similarly that gender dysphoria is not something to be cured and felt it should not be understood as a disorder:

The way I’ve looked at it, it’s not a sickness. It’s not. It’s not something that needs to be cured. I think the sickness comes from society’s reaction towards it, other people’s reactions and understanding of it. I can speak personally for myself. I didn’t necessarily have a problem. I did at first but then I got used to it. The fact that I identified as a woman and then me trying to transition with society caused a lot of the anxiety, caused a lot of depression. You know, it really changed the way I acted and treated other people and just myself. I became really reclusive and really quiet which is not me normally. But honestly, I don’t wanna say I blame society, but I blame society for that.

Coral's comments align with trans studies scholars who designate gender identity a social determinant of health (Pega et al. 2015). While transgender identification may be an individual level variable, participants understood the effects of transgender identity on mental health as resulting from *social* conditions. My participants embraced this social model of gender dysphoria and highlighted social conditions, rather than individual identity, as determinants of dysphoria.

Opal, an 18-year old trans woman and student, described gender dysphoria in the following way:

I think gender dysphoria is just the unhappiness with the gender you were born with and I think that's what people think of when they think of the medical type. But, I think the gender dysphoria is mainly caused by the things that are forced on us in society and not really a medical thing. Different things for different people, but normally I think it's just an unhappiness with who you are as most people see you and, or, just being nervous that most people see you in a certain fashion. And I think dysphoria really, like for people who have gender dysphoria, doesn't really go away because our society forces a lot of gender roles on us and if we don't match up with those roles I feel like we are always gonna feel dysphoric.

Opal's comments contextualize gender dysphoria in a larger "sex/gender system" (Rubin 1975) that holds all people, trans and cis, accountable to context-specific gender norms. That is, gender is a social rather than individual experience and must be accomplished in social interaction by both trans and cis people (West and Zimmerman 1987). This social accomplishment, theorized by West and Zimmerman (1987) as "doing gender," requires people to meet normative situated standards for gender presentations that cohere with assigned sex categories. Rather than isolating and pathologizing trans-specific experiences of unease with this system as disorder, Opal's comments suggest a more widespread social

problem of gender attribution and accountability of which trans people and trans-specific experiences are but one component.

### *Reframing Medical Intervention*

After the last workshop of the day, Trans South campers gathered in the field where their tents were set up to socialize while enjoying the cooler weather the July night brought with it. I dropped off my backpack in my small, one-person tent that was pitched among the others and joined a group of trans guys who were lying in the grass trying to name the constellations in the star-bright sky. Patrick, a 20-year old trans man who had not had gender affirming chest reconstruction or what is commonly referred to in trans communities as top surgery, dropped down next to me with a sigh, “It feels so free to not have to wear a binder right now!” A binder is a specially designed compression shirt for trans men who have not had top surgery but would like to conceal their chest. Jake, a trans man who also had not had top surgery, took in a deep breath and agreed with Patrick. Binders are uncomfortable, incredibly tight, and caused many of the trans men in Trans South to have trouble breathing, muscular atrophies, and broken ribs. While physicians recommend not wearing binders for more than five hours per day, many of the guys in Trans South wore them much longer than that and some even wore more than one at a time to increase compression and decrease their chances of being misgendered in social interaction. Patrick told us he was saving for top surgery. Jake had scheduled his with a physician in a neighboring state and added, “I’m ready for people to see me. Like, really see me, you know?” Everybody nodded.

While many of my participants rejected medical classification, they simultaneously stressed the importance of access to medical intervention for those that want it. This seemingly contradictory position speaks to the complexity of medicalization and medical classification. Participants did not want their experiences as trans people pathologized as disorder, disease, or sickness. Yet, they wanted access to the medical interventions that

pathologization supported. Claire, a 28-year old trans woman and graduate student, felt that interactional responses to perceived gender and sex category were a better rationale than psychological disorder for medical intervention:

I think a better way to think of it would be this, I guess, the social model of transition of treating people the way they want to be treated and identifying people the way they identify themselves. [...] Having estrogen is probably 20 percent: I'm happier looking in the mirror, and, 80 percent: people who don't know anything about trans issues look at me and know that I'm female. Like, that's it. Like, the people who know about trans issues would call me she whether or not I look like this. But, to get the general population to call me she without having to ask my pronouns requires hormones. [...] Is identifying as a girl enough for me? No. But is medical transition all of it? No. For me, it's both. The problem with the medical condition is that it acts like there is something inherently flawed with me when in reality there is something inherently wrong with society.

Claire felt that while medical intervention is a necessary component of transition for some people, the understanding of trans experience as a medical condition is overly simplistic. Claire's comments echo others' in the group who rely on hormones to facilitate gender-affirming interactions. While medical intervention may be a personal endeavor, Claire and others also possess a social impetus for medical intervention. As Claire mentions, "to get the general population to call me she without having to ask my pronouns requires hormones." The social impetus for medical intervention exists outside of individual pathology as well as individual desire. Gender affirming medical interventions do more than validate trans people's identities, they ease the social interactions wherein trans people are expected to *do gender* by adhering to preconceived notions of what men and women look and sound like (West and Zimmerman 1987). The risk for violence, aggression, harassment and



discrimination are more prevalent for trans people who are recognized as trans or gender diverse. Medical intervention is thus necessary for many trans people's quality of life.

Like Claire, Mikey felt that while necessary for many trans people medical intervention is intricately connected to social conditions:

I don't think it's the whole picture. I think you need to have an understanding of gender as a cultural force and to be able to think about that side of the experience to understand why then the medical treatments are necessary [...] it's not black and white, *this is the cause, this is what's gonna happen to you if we don't treat it, this is what treatment will do*. That type of thing. It's more like trying to adjust your experiences to improve your life.

Being misgendered in daily life takes a toll on trans people's mental health and gender affirming medical interventions may alleviate this social burden for trans people who desire them. However, negative mental health outcomes of social conditions do not constitute individual pathology. As Mikey and Claire pointed out, medical intervention is not so black and white. For members of Trans South, gender dysphoria is simply a descriptor of feeling uncomfortable with their bodies and the reactions that their bodies elicit from others. Medical intervention is one possible component of alleviating that discomfort. While participants reject being labeled disordered, they also value medical interventions aimed at alleviating the discomfort of trans people.

### *Strategically Reintroducing a Medical Frame*

The last day of the second annual Trans South summer camp featured a session in which family members of campers were invited to talk through their experiences and understandings of their trans loved one. Most of the guests in attendance were the parents of members of Trans South who were interested in being supportive of their trans child but were unsure of how to do so. The night before this session, standing in the dinner line, Jack tells

me his parents are coming to the workshop. Jack is a trans man in his early twenties whose parents are supportive but often make Jack feel uncomfortable with their lack of understanding. Over a bowl of the low country boil that a few of the members prepared for dinner, Kenny asks Jack how he got his parents on board. Jack responds with a smile, “I just told them that I have this medical condition, that I was screwed up in utero.” Kenny responds, “Whatever works, right?” A few of the people at the table laugh.

Members of Trans South generally rejected the medical frame of trans experience and identity. Yet, members also made clear the importance of medical intervention for many trans people. Given the dominance of the medical frame in social, medical, and legal contexts (Johnson 2015), participants tended to invoke the medical frame strategically in order to facilitate social understanding and medical intervention. Coral, mentioned above, recalled being strategic in her use of a medical frame to secure access to gender affirming care:

When I was going through therapy I had to kind of, I don’t want to say act through it, but I felt like I knew what I had to do to get a letter to go to the endocrinologist to get my hormones [...] I sat down and they started asking me these questions and I had to be really careful how I said things and what I said because I was like, in the back of my mind, I’m like, this person writes that letter and gets me what I need. I don’t want to say dishonest, because I was honest with my answers but I felt like I had to think about what I was saying.

Coral felt that she must deliver a narrative of gender dysphoria that aligns with a medical frame in order to communicate her experience to a medical professional. Invoking a medical model to describe experiences with gender dysphoria is not dishonest, as Coral points out, but rather is using a specific frame to translate personal experience to others in language they can understand.

Dustin, a 30-year old trans man and emergency medical technician, often uses a medical frame to explain his identity to his immediate and extended family members. Dustin does not identify with a medical frame but recognizes that society at large respects medical authority over personal experience:

It definitely makes it easier to explain to people who don't understand. You know, *well I have this disorder and this is how I handle it*. But personally, it's not. I mean, it's just, it's just who I am. Generally, if you can make it medical, people are gonna see it differently than if you just say, *well, I just, that's just who I am*. And then they don't understand it. *Well, why are you like this?* If you say, *well, I have a gender identity disorder and this doctor has done this for me and this doctor has done that for me and this is how I deal with it*. Then, they're like, *oh, well, okay*.

As Dustin explains, introducing a medical frame when explaining transgender identity or experience is an effective strategy for gaining others' understanding and acceptance, even if that frame does not reflect personal beliefs. Franky, a 24-year old trans man and retail manager, had a similar view:

The way the world works, it helps. I feel like it helps folks to be able to look at something and say, *oh, medically speaking... oh, you were born that way*. Or, *you were actually treated for this*. Or, *oh, you are actually diagnosed with this*. I feel like it helps people be more open to the fact that this is something that could go on. It's not something you choose.

Both Dustin and Franky speak to the authority of medical rhetoric in explaining human experience. While neither Dustin nor Franky believe that gender dysphoria is a medical condition, they recognize that medical language and explanations hold more sway than personal experiences. For trans people, whose experiences are contested across social

contexts and institutions, invoking medical language and medical explanations grants them credibility.

## Discussion and Conclusion

The medicalization of transgender experience is an ongoing and complex project. In 2013, the American Psychiatric Association made a symbolic gesture away from the pathologization of trans people by replacing Gender Identity Disorder with Gender Dysphoria in its *Diagnostic and Statistical Manual for Mental Disorders*. Yet, the continued presence of transgender experience in *DSM* undermines this gesture, reaffirming the professional psychiatric community's position that trans experience is constitutive of mental illness. Medicalization may have positive effects for transgender people, such as pathways to medical intervention and identity validation. However, for trans people who are already disproportionately disadvantaged, the negative effects of stigma and pathologization may undermine the benefits of medicalization. Thus far, research examining trans people's relationships to medicalization has focused primarily on trans activists or advocates' and trans health practitioners' stance toward or engagement with medical authority over transgender experience (Burke 2011; Davis et al. 2015; Dewey 2013; Dewey and Gesbeck 2015). In shifting focus to trans people in a community group, this paper explores how those less versed in scholarly and activist debates experience and engage medical authority over their gender identities and experiences. Further, existing research on trans medicalization has largely been conducted prior to the release of *DSM-5*. This project is unique in that it explores trans people's stance toward and engagement with medicalization post-*DSM-5*, under the new diagnostic label of gender dysphoria.

While the engines of medicalization may determine the dominant framing of trans experience as mental illness or disorder, the internalization of this frame is not inevitable. Participants in this study generally rejected the medical frame for understanding their

identities and experiences as trans people, arguing trans experiences of gender dysphoria should not constitute a medical condition. In a fact sheet released prior to the publication of *DSM-5*, the APA wrote, “Persons experiencing gender dysphoria need a diagnostic term that protects their access to care and won’t be used against them in social, occupational, or legal areas” (2013:1). The APA goes on to say that the shift from ‘disorder’ to ‘dysphoria’ “removes the connotation that the patient is “disordered” (2013:2). A curious position to take, considering that the APA is describing a psychiatric diagnosis in a book titled *Diagnostic and Statistical Manual for Mental Disorders*. While participants in my study use the community-circulated concept of gender dysphoria to describe their feelings of unease related to their gender identity, they reject the APA’s use of it as a euphemistic descriptor for mental illness.

In the same fact sheet referenced above, the APA wrote, “To get insurance coverage for the medical treatments, individuals need a diagnosis” (2013:2). While this is certainly true for diagnoses that are covered, most insurance companies have explicit restrictions on coverage for transgender people (Stroumsa 2014). Transgender people who wish to access medical intervention are most often required to pay for these services, including mental health services, out-of-pocket, despite statements from multiple professional medical associations encouraging insurance companies, both public and private, to provide coverage for medical services and procedures related to gender transition (Stroumsa 2014). Participants in my study who wished to access gender affirming medical intervention were required to pay for these services out of pocket and were more likely to see these services as facilitating social identity than alleviating symptoms of a disorder. Rather than accepting the APA’s classification of medical intervention as treatment for the condition of gender dysphoria, the participants in my study reframed medical intervention as a pathway to gender affirming social interaction. That is, gender affirming medical intervention better allows participants to

*do gender* (West and Zimmerman 1987) by positioning them to signal to others a sex category that more accurately reflects their gender identity.

One alternative to the medicalization of transgender identity via its inclusion in the DSM is the idea of morphological self-determination (Hughes 2006). That is, instead of requiring a medical condition before people can modify their bodies, approaching medical intervention from a perspective of morphological self-determination allows transgender individuals the freedom to do with their bodies what they wish, as do individuals who seek breast enhancements, calf implants, or other cosmetic surgeries that are gender-affirming in more indirect ways than those sought by trans and gender diverse people. Given the health insurance industry's overwhelming rejection of gender affirming care as medically necessary, the out-of-pocket expenses of these alternatives would remain steady for the vast majority of transgender people regardless of the presence of a diagnosis.

Projects of medicalization are complex and nonlinear. The current study suggests that individuals may reject medical hegemony in the framing of their experiences, yet also acknowledge and take advantage of the social power of a medical frame. Participants in this study were able to critically engage medical authority in context-specific ways that benefitted them. While participants rejected the medical frame in their understandings of their own and others' trans identities and experiences, they simultaneously reintroduced a medical frame when explaining trans experience to others. Both with medical professionals, in the pursuit of accessing medical intervention, or with family members, in the pursuit of understanding and acceptance, participants recognized that citing medical authority grants them more legitimacy than relying on personal feelings and desires. This stance is in line with Conrad's assertion that "medical explanations can provide coherence to patients' symptoms, validation and legitimization of their troubles, and support for self-management of their problem" (2007:11).

Even while rejecting the premise of their experiences constituting a medical condition, participants recognized the credibility of medical authority.

This study highlights the barriers that exist for people who wish to challenge or reject medicalization. For the trans people in my study, participation in a community of like-minded others allowed them to reject medical classification and reframe their experiences as trans people. However, once participants entered into interaction with community outsiders who were less knowledgeable, they recognized the power present in medical authority. While participants were able to reject the medical frame for themselves and other trans people, their strategic deployment of a medical frame may indeed serve to stabilize medical classification.

## CHAPTER 6

### SUMMARY AND CONCLUSION

In the three empirical articles that preceded this chapter, I draw on ethnographic and interview data collected from Trans South, a transgender community organization in the U.S. Southeast, to examine transgender and gender diverse people's experience of and engagement with medical authority. In analyzing this data, I have divided my dissertation into three article-length chapters. Chapter III focuses on participants' rejection of traditional mental health care in favor of peer-to-peer support in their management of the negative mental health effects of stigma, bias, discrimination, and violence. In Chapter III, I am guided by the following research questions:

1. How does peer-to-peer support affect the mental health experiences of transgender and gender diverse people?
2. What are the processes through which transgender community involvement alleviates negative mental health experiences for transgender and gender diverse people?

Answering these questions, I find that participants face both socioeconomic and sociocultural barriers to obtaining traditional mental health services. Resulting from these barriers, participants prefer the peer-to-peer support offered in Trans South rather than the services of traditional mental health practitioners in coping with their mental health care needs.

Participants frame traditional mental health care as a gatekeeping enterprise staffed largely by ill-equipped practitioners who regulate their access to gender affirming healthcare. Alongside and at times in place of traditional mental health services, participants' involvement in Trans



South promotes and facilitates peer-to-peer support that normalizes gender diversity, formalizes a strong social support network, and empowers participants to take control of their gender identity and experience.

Chapter IV focuses on participants' accountability to medical authority in their interactions with friends, family members, and healthcare practitioners. In Chapter IV, I am guided by the following research questions:

1. How does the medical model of gender diversity affect interpersonal dynamics among transgender and gender diverse people?
2. How does the medical model of gender diversity affect interpersonal dynamics between transgender and gender diverse people and their cisgender friends and family members?
3. How does the medical model of gender diversity affect the healthcare interactions of transgender and gender diverse people?

Answering these questions, I find that participants' experience accountability to a medical model of transgender identity and experience in their interactions with their cisgender friends, family members, and healthcare providers. Accountability from cisgender friends, family members, and healthcare providers took the form of persistent questions or assumptions related to participants' interest in or intent to undergo gender affirming medical interventions such as hormone replacement therapy or surgical intervention. Participants do not, however, experience accountability to a medical model in their interactions with other transgender and gender diverse people. This finding departs from earlier research on transgender community dynamics that position transgender community groups as sites of accountability and conformity pressure (Gagne and Tewksbury 1998, 1999; Gagne et al. 1997; Schrock 1996; Schwalbe and Schrock 1996). Such a departure suggests that as the sociocultural response to

gender diversity shifts, so too does the interpersonal community dynamics among transgender and gender diverse people.

Chapter V focuses on participants' engagement with the medicalization of gender dysphoria under the purview of the American Psychiatric Association. In Chapter V, I am guided by the following research questions:

1. How do transgender and gender diverse people employ a medical frame to understand and explain their identities and experiences?
2. How do transgender and gender diverse people frame gender affirming medical intervention?

Answering these questions, I find that participants reject a medical frame for understanding gender diversity, arguing overall that gender diversity is not a medical condition. Yet participants also stress the importance of access to gender affirming medical interventions for transgender and gender diverse people who need them to live a healthy life. Participants characterize gender affirming medical intervention as facilitating social interaction and gender recognition. Finally, while rejecting a medical frame in explaining their own and others' gendered experiences and interventions, participants simultaneously reintroduce a medical frame in order to facilitate medical and social recognition and validation.

#### Common Themes Across Empirical Chapters

Taken as a whole, this dissertation suggests that medical authority persists in its influence on transgender and gender diverse people's interpersonal and healthcare interactions in spite of their rejection of medical authority. Thus, across the three empirical chapters of the dissertation, three common themes emerge related to transgender and gender diverse people's engagement with and experience of medicalization: 1) the rejection of medical authority by transgender and gender diverse people; 2) the persistence of medical authority's influence on the interpersonal and healthcare interactions of transgender and

gender diverse people, and 3) the effects of a medicalized gender embodiment on the social recognition of gender for transgender and gender diverse people.

### *Rejection of Medical Authority*

Participants in this study reject the power of medical authority to define their experiences of gender diversity and to manage their mental health experiences. The medicalization of gender diversity is an ongoing, negotiated process. *DSM5*, released in 2013, marked a change in terminology from *Gender Identity Disorder* to *Gender Dysphoria*. This semantic shift meant to depathologize the identities of transgender and gender diverse people while persisting in recognizing the potentially negative psychological consequences of gender incongruence. However, this shift failed to convince participants in this study of the need for a diagnosis specific to gender diversity. Moreover, participants rejected the power of medical authority in defining their experiences as mental illness or medical condition.

The engines of medicalization may determine the dominant framing of gender diversity as mental illness or disorder, however the internalization of this frame is not inevitable. As research has shown, groups are increasingly rejecting a medical frame in the explanation of their identities or experiences. For example, participants in Whitesel's (2014) study on fat gay men rejected the medical diagnosis of and treatment for obesity in favor of a model of "health at every size" (Bacon 2010). Similarly, participants in Wentzell's study on aging Mexican men rejected the medical diagnosis and treatment for erectile dysfunction, characterizing their experience as a growth process that allows them "to embody a 'mature' masculinity focused on home and family" (2013:3). Participants in my study generally rejected the medical frame for understanding their experience, arguing that gender diversity and gender dysphoria should be understood as an identity category not a mental illness. While participants in my study use the community-based concept of *gender dysphoria* to

describe their feelings of unease related to their gender identity, they reject the APA's use of it as a euphemistic descriptor for mental illness.

Medicalization is a complex process. While rejecting the medical frame in their own and others' understandings of gender diversity, participants invoke the power of medical authority when seeking validation, legitimation, or approval from cisgender friends, family members, and healthcare providers. As Conrad writes, "medical explanations can provide coherence to patients' symptoms, validation and legitimation of their troubles, and support for self-management of their problem" (2007:11). My participants reject the hegemony of the medical model in framing their experiences, yet also acknowledge and take advantage of the social power of medical authority. Participants are able to critically engage medical authority in context-specific ways that benefit them.

#### *Persistence of Medical Influence*

While rejecting the power of medical authority, participants simultaneously acknowledge the persistence of medical authority's influence on their interpersonal and healthcare interactions. In addition to invoking the power of medical authority in context specific ways, participants also report being subject to medical accountability via persistent questions and assumptions from cisgender friends, family members, and healthcare practitioners related to their medical history and their plans to pursue gender affirming medical interventions.

Given the medical model's current position as the hegemonic explanatory frame for understanding gender diversity, it is perhaps unsurprising that it exerts influence on the interpersonal and healthcare interactions of transgender people. Prior research has shown that the medical model operates as both an empowering and constraining force in transgender and gender diverse people's lives (Burke 2011; Butler 2006; Koenig 2011; Romeo 2004; Spade 2003, 2008;). As I stated earlier, the medical model—when deployed in strategic, context

specific ways—can facilitate acceptance and validation of participants’ gendered experiences. While participants do not necessarily internalize this frame as accurate in explaining their experience, they recognize the power of medical authority and deploy it as necessary. Strategic deployment allows transgender and gender diverse people to negotiate the terms of medicalization – accepting its language and utility in social interactions while simultaneously rejecting the definition of transgender and gender diverse identities as disordered and the APA’s narrow prescription for their management.

While empowering for participants in certain contexts, the medical model also operates as a normative accountability structure for participants. I identify the hegemony of this medical model of gender diversity as transnormativity (Johnson 2013, 2015, 2016), defined as a regulatory, normative ideology that deems some transgender identifications, characteristics, and behaviors as legitimate and prescriptive while others are marginalized, subordinated, or rendered invisible. Transnormativity is maintained and enforced through transnormative accountability when transgender and gender diverse people are held to medical standards wherein they are expected and/or pressured to undergo gender affirming medical interventions, develop a narrative of gender dysphoria over the life course, and adhere to binary models of gender, sex, and sex category. Accountability to a medical model manifests for participants in persistent questions or assumptions from cisgender friends, family members, and medical professionals related to their interest or intent to undergo gender affirming medical procedures including hormone replacement therapy and gender affirming surgical intervention.

### *Doing (Trans)Gender*

Participants’ accountability to a medical model of gender diversity across social contexts and institutions may be a result of the social structure of gender in contemporary society. As West and Zimmerman (1987) suggest, gender is something that individuals do.

That is, gender is a social accomplishment rather than an essential component of the self. As a social accomplishment, gender is subject to social norms including those related to the body and embodiment (Connell 2009). Part of doing gender is signaling embodiments that cohere with one's assigned sex category. While the accomplishment of gender is a social process wherein individuals are always at risk of gender assessment, the process is rarely as overt for cisgender people as it is for transgender and gender diverse people. Catherine Connell (2010) coined the term "doing transgender" to highlight transgender and gender diverse people unique experiences of doing gender. As Connell defines it, doing transgender is transgender and gender diverse people's "unique management of situated conduct as they, with others, attempt to make gendered sense of their discordance between sex and sex category" (2010:50).

For participants in this study, experiences of doing transgender centered on embodiment. As participants report, transgender and gender diverse people are consistently held accountable to an embodiment that their interaction partners deem appropriate to their gender identity. This accountability manifests for participants in persistent questions or assumptions by healthcare providers, friends, and family members regarding their experiences of medical transition or intent to undergo gender affirming medical care. For some participants, their physicians held clinical beliefs about what a male or female embodiment meant anatomically and assumed their patients would comply with those beliefs. For other participants, their cisgender friends and family members had a social understanding about what embodiments determined sex and were persistent in their inquiry as to if and when participants would conform to those embodiments. Against the backdrop of our normative sex/gender system, accountability to medical authority is often required for transgender people to access embodiment and thus social recognition that coheres with their gender identity. The medicalization of transgender experience reinforces the relationship

between embodiment and gender identity, levying medical authority and prescribing clinical pathways to individual experiences of *doing transgender*.

### Implications

The findings in this dissertation have implications specific to medical sociology and the study of transgender and gender diverse people. As a whole, the dissertation suggests that medical authority operates in complex ways for medicalized communities. Medicalization may determine the terms of definition and the treatment for specific conditions or experiences, but the participants in this study reveal that the internalization of medical definitions and the compliance with medically sanctioned treatments are not inevitable. Further, the findings outlined in the dissertation suggest that individuals engage strategically with medical authority, deploying medical frames in moments where they may facilitate acceptance, validation, and legitimacy and rejecting medical frames in contexts where they would restrict their identities and experiences.

For transgender and gender diverse people, medical authority operates through ideology and accountability related to standards of transgender identity and prescriptive models of gender transition. Prior research on the dynamics of transgender community groups, conducted largely in the late 1990s, suggests transgender and gender diverse people police each others' identities according to a medical model and sanction each other when their experiences do not line up with hegemonic standards (Gagne and Tewksbury 1998, 1999; Gagne et al. 1997; Schrock 1996; Schwalbe and Schrock 1996). Prior findings, however, may be a relic of the time period at which those studies were conducted as the locus of accountability shifted from transgender interactants in prior studies to cisgender interactants in the current study. Rather than locating constraint in their interactions with transgender and gender diverse people, the constraint participants experience resulting from

medical authority manifests in conformity pressures from cisgender friends, family members and medical professionals.

Further, findings here support recent claims in transgender health research that suggest that peer-to-peer contact moderates the effects of stigma and discrimination and enhances the mental health experiences of transgender and gender diverse people (Bariola et al., 2015; Bockting et al., 2013; Bradford et al., 2013; Testa et al., 2014). The current research goes beyond those claims to examine the processes through which peer-to-peer contact comes to benefit transgender and gender diverse people. Findings here suggest that feelings of normalcy and belonging are central to the mental health experiences of transgender and gender diverse people. It is important that, alongside the provision of traditional mental health services, transgender and gender diverse mental health care must include efforts at building peer-to-peer transgender community networks that create feelings of normalcy and belonging by mirroring the people they serve.

#### Limitations and Opportunities for Future Research

Using ethnographic methods to examine transgender and gender diverse people's experience of medical authority allows for a robust understanding of the ways that medical definition and social interaction work together to structure transgender and gender diverse people's gendered identities, bodies, and experiences. However, there are several limitations specific to the methods used and the population studied that provide useful points of departure for future research in this area. The first of these limitations is the use of ethnographic methods. While ethnographic methods allow for an in-depth analysis of the meanings and consequences of medical authority for transgender and gender diverse people, the findings of this dissertation are limited to Trans South. Future research would allow for an exploration of transgender people's engagement with medical authority on a larger scale. Either an ethnographic study of another transgender community organization or a quantitative



study examining transgender experience more generally would validate the results and perhaps offer insights not covered in my case study of Trans South.

Another limitation of my methodology is that sampling was limited to the membership of Trans South, which was comprised mostly of white, male-identified transgender people. My interview sample included 33 participants, the majority of whom are white, working class, and male identified. Moving forward, research on this topic must answer calls for an intersectional approach to transgender studies (Broad 2002; Vidal-Ortiz 2008; Vries 2012). An intersectional approach should not only account for heterogeneity among transgender people (Hines 2006) but also highlight how categories of social difference affect transgender people's experiences of engagement with medical authority. Specifically, the effects of medical authority and medical accountability must be examined in relation to racialized class experiences. Largely missing from my sample, transgender and gender diverse people of color are the most economically disadvantaged members of the transgender community (Gehi and Arkles 2007; Grant et al. 2011). The social circumstances of poverty and marginalization make it nearly impossible to afford the services that are constitutive of a medical model of gender diversity. Accountability to a medical model of gender diversity or pressure to engage with medical authority may create social conditions of additional marginalization for low-income transgender people, disproportionately low-income people of color, within an already marginalized community of transgender people.

In addition to recognizing racialized class consequences for the engagement with medical authority, future research must explore the effect of medicalization on gender diversity globally (Aizura et al. 2014). As Roen (2001) and Vries (2012) have pointed out, the dominant frames used to understand gender diversity—including, but not limited to, the medical model—may not be as salient for populations who resist white western medical imperialism. However, one need not be invested in a system to be subject to its effects and

continued research is necessary to better understand how engagement with medical authority operates for transgender people of color and non-western gender-variant people subsumed under the transgender umbrella.

As mentioned above, the majority of my sample was male-identified. It is important for future research to examine how transgender men, transgender women, and non-binary gender diverse people engage medical authority. Transgender people have different relationships to their gendered body parts, the gender affirming medical care specific to them, and the level of accountability they experience from others (Prosser 1998). Moving through the world as a largely invisible minority population, the experiences of white transgender men that dominated the findings of this dissertation may underestimate the effects of medical authority and transnormative accountability. Future research must examine the nuances that arise in the engagement with medical authority at the intersection of gender, sex, and sex category.

Overall, this dissertation offers an ethnographic exploration and analysis of transgender and gender diverse people's experiences of medical authority and transnormative accountability. The persistent power of medical authority in defining the identities and experiences of transgender and gender diverse people is apparent throughout the three empirical chapters. As transgender and gender diverse people come to understand their identities and present themselves authentically in social and healthcare interactions, they are held accountable to medical models of gender diversity through interactional conformity pressures and gatekeeping processes that restrict their access to acceptance, validation, and medical care. The ideological practice of transnormative accountability restricts gender diversity to the realm of medical authority and holds transgender and gender diverse people accountable to its meanings and its prescription for management. Individual transgender and gender diverse people are agentic, however, and engage medical authority in strategic ways.

When beneficial to them and their community members, individuals adopt the language of medical authority and deploy it in context specific ways. When restrictive for them, individuals reject medical authority, opting instead for the language and practices of their local transgender community.

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## APPENDIX A

### HUMAN SUBJECTS APPROVAL FORMS

RE: IRB # 14-235 entitled “Transgender Identity, Health, and Community”

I am pleased to inform you that the Kent State University Institutional Review Board reviewed and approved your Application for Approval to Use Human Research Participants. This protocol was reviewed at a fully convened board meeting on May 7, 2014. Approval is effective for a twelve-month period:

May 7, 2014 through May 6, 2015

*\*A copy of the IRB approved consent form is attached to this email. This “stamped” copy is the consent form that you must use for your research participants. It is important for you to also keep an unstamped text copy (i.e., Microsoft Word version) of your consent form for subsequent submissions.*

Federal regulations and Kent State University IRB policy require that research be reviewed at intervals appropriate to the degree of risk, but not less than once per year. The IRB has determined that this protocol requires an annual review and progress report. The IRB tries to send you annual review reminder notice to by email as a courtesy. However, please note that it is the responsibility of the principal investigator to be aware of the study expiration date and submit the required materials. Please submit review materials (annual review form and copy of current consent form) one month prior to the expiration date.

HHS regulations and Kent State University Institutional Review Board guidelines require that any changes in research methodology, protocol design, or principal investigator have the prior approval of the IRB before implementation and continuation of the protocol. The IRB must also be informed of any adverse events associated with the study. The IRB further requests a final report at the conclusion of the study.

Kent State University has a Federal Wide Assurance on file with the Office for Human Research Protections (OHRP); FWA Number 00001853.

If you have any questions or concerns, please contact the Office of Research Compliance at [Researchcompliance@kent.edu](mailto:Researchcompliance@kent.edu) or 330-672-2704 or 330-672-8058.

Respectfully,  
Kent State University Office of Research Compliance  
224 Cartwright Hall | fax 330.672.2658

Kevin McCreary | Research Compliance Coordinator | 330.672.8058 | [kmccreay@kent.edu](mailto:kmccreay@kent.edu)  
Paulette Washko | Manager, Research Compliance | 330.672.2704 | [pwashko@kent.edu](mailto:pwashko@kent.edu)

RE: IRB # 14-235 entitled “Transgender Identity, Health, and Community”

Hello,

The Kent State University Institutional Review Board (IRB) has reviewed and approved your Annual Review and Progress Report for continuing review purposes. The protocol approval has been extended and is effective:

May 7, 2015 through May 6, 2016

*\*A copy of the IRB approved consent form is attached to this email. This “stamped” copy is the consent form that you must use for your research participants. It is important for you to also keep an unstamped text copy (i.e., Microsoft Word version) of your consent form for subsequent submissions.*

Federal regulations and Kent State University IRB policy requires that research be reviewed at intervals appropriate to the degree of risk, but not less than once per year. The IRB has determined that this protocol requires an annual review and progress report. The IRB will try to send you an annual review reminder notice by email as a courtesy. However, please note that it is the responsibility of the principal investigator to be aware of the study expiration date and submit the required materials. Please submit review materials (annual review form and copy of current consent form) one month prior to the expiration date.

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If you have any questions or concerns, please contact me at 330-672-2704 or [pwashko@kent.edu](mailto:pwashko@kent.edu).

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## APPENDIX B

### INFORMED CONSENT FORMS

#### Informed Consent to Participate in Qualitative Interviews for Research Study

Study Title: Transgender Identity, Health, and Community

Principal Investigators: Austin Johnson and Clare Stacey (Advisor)

You are being invited to participate in a research study. This consent form will provide you with information on the research project, what you will need to do, and the associated risks and benefits of the research. Your participation is voluntary. Please read this form carefully. It is important that you ask questions and fully understand the research in order to make an informed decision. You will receive a copy of this document to take with you. Keep in mind that even if you agree to participate, you are free to withdraw without penalty at any time.

#### Purpose:

This research is geared toward understanding the role of transgender community in transgender people's exposure to, understanding of, and identification with transgender as a medical diagnosis, personal identity, and collective identity.

#### Procedures

If you agree to participate, you will be asked questions about your gender identity, your experience in the Trans South group, and your perspective on transgender. If at any point, you feel uncomfortable or do not wish to answer a question, you have the option to change the subject or you may "pass." If you do either of these things, the researcher will move on without pushing for more information.

#### Audio Recording

The interviews will be audio recorded and transcribed for research purposes only. Your name will not be attached to the transcript of your interview. The audio will be kept in a secured location on campus. The recordings of the interviews collected for this study will be de-identified and may be used for research purposes at a later date.

#### Benefits

This research will not benefit you directly. However, your participation in this study will potentially inform a better understanding of identities and experience in the transgender community.

### Risks and Discomforts

There are no anticipated risks beyond those encountered in everyday life. However, some of the questions I ask, you may not feel comfortable answering them. If you do not wish to answer a question, you may skip it and go on to the next question.

### Privacy and Confidentiality

Participation in this study is confidential. Your signed consent form will be kept separate from your study data, and responses will not be linked to you. Identifying information will not be included in the data that you provide.

### Voluntary Participation

Taking part in this research study is entirely your decision. You may choose not to participate or you may discontinue your participation at any time without penalty. You will be informed of any new, relevant information that may affect your health, welfare, or willingness to continue your study participation.

### Contact Information

If you have any questions or concerns about this research, you may contact Austin Johnson at (*ajohn184@kent.edu*) or Dr. Clare Stacey at (*cstacey@kent.edu*). This project has been approved by the Kent State University Institutional Review Board. If you have any questions about your rights as a research participant or complaints about the research, you may call the IRB at 330.672.2704.

### Consent Statement and Signature

I have read this consent form and have had the opportunity to have my questions answered to my satisfaction. I voluntarily agree to participate in this study. I understand that a copy of this consent will be provided to me for future reference.

---

Participant Signature

---

Date

## Informed Consent to Participate in Ethnographic Observation for Research Study

Study Title: Transgender Identity, Health, and Community

Principal Investigators: Austin Johnson and Clare Stacey (Advisor)

You and your group are being invited to participate in a research study. This consent form will provide you with information on the research project, what you will need to do, and the associated risks and benefits of the research. Your and your group's participation is voluntary. Please read this form carefully. It is important that you ask questions and fully understand the research in order to make an informed decision. You will receive a copy of this document to take with you. Keep in mind that even if you agree to participate, you are free to withdraw without penalty at any time.

### Purpose:

This research is geared toward understanding the role of transgender community in transgender people's exposure to, understanding of, and identification with transgender as a medical diagnosis, personal identity, and collective identity.

### Procedures

If you agree to participate, a researcher will attend your group's events to observe how your group interacts with each other to form community. If at any point, you feel uncomfortable or wish the researcher would leave, you have the option to withdraw or pause the study. If you do either of these things, the researcher will leave without contest.

### Benefits

This research will not benefit you or your group directly. However, your participation in this study will potentially inform a better understanding of identities and experience in the transgender community.

### Risks and Discomforts

There are no anticipated risks beyond those encountered in everyday life. However, your group may feel uncomfortable with the researcher being present at some events. If this is the case, the researcher will leave without contest.

### Privacy and Confidentiality

Participation in this study is confidential. Your signed consent form will be kept separate from your study data, and the observations will not be linked to you or to the other group members. Identifying information will not be included in the data that you or your group members provide.

### Voluntary Participation

Taking part in this research study is entirely your decision. You may choose not to participate or you may discontinue your participation at any time without penalty. You will be informed

of any new, relevant information that may affect your health, welfare, or willingness to continue your study participation.

#### Contact Information

If you have any questions or concerns about this research, you may contact Austin Johnson at (*ajohn184@kent.edu*) or Dr. Clare Stacey at (*cstacey@kent.edu*). This project has been approved by the Kent State University Institutional Review Board. If you have any questions about your rights as a research participant or complaints about the research, you may call the IRB at 330.672.2704.

#### Consent Statement and Signature

I have read this consent form and have had the opportunity to have my questions answered to my satisfaction. I voluntarily agree to participate in this study. I understand that a copy of this consent will be provided to me for future reference.

---

Participant Signature

---

Date

## APPENDIX C

### INTERVIEW GUIDE

Which of the following best describes the sex category were you assigned at birth?

1. male
2. female
3. other (please specify) \_\_\_\_\_

Which of the following best describes your current sex category identification?

1. male
2. female
3. other (please specify) \_\_\_\_\_

What are your preferred gender pronouns?

1. He/Him/His
2. She/Her/Hers
3. Ze/Zir/Zirs
4. They/Them/Theirs
5. Other (please specify) \_\_\_\_\_

What is your race? (Choose All That Apply)

1. White
2. Black
3. Latino/a
4. Asian / Pacific Islander
5. American Indian / Native American
6. Other (please specify) \_\_\_\_\_

What is your mother's highest level of education?

1. less than high school diploma
2. high school diploma
3. Associate's or technical degree
4. Bachelor's degree
5. Graduate or professional degree

What is your father's highest level of education?

1. less than high school diploma
2. high school diploma
3. Associate's or technical degree
4. Bachelor's degree
5. Graduate or professional degree

What is your highest level of education?

1. less than high school diploma
2. high school diploma
3. Associate's or technical degree
4. Bachelor's degree
5. Graduate or professional degree

Are you currently...

1. Employed for wages
2. Self-Employed
3. Unemployed, currently looking for work
4. Unemployed, not currently looking for work
5. Homemaker
6. Student
7. Military
8. Retired
9. Unable to work

What is your annual household income?

1. Below 30,000
2. Between 30,000 – 50,000
3. Between 50,000 – 75,000
4. Between 75,000 – 100,000
5. Between 100,000 – 150,000
6. Above 150,000

Which of the following describes where you live?

1. Large City
2. Medium City
3. Small City

What is your age? \_\_\_\_\_

Tell me about yourself...

- *Follow ups / Probes:*
  - How old are you?
  - Where'd you grow up?
  - Did you go to college?
  - What do you do for a living?
  - Are you partnered?

Tell me about your identity....

- *Follow ups / Probes:*
  - How do you identify in terms of gender?
  - Preferred gender pronouns?
  - Has this changed over time?
  - When did you come to this way of identifying yourself?
  - How did you come to this way of identifying yourself?
  - Does your family support this identification?
    - How so? or How not?

Tell me about the word *transgender* ....

- *Follow ups / Probes:*
  - What does that word mean to you?
  - Do you identify with this term, why or why not?
  - Are there other trans-related terms that you identify with?

Tell me about *gender transition* ...

- *Follow ups / Probes:*
  - What does that mean to you?
  - What does gender transition look like for you?
  - Is it the same or different for other trans people?

### Trans Community Interaction

When did you first learn about the Trans South group?

- *Follow ups / Probes:*
  - Did you seek it out?
    - What were you looking for?
  - Did someone tell you about it?
    - What was the context of that conversation?
  - What was your first impression of the group?
  - What did you think it was for?

Tell me about the Trans South group ...

- *Follow ups / Probes:*
  - What's it like?
  - Who are the people in the group like?
  - What is the purpose of the group?
  - What kinds of things do y'all do together?
  - Does the group have a collective understanding of what transgender means?
  - Do y'all ever discuss medical transition? How so?
    - Tell me about a time when medical transition was discussed...
  - Do y'all ever discuss alternatives to medical transition? How so?
    - Tell me about a time when alternatives were discussed...

Tell me about your experience in the Trans South group ...

- *Follow ups / Probes:*
  - Why do you go to the meetings?
  - What do you get out of being in the group?
  - What, if anything, do you like about the group?
  - What, if anything, do you dislike about the group?
  - Has the group changed the way you feel about your identity?

Are there ever times with members of the group disagree or fight about how to talk about, define, or react to things related to being trans?

- *Follow ups / Probes:*
  - How do they handle this?
  - Tell me about a time when a disagreement happened...

Aside from the GB group, are you a part of any other trans groups or communities?

- *Follow ups / Probes:*
  - If so, how do those groups differ from the GB group?

Aside from the folks you met in the Trans South group, do you know any other trans people?

- *Follow ups / Probes:*
  - If so, tell me about those relationships.
  - Are these friendships different than the friendships you have with those in the GB group?
  - If not, do you want more trans friends?
  - Is it important for you to know and interact with other trans folks?
  - How important is the GB group in your life?

### Trans Medicalization

Have you ever heard the phrase “medical model of transition” when talking about trans people? If so, tell me what that means....

- *Follow ups / Probes:*
  - When/Where/From whom did you hear this phrase?
  - Are there alternatives to the “medical model” ?
    - How did you learn about these?

Have you ever felt pressured to conform to a specific model of transition?

- *Follow ups/ Probes:*
  - If so, which model?
  - If so, tell me about a time when you felt pressured...
  - If no, have you ever felt any pressure about how to be trans?
    - If so, tell me about that...

Some people say that being trans is a medical condition, have you ever heard it talked about this way? If so, tell me what that means....

- *Follow ups / Probes:*
  - What do you think about that?
  - Do you think of yourself as having a medical condition? Why/Why not?
  - Do you think of other trans people as having a medical condition? Why/ Why not?
  - Do some trans people have a medical condition while others do not? Why/ Why not?
  - Does the Gender Bender group talk about trans as a medical condition?
  - Do you see benefits to thinking of trans as a medical condition?
  - Do you see disadvantages to thinking of trans as a medical condition?

Have you felt pressured to describe yourself as having a medical condition?

- *Follow ups / Probes:*
  - Tell me about a time when you felt that pressure...

When I say “Gender Identity Disorder,” what does that mean to you?

- *Follow ups / Probes:*
  - Do you identify with this label? Why or why not?



How familiar are you with the Diagnostic and Statistical Manual of Mental Disorders or the DSM? What do you know about it?

The DSM defines GD as:

*“Gender dysphoria refers to the distress that may accompany the incongruence between one’s experienced or expressed gender and one’s assigned gender. Although not all individuals will experience distress as a result of such incongruence, many are distressed if the desired physical interventions by means of hormones and/or surgery are not available. The current term is more descriptive than the previous DSM-IV term *gender identity disorder* and focuses on dysphoria as the clinical problem, not identity per se.”* (emphases in original, APA 2013:451)”

When you hear “Gender Dysphoria,” what does that mean to you?

- *Follow ups / Probes:*
  - How do you feel about *Gender Dysphoria* replacing *Gender Identity Disorder* or *GID* as a diagnostic label for trans people?
  - Do you identify with this label as it reads in the DSM? Why or why not?

### Trans Healthcare

Have you had any interactions with healthcare professionals specifically dealing with your gender transition?

- *Follow ups / Probes:*
  - If so, tell me about that...
    - Did you feel that your gender identity was respected in that encounter?
      - If so, tell me about that
      - If not, tell me about that
    - Did you feel that your needs were met?
    - Was medical transition discussed?
    - Were you informed of alternatives to a medical model?
    - Were you pressured to adhere to a medical model?
  - If not, why?
    - Are you not interested in medical transition?
    - Are there other reasons?

Tell me about your interactions with healthcare professionals in general...

- *Follow ups / Probes:*
  - Do you have any other healthcare diagnoses or health problems for which you see a doctor regularly?
    - If so, what are they?
  - Are you comfortable interacting with healthcare professionals?
    - If not, what makes you uncomfortable?
  - When you go to doctors for reasons unrelated to transition or gender identity, do you tell your physicians that you are trans?
    - Why or why not?
  - When you go to doctors for reasons unrelated to transition or gender identity, do you feel that the doctors bring up your transition status?
    - In what ways?

- Why do you think that is?

Do you think your race affects your experiences as a trans person?

- *Follow ups / Probes:*
  - When you interact with healthcare professionals?
    - How so?
  - In the GB group?
    - How so?

Do you think your class status affects your experiences as a trans person?

- *Follow ups / Probes:*
  - When you interact with healthcare professionals?
    - How so?
  - In the GB group?
    - How so?

Are there things about you, besides race and class, that you feel affect your experiences as a trans person?

- *Follow ups / Probes:*
  - When you interact with healthcare professionals?
    - How So?
  - In the GB group?
    - How so?

What would you like to see change in the future in terms of the way we think about trans as a medical condition?

What would you like to see change in the future in terms of trans health?