

Assessing Gender: An Exploration of Transgender Individuals' Experiences of
Assessments for Hormone Therapy or Surgery in Nova Scotia

by

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Abstract

Transgender individuals living in Nova Scotia and wishing to undergo gender-confirming hormone therapy or surgery must participate in a mandatory mental health assessment to determine whether they meet the diagnostic criteria for gender dysphoria. This project explores the experiences of eleven transgender individuals in Nova Scotia who had received an assessment for gender-confirming hormone therapy or surgery. It considers these experiences in light of a framework of medicalization, examines the range of experiences by considering the role of private and public systems, the experiences of the standard WPATH (World Professional Association for Transgender Health) model versus the emerging model of Informed Consent for access to care, and explores areas for change. This work presents an opportunity to listen to first-voice accounts of the experiences of trans Nova Scotians, and to use these to advocate for a more equitable and anti-oppressive healthcare system for transgender individuals wishing to access transition-related care.

List of Abbreviations Used

APA	American Psychological Association
Dal	Dalhousie University
DSM	Diagnostic and Statistical Manual
IWK	Izaak Walton Killam Health Centre for Children
GID	Gender Identity Disorder
HRM	Halifax Regional Municipality
HRT	Hormone Replacement Therapy
HSHC	Halifax Sexual Health Centre
LGBTQ+	Lesbian, gay, bisexual, transgender, two-spirit, queer, questioning, plus
Trans	Transgender
MSI	Medical Services Insurance (Nova Scotia)
SOC	Standards of Care
WPATH	World Professional Association for Transgender Health

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CHAPTER 1 | Introduction

This project explores the experiences of transgender individuals during the early stages of accessing transition-related health care in Nova Scotia. While a growing number of jurisdictions are adopting an informed consent model for access to care (Bourns, 2015), which emphasizes self-identification and reframes the role of the professional as a facilitator for accessing hormone therapy, the Nova Scotia system continues to rely on psychological assessment grounded in the DSM-5 criteria for Gender Dysphoria; that is, the distress resulting from a misalignment between one’s gender and assigned sex (Pride Health, 2013). A growing body of academic literature on transgender-related health points to the ongoing and considerable barriers transgender people face when accessing health care in Canada — barriers that lead them to conceal their gender identity: transphobia from professionals; fear of judgement; limited resources and knowledgeable providers; and previous negative experiences (Vermeir, 2016). Indeed, a 2015 survey (Saewyc et al., 2015) of 932 transgender youth found that 47% of youth have family doctors who are unaware of their gender identity. Of the remaining 53% of youth with doctors who are aware, only 15% feel “very comfortable” discussing transgender-related healthcare — even fewer reported this comfort in walk-in clinics. While offering significant insight, this survey, like the literature on transgender health more generally, is limited in its applicability to the Nova Scotian context, with only 0.07% of surveyed participants from the province. What is known within Nova Scotia relies on anecdotal evidence (Calio, 2016), small exploratory studies with health care providers (Beagan, Fredericks, & Goldberg, 2012), or studies on the LGBTQ+ community more broadly (Colpitts & Gahagan, 2016). In other words, there is little

research with an explicit focus on the experiences of transgender people, or where there is, the focus tends to be on more generalized experiences and outside of health care settings. In a similar vein, there is an emerging but important critique of the assessment process for accessing hormone replacement therapy (HRT) or gender confirmation surgery (GCS), from within both academic and activist communities, that posits that the assessment process results in increased barriers to care, including long wait times within the public system (“Wait Times”, 2018), high costs within the private system, and, significantly, the need to “prove” one’s gender to a professional prior to approval for treatment (Serano, 2009). While this has been well demonstrated in other jurisdictions (Sperber, Landers, & Lawrence, 2005), resulting in the move to the informed consent model (Sanchez, Sanchez, & Danoff, 2009), there has been no comparable research conducted in Nova Scotia.

This study redresses that gap, with an eye to determining what barriers to care currently exist, and how the system might be improved to serve transgender people moving forward. To this end, it offers an in-depth exploration of the experiences of transgender individuals with the current system in Nova Scotia, drawing on eleven semi-structured interviews conducted with individuals who received an assessment for hormone therapy in the last two years. The interviews focused on the benefits and limitations of the assessment as experienced and perceived by participants, as well as the barriers associated with it. Interview transcripts were analyzed using a combination of inductive and deductive coding conducive to qualitative research (Berg, 2008). This means that the data was reviewed and re-read in an iterative fashion, allowing the author to identify salient examples that corresponded to the existing literature (deductive) and

those themes and patterns that emerge from the data (inductive). Such a methodological and analytical approach provides for a nuanced and detailed account of the data provided by participants that simultaneously responds and contributes to the scholarly and grey literature on transgender health care.

More precisely, processes of medicalization as they occurred within two separate yet connected systems of gender assessment (private and public) are revealed and analyzed through a theoretical framework informed by social constructionism, queer theory, and intersectionality. These analytical insights are, in turn, operationalized in the service of critical social work practice that more effectively responds to the needs of transgender individuals in Nova Scotia.

As a researcher, I am coming to the project from within the queer and trans community; I am a queer, non-binary lesbian, and my partner is genderqueer and transfeminine. I came out to myself and some friends in high school, but did not have a LGBTQ+ community available to me until I moved to Halifax in 2010 (at age 17) for university. It was during my first year of university that I began to meet other LGBTQ+ people; I also began to get involved with local activist groups and to gain an understanding of the issues facing LGBTQ+ people in Halifax — notably, of the ways in which transgender people are marginalized.

My positionality, however, is somewhat complicated with regard to the community I have engaged in this project. I am a queer and non-binary individual who is largely surrounded by other LGBTQ+ people, and I have witnessed several friends (as well as my partner) pursuing transition-related care. I learned about the process for accessing transition-related care from living within this community — even sitting in on

some mental health assessment sessions with my partner — long before it became an academic interest. At the same time, I am someone who does not want to transition via hormone therapy or surgery, and I will likely never seek out a gender assessment personally.

My ties to the community inform my interest in the subject matter presented here, and I hope that they would also inform the credibility of my work — especially as I do question whether cisgender professionals have a valid role in providing access to transition-related care — however, I do not presume to know what it is like to personally navigate the process that I describe and evaluate in this project, which is why I found it crucial to highlight as many first-voice accounts as possible rather than centering my own views.

It is also worth considering my privileges within this project as someone who not only is university-educated, but also as someone who is entering a profession (social work) which can become trained in providing mental health assessments for transgender people seeking hormone therapy or surgery; some of the participants may have even met with social workers in the past. Social workers often reproduce the same harms that I critique throughout this project; as a researcher in a position to meet transgender people who are navigating the gender assessment process, this was important to keep in mind.

The onus is on me, then, to be an anti-oppressive facilitator and not another health professional who controls and gatekeeps others' access to the services we provide. This is not to say I was “neutral” in exploring these accounts — all researchers come to their research matter with a wealth of prior knowledge and experiences, as well as social locations, that inform their position on the subject — but rather, that I made it my

intention to prioritize the participants' thoughts and feelings (as the true experts in this research) over my own.

Research Objectives

This work presents an opportunity to listen to first-voice accounts of the experiences of transgender Nova Scotians, and to use these to advocate for a more equitable and anti-oppressive healthcare system (Larson, 2008) for transgender individuals wishing to access transition-related care. Such is the overarching objective of this project. More precisely, the project does the following:

1. To explore and gain a better understanding of transgender individuals' experience of assessment for hormone readiness in Nova Scotia.
2. To examine the strengths of the current process and to explore its limitations according to those people who have accessed assessment.
3. Drawing on the experiences and perspective of transgender individuals, to consider how the process might be improved or modified to enhance the wellbeing of transgender people medically transitioning.

Theoretical Framework

At the centre of this work are the scholarly debates on medicalization as a social process that simultaneously expands and restricts the ability of individuals to medically transition, and shapes — in the current Nova Scotian context — the ways in which care providers offer service to these individuals. To understand medicalization, and to better understand the experiences of the work's eleven participants, the project draws on social constructionism, queer theory, and intersectionality — each elaborated below. Taken together, these offer a critical lens for exploring and understanding the unique

experiences of transgender people as they navigate health care systems that are historically and often contemporaneously determined by the dictates of medicalization. These theories and their insights as they relate to the experiences of people medically transitioning are, in turn, operationalized in the service of a critical social work practice that is simultaneously responsive to the critique offered by theories vis-à-vis medicalization and to the experiences of transgender people as elaborated in this thesis. Campbell and Baikie (2012) describe those who take up critical social work as “committed to understanding, critiquing and transforming the profession of social work and the unjust nature of society. Critical social workers therefore include an analysis of power and understand social relationships as both personal and political.”

Social constructionism. Under a social constructivist paradigm, the concept of “gender” (as well as societal perceptions of gender) is not simply defined by an unchanging biological system of binary sex, but rather, is a construction of the social world (Burr, 2006). That is, while gender may be informed by certain biological sex categories (which may in and of themselves be considered to be socially constructed), the concept of gender itself is psychological, cultural, historically-situated, context-dependent, and continually changing. However, though gender may be a social construction, this does not preclude it being a meaningful concept that affects our lives on a constant basis. For transgender and non-binary communities especially, the fact that there are numerous ways to present one’s gender (regardless of sex assigned at birth) is a fundamental concept which will guide this analysis.

Queer theory. Queer theory is a form of critical, post-structural, and postmodern theory, which emerged out of third-wave feminism in the 1990s as well as from gender

theory. As Mulé (2008) discusses, queer theory differs from previous “gay and lesbian” studies in that it emphasizes the social construction of gender and sexual orientation, questioning the biological determinist nature of sex and gender (as upheld by previous theories), as well as the boundaries of binary genders and sexual orientations (in line with post-structural and critical thinking). As a term, “queer” resists a simple definition, as its meaning is ever-changing within the complexities of the LGBTQ+ community. Put simply, queer can be used as an umbrella identifier for someone who is either not heterosexual or not cisgender. In questioning (and ultimately resisting) the notion that gender and sexuality must be a binary, biologically determined construct, queer identities become intentionally political; transgender activist Alok Vaid-Menon (2015) describes their hope for a future world “where we stop making assumptions around everything; where we allow people to self-narrate their bodies”.

Queer theory also resists the heteronormative, neoliberal, rights-based approach to LGBTQ+ justice (for example, conversations around same-gender marriage or transgender people in the military), and instead aims to integrate anti-oppression, feminism, and intersectionality within queer activism (conversely, questioning the institution of marriage itself, or critically examining the role of the military in the perpetuation of imperialism, colonialism, and cycles of marginalization and poverty). Similarly, I am less interested in ways to make the healthcare system incrementally better through small, gradual, or short-term fixes (such as increased training of professionals, cutting wait times, or reducing the number of required appointments) than I am in considering ways to overhaul or even create entirely new approaches to accessing care. It is particularly relevant to this project that queer theory considers the adverse impact of

the binary model of sex and gender, as well as the historical effects of (cis)heterosexism, especially as it intersects with other forms of oppression.

Intersectionality. The term “intersectionality” follows from the critical legal scholarship of Kimberlé Crenshaw, who argued for and developed a model of identifying and analyzing the ways in which different registers of oppression can intersect in the context of a person’s life. The impact of such intersecting identities, she argues, has the effect of obscuring the experiences of individuals who find themselves subject to, for example, both misogyny and anti-black racism. The political project of the theory, then, is to make visible the ways in which manifold forms of systemic oppression and violence can simultaneously impact individuals and groups. The multiple ways transgender individuals are oppressed within health care systems, for example, is obscured when we focus our attention on a single axis of oppression — race, gender, socioeconomic status, and other social locations. (Crenshaw, 2018).

To understand as accurately as possible how transgender persons are affected within this system, we must view these as overlapping and interconnected, and not as distinct units. Within queer and transgender scholarship, a number of important efforts have been made to bring the intersecting experiences and identities of transgender people to the fore. Coined by Julia Serano, the concept of “transmisogyny” describes the unique kind of oppression faced by trans women and transfeminine individuals assigned male at birth (Serano, 2016). Transmisogyny, then, is the intersection of transphobia and misogyny, and describes the unique combination and interplay of oppression faced by trans women. While trans men might face transphobia due to being transgender, they might concurrently face privilege for being men. Similarly, trans women face transphobia

due to being transgender, but face the additional misogyny of being women.

Medicalization: an overview. These theoretical frameworks offer a critical vantage point from which to understand medicalization — a key social process and mechanism through which gender is understood by mainstream healthcare. Elaborated more fully in the following chapter, medicalization is a social process wherein individual experiences that may be otherwise interpreted as “nonmedical” become classified and treated as medical problems (Conrad & Schneider, 2010). Reflecting its relationship to what is frequently referred to in critical social work scholarship as the “medical model”, medicalization prompts the downplaying of the role in complex issues related to the body, while interrupting otherwise routine bodily functions according to the dominant discourses underpinning the medical model.

Typical analyses of medicalization suggest that health professionals are the dominant actors of medicalization, who through their engagement with patients affirm medical authority over issues which are not necessarily directly related to health (Furedi, 2006). Put differently, in their management of health-related concerns, health professionals collude with dominant systems of power, reinforcing the discourses and ideologies that sustain them. In so doing, health professionals enact an agenda of social control (Bury, 2006). In its most harmful form, then, medicalization can stigmatize or pathologize social issues, be used to justify unnecessary intervention, and deny individual agency in care. For example, medicalization of the LGBTQ+ community has been used both to justify use of conversion therapy in children and adults as well as to deny LGBTQ+ rights and social acceptance.

While medicalization is often portrayed as a harmful force happening to

nonprofessional individuals outside of medical realms, more recent work challenges this assumption. Medicalization “from below” (Bury, 2006) considers the role of lay people (outside of scientific and medical structures) within the process of medicalization itself; in many cases, medicalization helps to fashion and maintain a social identity based on group experiences, encourages social acceptance, and advocates for access to treatment. In this sense, medicalization can be powerfully validating to certain populations, and often operates outside of medical consensus. Although work on medicalization overwhelmingly focuses on its overt negative effects, benefits such as collective identity formation and recognition can be significant.

Central to the analysis and recommendations put forth in this thesis, Gender Dysphoria as a required DSM-5 diagnosis for transgender people seeking transition-related care demonstrates the double-edged nature of medicalization. While a diagnosis may provide access to necessary treatment, and moreover, might provide some of the validation of transgender identities as described above, it also potentially and simultaneously subjects transgender individuals to an oppressive health care system. Although there are a growing number of advocates who align themselves with medicalization as a means of ensuring access to care and the affirmation of identity, many scholars suggest that through the portrayal of gender variance as an individual biological deviance, such diagnoses (despite “good intentions”) ultimately uphold the normative binary gender system (Reicherzer, 2008). Medicalization of gender identity is also critiqued as requiring and reinforcing the authorities of medical “gatekeepers”. Here, the critique centres on the authority of medical professionals to approve or reject transgender individuals’ access to transition-related care on the basis of their compliance

to problematically defined gender standards (Serano, 2016, pp. 115-160).

Critical social work. Critical social work helps us move beyond simply knowing and describing social issues, toward a state of critiquing society and working for change (Campbell & Baikie, 2012). Drawing on the theoretical contributions of queer theory, social constructivism, and intersectionality, this project adopts such critical perspective; it listens to first-voice accounts with the objective of critiquing and transforming the current system of accessing transition-related care. In my exploration with the participants, I hope to unpack certain assumptions, values, and concepts, and use these to critically analyze the participants' experiences of medically transitioning to explore directions for radical — not incremental — changes within the system, but also in the context of social work practice more broadly. As such, the work is inherently politicized in that the personal experiences of transgender people in Nova Scotia can be linked to much broader conditions of transphobia, and ultimately, state and/or medical control of non-(cis)heteronormative bodies (Spade, 2015).

Methodology

Sample. At the centre of this work are eleven participants, all of whom received a completed or partial gender assessment for hormone replacement therapy in Nova Scotia in the last two years. A small sample allowed for a more in-depth interviewing process and analysis. Also, it reflects the small population of transgender people who have recently received this assessment. To gain a diverse understanding of experiences of various gender and sex assignments, and to avoid having a majority of voices from a particular group, interviews with similar proportions of trans women, trans men, and non-binary individuals who were assigned male and assigned female at birth. Vermeir's

recent study of transgender Nova Scotians accessing primary health care (2016) estimates that the transgender community makes up approximately 0.05% of the general population.

Using this figure, Vermeir estimates that the transgender population within Nova Scotia is approximately 4,715 people, with at least 2,075 living in the HRM. Other studies (Aramburu Alegria, 2011) indicate that the percentage of known transgender individuals in the general population is rapidly rising (by approximately 15% each year), as more people come out publicly about their gender identity. Due to the small size of the transgender population in Nova Scotia, recruitment was mainly purposive and relied on snowball sampling. I recruited both on- and offline, via posters and social media posts in locations and facebook groups relevant to the transgender community in Nova Scotia, such as the Halifax Queer Exchange (facebook group), The Youth Project (facebook group and physical location), Venus Envy (physical location), and South House (physical location).

Numerous studies have explored social media as an effective tool of recruitment (Batterham, 2014) and have confirmed the value of the internet and social media in accessing hard to reach and vulnerable populations (UyBico, Pavel, & Gross, 2007). In relation to this project, given the prevalence of transphobia, closed social media groups may be one of the few public places where the trans community in Halifax feels safe and able to make connections with others (Shapiro, 2004). To minimize the potential risk associated with using social media to recruit participants, I have only accessed moderated groups where membership is regulated by the approval of group administrators. Additionally, the comment feature on all posts was deactivated, and it was made clear

that potential participants must email the researcher in order to express interest in participating.

In light of the continually changing nature of transgender health in Nova Scotia (e.g., the shift from the DSM-IV to the DSM-5 in 2013, which prompted several changes to the system), this project focuses on the last two years (2016 through 2018). Following from this, all interview participants have completed an assessment recently (defined as within the last two years). However, in the event that it proved difficult to meet the projected sample size (after attempting to recruit those with a recent assessment), I allowed for the consideration of those who have had assessments in the last four years — the study ultimately contained 10 participants who were assessed in the last two years, and one participant who was assessed in the last four years.

Project participants were at least 18 years old at the time of the interview, and all had gone through the gender assessment process between 2015 and 2018 in Nova Scotia. In Nova Scotia, transgender individuals over the age of 16 who wish to transition medically have the option to pursue either assessment via a private practice or through Community Mental Health within the Nova Scotia Health Authority. Transgender individuals of age 16 or younger are typically referred to the IWK Trans Health Team for assessment, though some also pursue private assessment. Given the similarity in approach to assessment and treatment in these settings, but also the important insights that are revealed through comparing these systems, both groups, regardless of private or public access, were eligible to participate in this study so long as they were 18 years of age or older at the time of the interview. This research was interested in exploring adults who were able to fully consent to medical treatment and therefore follow the standards of

care for adults (either WPATH or informed consent); in contrast, those who are below the age of consent for medical care follow another set of standards of care, which emphasizes parental involvement and perhaps the delay of puberty.

Eleven individuals participated in this study through semi-structured interviews and through a demographic survey. According to the survey, three participants were between the ages of 18 and 22. Five participants were between the ages of 23 and 27. One participant was between the ages of 28 and 32. One participant was between the ages of 38 and 42. One participant was between the ages of 48 and 42. When asked about racial identity, 10 of the participants identified as white, and one of the participants identified as Indigenous. In terms of education level, five of the participants had completed a university degree; four reported having completed some level of college or university; one had completed high school; and one participant had completed graduate school.

Regarding place of residence, eight of the participants lived in the HRM. Two participants lived in Nova Scotia outside of the HRM, and one participant lived outside of Nova Scotia. When asked about place of birth, six participants were born in the HRM. Three of the participants were born in Nova Scotia outside of the HRM. Two participants were born in Canada outside of Nova Scotia, and one participant was born in the United States. In terms of employment, four participants were employed full-time. Three participants were currently students. Three participants worked part-time. One participant was on long-term disability. Regarding their level of income, two participants made \$10,000 annually or less. Four participants made \$11,000 to \$20,000 annually. Two participants made \$21,000 to \$30,000 annually. Two participants made \$31,000 to

\$40,000 annually. One participant made \$61,000 to \$70,000 annually. Finally when asked about relationship status, six participants were single. Three participants were in a relationship. One participant was married. One participant was separated. One participant was in multiple relationships.

Each participant also identified their gender identity during the interview and indicated on the consent form whether they would like to be referred to using a typically “female” pseudonym, a “male” pseudonym, or a “gender neutral” pseudonym. “Liam”, “Brandon”, and “Daniel” are transgender men, and use he/him pronouns. “Michelle”, “Elizabeth”, “Rachel”, and “Amy” are transgender women, and use she/her pronouns. “Noah” described himself as both a transgender man and agender, and uses he/him pronouns. “Jamie” described themselves as both transmasculine and non-binary, and uses both he/him and they/them pronouns. “Sage” described themselves as both transmasculine and non-binary, and uses they/them pronouns. “Riley” described themselves as both transfeminine and agender and uses they/them pronouns.

Data Collection. Qualitative in design, the project draws on data collected over a one-month period. In May 2018, the author interviewed 11 participants. To meet the study’s objective of critically examining the “why” and “how” of participant experience, interviews were semi-structured. Given the open-ended nature of the interview guide, participants were invited to provide as much or as little information as they wished, and to elaborate on the issues they experienced as most significant. As a result, the exact time commitment of each interview varied, ranging from 1.5 hours to three hours. Each interview was recorded on a digital recording device in a private location chosen by the participant.

To integrate and apply the theoretical framework of this project (described below) and go beyond simply describing and reporting experiences, in-depth qualitative interviews are particularly suitable. Specifically, in-depth, semi-structured interviews (which are designed to be flexible with regard to the participant's experiences) present the opportunity to validate personal experiences and points of view, while allowing for a more thorough understanding of these experiences. Conversely, an attempt to quantify the complex lived experiences of this population via survey data (or a similar quantitative approach) would have been much less useful in achieving the research objectives. Other qualitative methods were briefly considered, such as the use of focus groups, which has the benefit of reaching many participants at once for a facilitated discussion. I ultimately favoured a one-on-one approach to the interviews, which, while more time-consuming, provides a person with the space to tell their own individual story with nuance and rich detail, rather than speaking in generalities (as may be promoted by a focus group environment). As someone who is also aware of community politics, group dynamics, and the role of social capital within the LGBTQ+ and activist communities, I wanted to facilitate a safer space where marginalized people, those who have trouble speaking up, or perhaps those with differing views from the majority were able to express their thoughts and feelings.

Qualitative research is particularly compatible with the tenets and objectives of the theories underpinning this study — notably, poststructuralism and queer theory (Hammers & Brown III, 2004). Warner (2004) provides a critique of “traditional psychological research methods” when it comes to LGBTQ+ research, in that those methods seek a kind of objectivity difficult to achieve when gender and sexuality binaries

and boundaries are subverted. In trying to quantify or codify complex experiences in an often prejudicial and discriminatory society, quantitative methods or even some forms of qualitative methods (i.e. surveys or structured interviews) may in fact “normalize” or “limit” LGBTQ+ individuals. In contrast, qualitative methods allow for the contingency, complexity, and depth that is required for an exploration of queer identities and experiences (Levy & Johnson, 2012).

Ethical considerations. Informed consent was obtained before conducting the interview. The researcher provided all participants with a consent form that detailed the nature of the project, its objectives, and its methods. This form was emailed to participants in advance of their interviews, and was reviewed in person prior to the interview. If required, I would offer to read the form to the participant. If the participant agreed to participate, they would be asked to sign two copies of the form — one of which they were able to keep, the other of which remained in my possession. Participants were informed prior to the interview that they would be able to stop the interview at any time, and that they could withdraw from the study (including after the interview) at any time without penalty. Participants were also informed that they could skip questions. In the event that that a participant stopped the interview or decided to withdraw from the study, the honorarium would still be provided and transportation costs (bus tickets) still covered.

Given the small number of transgender individuals in Nova Scotia and my involvement with the community, it was possible for there to be a perceived conflict of interest among members of the community. That is, there was a small but significant chance that I may have known some of the potential participants personally (and that such a person may feel obligated to participate, or may feel pressured to respond to

interview questions). Thus, I did not approach any potential participants, or discuss my research with any potential participants, outside of specific communications surrounding an expression of interest that the potential participant has initiated. Whenever possible, I aimed to interview participants who were unknown to me.

During the interview, I made a specific effort to refrain from “agreeing” or “disagreeing” with any comments made in response to the interview questions, but rather, to validate all experiences and make as few comments as possible, except to seek clarification. I initially claimed that I was “neutral” in this regard, but this is not exactly so. Researchers do carry the capacity to influence interviews and encourage narratives that they see as in line with previous research or with their own views — however, and at the same time, to be an entirely neutral party in interviews is not possible, as people are unavoidably impacted by their worldview, biases, and knowledge of the subject. For instance, since the participants knew that I identified as a queer and non-binary researcher, it may be that some participants had a greater level of comfort with me than they would have with a cisgender, heterosexual researcher. Thus, while I made an effort to not predetermine the stories and feelings discussed in the interviews, the capacity to be purely objective is not something that was realistically sought after.

Participants received an honorarium of \$30, which was offered at the end of the interview. Depending on the meeting space, some participants incurred travel expenses, which I reimbursed with bus tickets. A receipt of honorarium was included on the consent form.

Analysis. The analysis began as the first interview began. Through my conversations with the participants, new questions were raised, which prompted me to

reframe my thinking, and therefore, the specific questions I asked the following participants. For example, it was unexpected that some participants who accessed the public mental health system had an overall positive experience. This prompted me to meet with others who had accessed the public system to see if this was a unique experience or one that happened to others. Additionally, when one participant began discussing (of his own accord) the differing models of care for access to transition-related care, I realized that this was something that other people may have thoughts about, and began asking this of subsequent participants. As the interviews were completed, it seemed as though experiences could generally be grouped into two of four categories: whether the experience was from the private or public systems of assessment, and whether the experience could be considered positive or negative. As is explored more fully in the following analysis chapters, these public/private and positive/negative contrasts are broken down and complicated in terms of experiences and reflections on those experiences, though they do provide the initial basis for guiding the analysis.

The interviews were then transcribed and coded for themes that corresponded to the existing literature and that emerged from the data. I began with the creation of a table, which assisted in organizing and analyzing the data. Each column of the table represented a theme, and each row represented a participant. This format allowed for the development of overarching themes, and ensured that the content of each participant's point of view was maintained. The initial basic analysis explored the interviews in terms of positive and negative experiences, as well as of the differing systems of health care that were accessed (either public or private systems of care, i.e., whether the participant experienced the assessment from a public or private mental health professional). The following

overarching themes were identified and will be developed more fully in the following chapters:

1. Positive and negative experiences alike, in light of both the system being accessed, and the individual social locations of the participant (in terms of the intersectionality of points of privilege and marginalization).
2. The highly variable, complicated, and continuously changing health care system, combined with the roles of expectation, luck, and self-advocacy (and the ways in which these have impacted the participants).
3. The health care practitioner as gatekeeper.
4. The variability in how this role is taken up by individual practitioners.

A case study approach (Merriam, 1988) was used to map out three participants' experiences in greater depth by tracing the experience step by step. This approach was chosen in part because of how complicated some of the participants' experiences were; examining them with a greater level of detail enhanced the clarity of what happened in each situation, and also provides a springboard for the following analysis chapters. A case study approach also contributes to the existing literature by offering rich evidence of what actually happens to people who pursue medical transition in Nova Scotia. Rather than attempting to highlight snapshot experiences of the various steps out of context, the three case studies go into a level of detail that demonstrates the confusion, variability and stress to which healthcare systems can subject people in order to receive treatment.

By way of conclusion, this project considers the significance of the resulting findings, along with recommendations for change to the system of gaining access to transition-related medical care in Nova Scotia. My recommendations stress the feasibility

and necessity of developing an informed consent model for gaining access to HRT in Nova Scotia, as well as for strengthening the current public system to ensure that all clients have the opportunity to pursue transition in as free and appropriate a manner as possible — while also considering a recommendation to downplay the normalized role of a private therapist in the role of assessment. This project also has further-reaching relevancy in considering the ways in which transgender people are treated by health care professionals more generally, and is significant to those within the fields of social work, nursing, medicine, surgery, and other primary care fields. Thus, the findings may be used to help guide policy and health services in regards to best practice strategies for treating transgender clients — as well as in the development of more generally anti-oppressive policies and practices, which could improve transgender adults’ overall experiences within mental health and primary health care encounters. Finally, throughout the thesis, I draw directly on the words of participants, in which the participants “speak for themselves”. Such an approach is long standing within critical social work research, and reflects a trust in the perspectives and convictions of participants, rather than diluting them with my own speculations about what they meant to say. In the following chapter, I provide a review of the relevant literature on medical transition in Canada, as well as a more fulsome discussion of the medicalization scholarship. Here, the objective is to contextualize the findings put forth in the latter part of the thesis, and to begin to develop the conceptual framework that shapes my analysis.

Chapter 2 provides an overview of the theoretical framework in which the research is rooted. It explores the process of medicalization and how it has been used to control marginalized bodies, including women (and other female-assigned-at-birth

people), LGBTQ+ people, and transgender people. Chapter 3 examines the experiences of transgender people in Canada, and details the competing models of transition-related care that exist within healthcare systems.

Chapters 4, 5, and 6 provide analysis. Chapter 4 explores three case studies of participants whose stories highlight important aspects of the various systems of accessing transition-related care in Nova Scotia, with a focus on the private system of care. Chapter 5 traces the experiences of participants with a focus on public access. Chapter 6 offers a reflection of the experiences, and more broadly on the state of the various systems, with a focus on the participants' specific actions taken within the process. The conclusion provides recommendations given by the participants, as well as some consideration of systemic changes to the concept of assessing and diagnosing transgender people prior to access to care.

CHAPTER 2 | The Medicalization Debates

Following a brief introduction to “sex” and “gender”, this chapter turns to the medicalization debate within transgender scholarship and activism. Here, the objective is to provide additional insight into the process of medicalization, while assessing its worth vis-à-vis access to medically assisted gender-affirmation care. Calling attention to the distinction between “sex” and “gender” has been a long-standing project within the feminist, queer, and transgender academy; efforts that have been paralleled within activist communities since the late 1970s (Muehlenhard & Peterson, 2011). These conventionally taken-for-granted terms correspond to deeply held beliefs and practices concerning the social and physical differences and similarities of human bodies. Historically conflated — such that to have a penis was to be a “man” and to have a vagina was to be a “woman” — sex and gender have been central to socialization, divisions of labour, and social hierarchies for several centuries (Scott, 1999). This is particularly true in European contexts, as well as the context of settler colonialism in the Americas (Moane, 2010; Jacobs, Thomas & Lang, 1997). The dominant conceptual and practical correlation between sex and gender has been central to the project of mainstream medicalization (and its adjoining violence). As such, understanding their history and contemporary disentanglement is critical for understanding medical transition.

While sex is often used to describe the physical, biological categories of “male” and “female” (which is to say, a binary of contrasting chromosomes, gonads, genitals, hormones, and secondary sexual characteristics such as breasts or body hair), and gender is often contrasted with sex to be a social and psychological identity, the apparent distinction between sex and gender becomes more complicated upon further examination.

That many sexual characteristics — such as hormone levels, secondary sex characteristics, and genital configuration — are all changeable via medical intervention (to say nothing of the existence of intersex people, who are considered to have “atypical” chromosome types or other sex characteristics) already implies that sex is not strictly a fixed biological destiny of two stable categories of male and female. Gender can then be thought of as the socially constructed expression of sex; for instance, the idea that women are primarily responsible for the care of small children is an example of a gender role which is informed by sex-based reproductive systems (an assumption that becomes complicated when taking into account the fact that some trans men and non-binary people can give birth, and that trans women and some non-binary people are unable to). That said, many aspects of gender are not as strictly tied to sex and are more changeable and variable across historical periods and cultures (such as gender norms in fashion). Although there exists a long-standing feminist literature that maps gender to biological function and/or social role (Petchesky, 1984; Flax, 1987), for the purposes of this project the concept of gender will be viewed in terms of internal psychological identity — while integrating feminist perspectives of gender as a system in which men oppress women (as well as others who may be considered “non-men”). This is consistent with queer scholarship that, over the last several decades, has elaborated, expanded, and refined notions of gender as socially constructed and malleable (Wlchins, 2011; Elliot, 2016; Bornstein, 2013).

The term “sex assigned at birth” is used by transgender people (and some intersex people) to describe the determination made — typically by a medical profession based on observed genitals — of male, female, or intersex at birth. “Sex assigned at birth” as a

designation signals a potential contrast with one's actual gender identity, as well as with sex characteristics that, once again, may be altered via hormones or surgery. Following from theories of sex and gender that developed in the 1980s, the term "transgender" is typically viewed as an umbrella term describing anyone whose gender does not match their "sex assigned at birth" (Stryker, 2008; Stryker & Whittle, 2006). The term "transgender" (frequently shortened to "trans") is an adjective. For example, one would describe a transgender man as someone whose sex was assigned female at birth but psychologically and socially identifies as male. Similarly, a transgender woman is someone whose sex is assigned male at birth, but psychologically and socially identifies as female. (Though historically common, and frequently misused, describing someone as "a transgender" or as "transgendered" is not correct usage.) The term "cisgender" refers to those whose gender *does* match their sex assigned at birth (sometimes deemed the "opposite" of transgender); for example, a cisgender woman is someone who was assigned female at birth and identifies as female. The language of "cis" is particularly important given the ways in which gender variance has been regarded as just that: a variation. Here, the question is, *in relation to what?* Put differently, *cis* signals the ways in which all gender is, in the first instance, constructed and in the second, that to be cis is to have gender; it is not the "neutral" or "natural" position against which gender is understood, identified, or measured (Cava, 2016).

Because "transgender" is an umbrella term, it is inclusive of those whose gender does not fit within the dominant socially constituted male/female binary of gender (Richards, Bouman, & Barker, 2017). A transgender individual whose gender is outside of the gender binary may be "non-binary", "genderqueer", "agender", or a similar term.

There are also many culturally specific terms, such as two-spirit, which is an Indigenous term describing someone who does not identify as exclusively male or female, and which can also describe an Indigenous person who occupies a third gender role. Identities such as Two-Spirit underline the ways in which the current understanding of the gender binary is a Western model of knowledge that was used in colonization and imposed upon indigenous cultures whose framework and traditional understanding of gender not only varies among differing Indigenous nations, but also can look altogether different from the Western gender binary.

Medicalization and the Construction and “Normalization” of Gender

Briefly defined in this work’s introduction, medicalization is a concept that draws attention to how a range of health professionals ascribe medical significance to otherwise routine physical experiences. Put differently, medicalization is a social process in which the experiences of individuals or groups that may be otherwise interpreted as “nonmedical” become classified and treated as medical problems, illnesses, or syndromes. As Conrad & Schneider (2010) explain, medicalization “encourages medical solutions while ignoring or downplaying the social context of complicated problems” (p. 75). Such a process effectively serves to pathologize — to make problematic and to align with illness — naturally occurring physical phenomena. Of importance is that despite reference to objectivity and neutrality, medicalization draws on dominant discourses and ideologies to determine what is (and what is not) problematic. As such, naturally occurring physical phenomena as experienced by populations on the margins is regarded as deviation (from an unstated, though always present and powerful, norm) and as illness. Gender — but more precisely, the experiences of those who are not “typically” male

(white, heterosexual, middle class, and other privileged social locations) — has been subject to a protracted history of medicalization, the legacy of which underpins the experiences of individuals seeking medical transition in the contemporary moment. The history of medicalization, then, provides an important foundation for understanding how gender is understood and handled in healthcare systems, as well as for unpacking the two competing models of access to transition-related care for transgender people in Nova Scotia: either psychological evaluation leading to a diagnosis of Gender Dysphoria, or, more recently, an informed consent model of access.

As argued in and across more recent critical scholarship, medicalization (despite its early pathologizing tendencies) can lead to both negative and positive effects for individuals (Conrad, 2007; Kvaale, Haslam, & Gottdiener 2013). Critical accounts of “medicalization from above”, or “medical imperialism”, maintain that doctors and other health professionals are the dominant actors of medicalization, and that, through their actions, they seek to reinforce social hierarchies by pathologizing people and experiences that lay outside of the privileged norms (Bury, 2006). At once, this means that medicalization can re-define relatively uncommon issues (for example, alcoholism and obesity) as medically treatable conditions, while re-defining ubiquitous experiences (for example, menstruation and pregnancy) as medical problems requiring professional study and intervention (Furedi, 2006). Medicalization “from above” seeks to reaffirm medical authority, broaden medical spheres, and control social experiences that are not necessarily harmful if untreated. As a result of this re-framing, medicalization can stigmatize or pathologize social issues, can be used to justify unnecessary intervention, and can be used to deny human rights and oppress those who may not have the resources

to combat medical authority such as women, people of colour, and LGBTQ+ people (Kurz, 1987; Witzig, 1996; Epstein, 2003).

Medicalization and Feminist Perspectives

Medicalization is an essential mechanism through which the disciplining of gender has occurred. An expansive feminist scholarship has explored the medicalization of gender, but more precisely “women’s bodies” (i.e., bodies that are conventionally considered female or otherwise “non-male”) and their biological functions (Purdy, 2001; Kaufert & Gilbert, 1986; Bancroft, 2002). Through the process of medicalization, these bodies (“women’s bodies”) are othered and pathologized in a medical context that simultaneously prioritizes and reproduces a patriarchal view of what is healthy and functional (Plechner, 2000). Here, women posited as “other”, or as a deviation from (“healthy” and “normal”) men, require on-going and invasive treatment, intervention, and as a result, surveillance. A prominent example of this is the sharp decline of birthing at home with a female midwife (and the consequent rise of birthing in hospital, attended by a typically male doctor and using newly developed medical interventions) throughout the 19th and 20th centuries in North America and Europe, as documented by feminist historians (Cahill, 2001). Contemporary feminist reactions to this process of medicalization included reclaiming birth as a natural process with no need for unnecessary interventions, and to attempt, where possible, to relocate birthing outside of hospitals and into homes and birthing centres.

Feminist researchers have also argued that higher levels of depression and anxiety observed in women (one in four women, as opposed to one in seven men) is largely due to the medicalization of women’s normal range of emotions (Afifi, 2007), and to the

medicalization of women's normal reactions to a world that expects them to perform continuous unpaid reproductive and caring labour on top of working outside of the household (Mullin, 2005). Rather than questioning the social structures that place women under extreme and often unmanageable stress, the dominant model of care addresses such reactions through medication or other forms of medical intervention (so that women can better cope in a patriarchal world). As this example illustrates and as is argued across the feminist literature (Torres, 2015), then, medicalization serves to legitimize the system that burdens women through modifying women's ability to manage day to day demands. If extended periods of paid parental leave could be freely guaranteed, or if monthly menstruation leave were a normalized option, these structural societal changes may create conditions where women experience lower rates of mental illness; ultimately, a more supportive world would be one that sees the biological functions of childbirth and menstruation as normal human experiences, and provides for them accordingly (Hyde, Klein, Essex, & Clark, 1995).

While the early feminist literature largely prioritized an exploration and critique of the medicalization of cis women's (and other female-assigned-at-birth people's) experiences of reproductive issues and rights (Brubaker & Dillaway, 2009), this process also affects people of other marginalized genders (Dewey & Gesbeck, 2017). In particular, transgender people's otherwise normal experiences of their gender have become heavily pathologized in a cisnormative society, and their experiences of themselves and their own bodies have become symptoms of a diagnosable and treatable condition (i.e. gender dysphoria). And yet, in the contemporary moment in Canada (and to an extent the United States and several European states), medicalization has also

resulted in the validation of transgender identities, as diagnosis results in access to gender-affirming and life-altering treatments such as speech therapy, facial feminization, and breast, chest, and genital surgeries. Indeed, while the academic work on medicalization overwhelmingly focuses on its overt negative effects, it is clear that benefits such as collective identity formation and recognition are so significant that many scholars now argue that lay people have as much power within the direction of medicalization as health professionals (Bury, 2006; Cacchioni & Tiefer, 2012). Academic work on this topic can represent groups who are advocating for de-medicalization, increased medicalization, or some mixture of both elements, and how they relate to health professionals. The following section explores the on-going debates around medicalization vis-à-vis sexuality and gender.

Medicalization and LGBTQ+ Perspectives

The medicalization of non-heterosexual sexuality and gender non-conformity has been used to both deny people rights (to the point of justifying the use of conversion therapy in children and adults), and to promote acceptance and inclusion of LGBTQ+ people. Regarding the former, medicalization is often critiqued (as described above) as restrictive, limiting what can be considered “normal” and incorrectly portraying societal issues as individual deviations while ignoring alternative social commentary or solutions. At the same time, one positive outcome of medicalizing sexuality was the promotion (beginning in the late 1970s) of the concept of “born this way” (that LGBTQ+ people were born as their respective genders or sexualities; i.e. it is not a choice) (Cass, 1979; Harrub, Thompson, & Miller, 2004). In this vein, a number of studies sought to demonstrate the existence of a “gay gene”, or some biological or evolutionary cause

which results in the existence of LGBTQ+ people (O'Riordan, 2012). While critical scholarship might view such projects as wedded to biological determinism, these arguments used medicalization to their advantage, challenging the heteronormative notion that there is a “normal sexuality” and that LGBTQ+ decide to deviate from that norm of their own accord (and could simply be heterosexual if they wanted to be); rather, as the argument goes, because LGBTQ+ people are instead “born this way” (or the result of a “gay gene” or similar), this is a form of medicalization that actually serves to challenge what “normal” can look like.

While medicalization has been characteristically portrayed as a force happening *to* individuals outside of medical realms, more recent work challenges both the assumption that people are passive patients unable to resist the effects of medicalization (Wardrope, 2015), as well as the assumption that the effects of medicalization are inherently and always harmful (Hofmann, 2016). In contrast to medicalization “from above”, medicalization “from below” considers the role of lay people in the process of medicalization, and medicalization itself as something that lay people can purposefully engage to their own ends. In this way, medicalization helps to fashion and maintain a social identity of group experiences, encourages social acceptance, and advocates for access to treatment (Dillaway, 2017). In this regard, and as a number of transgender scholars argue (Johnson, 2015), medicalization can be powerfully validating to certain populations and can operate outside of medical arenas. Indeed, as this literature explores, these individuals are not merely responding submissively to the domination of medicalization “from above”, but are active participants who can make choices as to which aspects of medicalization to accept as beneficial and which aspects to reject or

critique as detrimental (Riseman, 2016).

The 2013 revision of the American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders, or DSM-5, is the first major overhaul of the manual since 1994 and the result of fourteen years of revision (APA, 2014). The DSM is a widely used source of diagnostic and treatment authority for American and Canadian health professionals working with individuals and their mental health. The APA revised several classifications in the DSM-5, receiving widespread attention and discussion from mainstream media outlets, online writers, and activists.

Up to 2013, transgender individuals wishing to medically transition (i.e. affirm their gender identities by undergoing hormonal or surgical procedures), would receive a diagnosis of "Gender Identity Disorder" by a psychologist or psychiatrist. However, understanding gender variance as a medical issue goes as far back as late 19th-century European sexological theories on "sexual inversion" and "cross-gender behaviour" (Hekma, 1996). The first edition of the DSM, published in 1952, included a broad category of diagnosable sexual deviance, "homosexuality", which encompassed and conflated homosexuality with "transvestitism" (Spitzer, 1981). "Homosexuality" as a diagnosis was finally dropped in a revised publication of the DSM-2 in 1973, largely in response to years of gay rights activism targeting the diagnosis in the late 60s and early 70s. "Homosexuality", however, was not entirely dropped, as it was replaced by "Sexual Orientation Disturbance" in 1973, which made homosexuality diagnosable only if the individual felt significant distress due to their sexual orientation (Spitzer, 1981). The DSM-3 was published in 1980, which first introduced "Gender Identity Disorder" as a separate diagnosis from the now removed diagnosis Homosexuality (Zucker & Spitzer,

2005). The DSM-3 diagnosis had several subtypes, including Transsexualism, Gender Identity Disorder of Childhood, and Atypical Gender Identity Disorder; it was located in the chapter called “Disorders Usually First Evident in Infancy, Childhood, or Adolescence”.

Gender Identity Disorder was revised again in 1994 for the DSM-4; in this edition, it was placed in a diagnostic chapter of Sexual and Gender Identity Disorders. The Transsexualism and Atypical diagnoses were replaced with a single diagnosis referred to as “Gender Identity Disorder in Adolescence or Adults” (Burke, 2010). The Gender Identity Disorder category has remained unchanged up until the DSM-5 publication in May 2013. In 2010, the APA released a draft for public review and feedback indicating a proposed new name for the diagnosis: Gender Incongruence, with two subcategories for adults and children (Burke, 2011). In 2012, the APA released another draft indicating that the name would instead be changed from Gender Identity Disorder to Gender Dysphoria to be more in line with current terminology; whereas Gender Incongruence was a newly coined term, Gender Dysphoria was previously routinely used to describe the symptoms associated with Gender Identity Disorder. The subcategories remain, and a post-transition specifier was added for those who have transitioned but continue to require access to gender-related treatments. Gender Dysphoria is also now situated within its own chapter in the DSM-5, and will be separated from Sexual Dysfunctions and Paraphilic Disorders.

The renaming of Gender Identity Disorder to Gender Dysphoria received a large amount of coverage by popular LGBTQ+ news websites (Heffernan, 2012) and some mainstream news outlets (Parry, 2013), as well as a significant amount of online

discussion and critical analysis by transgender activists (Winters, 2012). The changes in the DSM-5 were hailed, by some, as progress and a turning point in LGBTQ+ history, drawing parallels to the deletion of “homosexuality” as a diagnosis in the 1974 edition of the DSM, and underlining the supposed fact that transgender people are now no longer considered a “disordered identity” in psychiatry (Knudson, De Cuypere, & Bockting, 2010). A significant portion of the transgender community addressed and analyzed these changes and offered their own insight: while some saw this as progress, others still pointed to the question of why transgender people must have a gender-related DSM diagnosis at all (Serano, 2009).

Gender Identity Disorder (GID) as a DSM diagnosis corresponds to a debate between and amongst health professionals, academics within transgender studies, and transgender activists concerning the value of “more versus less medicalization” (Burke, 2011). Several scholars have stressed that the diagnosis of transgender identity as the medicalization of gender variance (Drescher, 2010; Reicherzer, 2008; Sennott & Smith, 2011), and much of their research is highly critical of medicalization. For example, a growing number of critical scholars suggest that the diagnosis of GID represents an effort of the medical establishment to reaffirm the normative binary gender system through the portrayal of gender variance as an individual biological deviance, rather than a socially constructed and valid occurrence (Serano, 2009; Spade, 2015). The medicalization of gender identity through the inclusion of GID in the DSM is also regarded by many academics as reinforcing the need for medical “gatekeepers” who have the authority to approve or reject transgender individuals’ access to transition-related health care on the basis of their compliance to problematically defined gender standards (Burke, 2010,

2011; Reicherzer, 2008; Dubov & Fraenkel, 2018). For example, according to Burke (2011), “the position long-held among medico-psychological professionals — as well as the general public — [is] that gender variance, at least in certain forms, is the rightful territory of the medical and mental health fields” (p. 191).

The recently published DSM-5 has also generated considerable interest amongst transgender activists, for whom there has been a range of responses to the modified diagnosis. While many argue that without the diagnosis, it may become difficult for public healthcare and insurance companies to cover medications and surgeries that many transgender people require (Cruz, 2014), others point to the way it might be applied to those who may never transition, or indeed never identify as transgender (Lev, 2013). Conrad & Angell (2004), for example, argue that while homosexuality has been significantly demedicalized, the diagnosis of gender dysphoria points to a possible re-medicalization of sexuality variation due to its application to gender nonconforming children:

GID may be medicalizing pre-homosexual behavior, and thus, contributing to the potential re-medicalization of homosexuality... Even the most ardent critics of the diagnosis, however, lobby for gender identity “reform” rather than removal; they propose the demedicalization of GID in childhood, but allow for some form of medicalized transsexualism to enable sex change operations (p. 35).

According to Burke (2010; 2011), “the debate over diagnosis and medicalization is a struggle over the definition of transgender as an identity versus a disorder.” Focusing on medicalization, pathologization, and diagnosis of transgender identity, her work involves in-depth interviews with transgender activists. According to her findings,

transgender activists generally and overwhelmingly reject the stigmatization that is associated with the medicalization of transgender identity. However, importantly, a significant number of these activists simultaneously reject a totally de-medicalised model. Rather, many embrace some of the medicalizing aspects of Gender Dysphoria as a mechanisms through which to access gender-confirmation hormones and surgeries. Burke emphasizes the importance of examining the medical forces surrounding transgender identity in a nuanced and more complicated manner. She writes:

...scientific and medico-psychological institutions are often central targets of transgender activism in so far as they shape not only the medical and mental health treatment of trans people but also centrally inform how gender variant individuals are defined as persons for the purposes of accessing rights of citizenship. Institutions such as the state still defer to medicopsychological institutions and actors in deciding who counts as a (trans)gendered [sic] citizen, a decision that has far-reaching ramifications if one considers how basic documents such as licenses, social security cards, and passports shape our ability to move freely, not just in terms of travel but in our everyday encounters with people and institutions (Burke, 2010, p. 5).

Similarly calling for more detailed and nuanced readings of the new diagnostic criteria, Rettew (2012) argues that the debate surrounding the inclusion of gender identity as a psychiatric diagnosis reveals many of the “fundamental shortcomings and inconsistencies” of the current APA classification and diagnostic system. And yet, Rettew underlines that fact that while healthcare for transgender individuals focuses on altering the body to create positive outcomes, most other psychiatric conditions

emphasize long-term changes of internal thoughts, feelings, and behaviours; thus transgender identity and its related diagnoses can be understood as separate from “other” mental illnesses. Other recent work surveying health professionals and psychiatrists, revealed that many working with the DSM believe that Gender Identity Disorder should remain in the DSM, but that it be renamed to something less stigmatizing, as the terms “identity disorder” might suggest the issue lies in the individual’s identity, and not with their physical body (Knudson, De Cuypere, & Bockting, 2010).

Transgender activist Julia Serano’s 2009 work *Psychology, Sexualization and Trans-Invalidations*, and transgender activist Kelley Winter’s 2008 book *Gender Madness in American Psychiatry: Essays from the Struggle for Dignity* offer a counterpoint to these more cautiously-optimistic takes on GID in the DSM-5. According to Serano, “mental health professionals play down or outright dismiss trans people’s concerns regarding psychological depictions, diagnoses, terminology and theories about transgenderism” (2009, p. 1). The DSM and its related diagnoses, she argues, inevitably cause transgender individuals harm:

I feel that a major obstacle that we as a trans community face is getting the greater psychological establishment, as well as the general public, to appreciate why our concern is legitimate, and to get them to understand in really concrete terms how certain psychological theories, therapies, terminologies and diagnoses cause us very real harm and injury, and therefore should be done away with.” (p. 2)

Serano and Winters describe the many ways medical institutions put forth “trans-invalidations... based on [presumed] mental inferiority or incompetence” (p. 5), which include use of “maligning language”, the existence of the Transvestic Fetishism

diagnosis, and the application of GID to children, people who may be gender-variant but may not be identified as transgender and require no treatment. Serano writes, “as long as the DSM and gatekeeper system position [themselves] as an authority on gender variant people, what [they have] to say will always effectively silence me. And that, frankly, makes me very legitimately angry” (p. 8).

Serano describes how the current model of medical care makes the position of the health professional above the experiences of transgender individuals — who largely do not see their experiences of gender and their bodies as something to diagnose, to label as “other”, and to treat from the perspective of cisgender health professionals. Similar to the experiences of cisgender women who saw their natural bodily functions unnecessarily medicalized and placed within a medical environment for unnecessary medical interventions, many transgender activists see their experiences of gender as within the realm of normal human experiences, and not something in need of psychiatric assessment, therapy, and diagnosis in order to receive approval for treatment. Winters (2012), for examples, argues that:

My objective for GID reform in DSM-5 is harm reduction — depathologizing gender identities, gender expressions or bodies that do not conform to birth-assigned gender stereotypes, while at the same time providing some kind of diagnostic coding for access to medical transition treatment for those who need it. I and others have suggested that diagnostic criteria based on distress and impairment, rather than difference from cultural gender stereotypes, offer a path for forward progress toward these goals.

From these varied perspectives, two models of care of emerged, each responding

differently to the critiques and concerns of trans scholars and activists. Elaborated in the next section and following a brief history of access to transition-related care, these are the WPATH model and the Informed Consent Model. What is important to note is that both models are used in Canadian and Nova Scotian contexts — such that, different individuals seeking to medically transition may have drastically different experiences despite their physical proximity and provincial residency.

CHAPTER 3 | Operationalizing Medicalization Or Not: Competing Views On Access

Having offered an overview of the medicalization debates within the critical (feminist, queer, and trans) scholarship, this chapter explores the national and provincial contexts navigated by individuals seeking to medically affirm their genders in Nova Scotia before offering a detailed account of the two models of transition-related care that exist in the province. This discussion is read through the framework of medicalization, which, despite its largely negative and pathologizing consequence for transgender people, has been — in recent years — used strategically to assert the rights of transgender people and to establish lines of access to necessary medical care.

There is little literature in Canada on transgender individuals experiences outside of large urban centres (Travers et al., 2013). There have been several recent projects to explore these experiences on a large scale and in-depth in Ontario and British Columbia, such as the *Being Safe, Being Me* survey (Saewyc et al., 2015), which surveyed close to one thousand transgender youth across Canada and was primarily made up of respondents from Ontario and British Colombia, and the Trans PULSE project (2010), a transgender-led community research initiative which collected information (through surveys and interviews) from 433 transgender individuals in Ontario, which has been releasing ongoing research studies from this population for nearly a decade. Studies like these reveal a general picture of what daily experiences are like for transgender individuals in large Canadian cities: *Being Safe, Being Me* (2015) revealed several key findings. Eighty-three per cent of participants “lived in their ‘felt gender’” (publicly expressed their gender identity) at least part-time, and half did so full-time. Those who did so all the time were almost 50 percent more likely to report good or excellent mental health. Nearly two-

thirds of participants reported self-harm within the past year. More than one in three had attempted suicide. Seventy percent of participants reported sexual harassment. Two-thirds reported discrimination because of their gender identity. More than one in three, or 36 percent, of participants ages 14-18 had been physically threatened or injured in the past year. One in three youth did not have an adult in their family they could talk to about problems, and seven in 10 felt their family did not understand them. When they felt cared about and supported by family, they reported better health.

What is known within healthcare is troubling. Saewyc and colleagues' (2015) national survey of 932 Canadian transgender youth found that 53% of transgender youth age 14-25 have family doctors who know about their transgender identity, and of those, just 15% feel "very comfortable" discussing transgender-related healthcare needs — even fewer reported this comfort level in walk-in clinics. One-third of younger (ages 14-18) and half of older youth (ages 19-25) reported missing needed physical health care during the past year, and even more missed needed mental health care (Saewyc et al., 2015). While *Being Safe, Being Me* paints a fairly grim picture for the experiences of transgender young people, the project does emphasize that outcomes are improved when transgender individuals are able to be "out" and have supportive family members. The Trans PULSE project from Ontario reports similar findings in that it zones in on the experiences of social exclusion and the impacts that transphobia have on health and other day to day experiences. Their 2015 report (Bauer & Scheim) provides robust statistics on the lives of transgender people in Ontario. For example, their statistics support the idea that transgender people understand their identities well from a young age, despite being allowed access to explore their identity:

While they may not have had language for it at the time, 59% knew that their gender identity did not match their body before the age of 10, and 80% had this knowledge by the age of 14. Gender identity is often clear years before people socially transition to live in their core gender. While approximately 80% of Ontario trans people have socially transitioned to live their day-to-day lives in their core gender, most full-time, only 8% report that they had begun living in their core gender by age 14. (Bauer & Scheim, 2015, p. 2).

Trans PULSE also reported on the experiences of structural discrimination in Ontario. Fifty-three percent of participants could not access academic records using the correct name or pronoun. Thirty-one percent did not have correct gender markers on any identification due to barriers to this process. Thirteen percent reported being fired specifically for being trans, and another 15% reported being fired for an unknown reason around the time of social transition (Bauer & Scheim, 2015).

Violence also figures centrally in the Trans PULSE project. Thirty-four percent of participants had been verbally assaulted or harassed — specifically for being transgender — while 20% were physically or sexually assaulted for being transgender. Trans PULSE points out that the majority of these incidents go unreported, and in fact nearly a quarter (24%) of participants reported harassment from police. Of the participants who had been incarcerated, one third reported experiencing violence specific to their gender identity — in addition to any other violence they may have experienced (Bauer & Scheim, 2015).

In terms of the impacts of these statistics, Trans PULSE unpacks the effects of what it means to be socially excluded and isolated. Transgender people increasingly avoid public spaces for fear of harassment or other forms of transphobia: two thirds of

participants reported doing this, and 86% of participants did this if newly out. Fifty-seven percent of participants avoided washrooms, and other public places such as gyms, malls, schools and restaurants were all commonly avoided. In turn, transgender individuals are extremely underemployed, with the Trans PULSE study noting the median individual income amongst the project's participants was 15,000 CAD, despite nearly half (44%) holding a post-secondary diploma. Trans PULSE also indicates extremely high levels of depression and anxiety, with 43% of individuals having a history of attempting suicide. Trans PULSE points out that suicidality tends to correlate with experiences of violence and harassment. As a compounding variable, transgender individuals tend to avoid mental health (and general health) care out of fear of further harassment. (Bauer & Scheim, 2015)

Taken together, these statistics offer insight into a daily existence for many transgender individuals that is marked by struggle, isolation, violence, poverty, and physical and mental ill-health. Avoiding public places, fearing violence, have trouble finding and keeping employment, avoiding healthcare despite having pressing mental health and potential transition-related healthcare needs — all of these factors speak to the pervasive and seemingly chronic oppression faced by transgender people. Both *Being Safe, Being Me* as well as Trans PULSE point to the need for strong social support for transgender individuals to provide some protective factors against the negative outcomes that already exist. The fact that 21% of transgender people will avoid the emergency room for fear of how they will be treated as a transgender person underlines how severe the consequences can be for a marginalized population; the consequences of this truly are life or death (Bauer & Scheim, 2015). In both studies, having supportive families and

non-familial social support (such as a supportive school or workplace) are associated with far fewer cases of suicide and mental illness. Trans PULSE also speculates that the increasing recognition and protection of transgender identities within healthcare, policy, and human rights movements will result in normalization and greater social acceptance.

What is known within Nova Scotia in terms of transgender experiences relies on anecdotal evidence and small exploratory studies (Vermeir, 2016). The vast majority of studies do tend to focus on a direct tie to either improved outcomes in mental health, healthcare, or policy, rather than the day-to-day functioning of typical experiences as a transgender individual. Much of the published research out of Nova Scotia tends to add transgender to the LGBT+ acronym. As a result, this research has the tendency to obscure transgender experiences, conflating them with those of cisgender lesbian, gay, and bisexual people (Colpitts & Gahagan, 2016). The national survey of transgender youth experiences, *Being Safe, Being Me*, recently released a specific analysis of their respondents in Atlantic Canada; of the nearly one thousand participants, just 63 were from Nova Scotia, leading to any differences in this region to be drowned out by the hundreds of respondents in Ontario and other provinces.

While limited in scale and scope where the Atlantic region is concerned, the survey does offer some insight into the experiences of transgender people in Nova Scotia, and serves as an important starting point for more detailed work. The Atlantic provinces survey of *Being Safe, Being Me*, released in 2018 (Gahagan, Ferguson, Saewyc, Frohard-Dourlent, & Veale), included 122 youth from PEI, New Brunswick, Nova Scotia, and Newfoundland and Labrador. This analysis tended to highlight greater disparities in the Atlantic provinces as compared with the national findings. One that stood out was a

question on “school connectedness”. Transgender youth in Atlantic Canada had the lowest reported scores of school connectedness (3.8/10) compared with all provinces, with the average being 4.9/10. Transgender youth in the Atlantic provinces also notably reported far greater discomfort with doctors: 90% were “very uncomfortable” with a walk-in doctor (versus 69% national); 77% were “very uncomfortable” with their family doctor (58% national). In the survey’s consideration of hormone use, 21% reported being unable to take hormones because they can not find a doctor who will prescribe (13% national), and 17% reported getting hormones from a friend or relative (10% national). When Atlantic trans youth were asked about emotional distress, 53% reported the highest level of emotional distress (28% national). The survey concludes that there are serious concerns in Atlantic Canada and recommend initiatives to provide support to the families of transgender youth, developing safer schools, appropriate healthcare services, and initiatives to address the striking disparities between Atlantic Canada and the rest of the country:

In some areas of health, the provincial differences were striking. Trans youth in every province should have equitable access to safe schools, high quality health care, and supportive networks for them, their families, and their peers. This requires commitment from a variety of government agencies to work to eliminate the cross-provincial disparities in access to care, and ensure policies and programs are supportive, not discriminatory (p. 69).

While there does exist, then, a fairly comprehensive (if small) body of literature on the experiences of transgender individuals both in Canada, as well as one emerging in Nova Scotia, these studies are mainly focused on daily occurrences of harassment and

transphobia, or to specific health outcomes or engagement with the healthcare system broadly. Less developed in Canada, and relatively non-existent in Nova Scotia, is a research literature that focuses on the experiences of accessing transition-related care in the early stages of transitioning. As described in the introduction, this study's objective is to begin redressing this gap through the provision of an in-depth exploration of the experience of transgender individuals who are seeking medical services to affirm their gender identity (such as hormone therapy or surgery) in Nova Scotia.

In Nova Scotia, transgender individuals wishing to transition, that is, align their lived gender to their outward appearance, are able to pursue medical interventions such as hormone therapy or surgery (Pride Health, 2013). To do this, current standard practice requires that transgender people undergo an assessment by a mental health professional who determines if they meet the DSM criteria for gender dysphoria. In Nova Scotia, transgender individuals are either assessed through Community Mental Health Services or through private mental health practitioners using the Standards of Care.

A small body of literature offers insight into the history of gaining access to treatment as being variable and unnecessarily prolonged, such as enforcing a "real life test", in which the individual must openly and publicly express their internal gender before being allowed hormonal transition. Reisner et al. (2015) describe work done in an LGBT+ clinic in Boston that began, in 2007, doing away with specific requirements that "have long been embedded in existing standards of care," including the "real life test" as well as mandated therapy to gain access to transition-related care. Other studies have reported a perception by health professionals that hormone therapy is either risky or unsafe (Weinand & Safer, 2015) or that it does not positively impact mental health

functioning (White Hughto & Reisner, 2016). Levine (2009) explains that the “real life test” has been a mandated part of transition-related care for over four decades, and their research recommended that the practice be dropped in favour of individuals’ self-determination. The real life test (later renamed real life experience) was an element of the Standards of Care (SOC) put forward by the World Professional Association for Transgender Health (WPATH), the first set of standards having been released in 1979 (Walker et al., 1979). The aim of the original standards was to set standards for assessment and determination of eligibility for hormone therapy or surgery. These standards set a precedent that the recommendation to hormone therapy or surgery will be made by a psychologist or psychiatrist (Coleman, 2009).

The Standards of Care are updated approximately once every decade, and by the year 2001 (the sixth edition), the requirements for hormone therapy were: Age 18 years (exceptions can be made); 3 months of real-life experience, or a minimum of 3 months of psychotherapy; informed consent; and one letter from a behavioural clinician to a physician (Coleman, 2009). This marked a change in which three months of ongoing therapy could be substituted for the real-life experience, which was implemented in the sixth version of the standards of care in 2001. The seventh edition was released in 2012; at present, the requirement for the initiation of hormone therapy may be undertaken after a psychosocial assessment has been conducted and informed consent has been obtained by a qualified health professional. A referral is required from the mental health professional who performed the assessment, unless the assessment was done by a hormone provider who is also qualified in this area (Standards of Care, WPATH).

In sum, the criteria for hormone therapy are as follows:

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country (if younger, follow the SOC outlined in section VI);
4. If significant medical or mental health concerns are present, they must be “reasonably well controlled” (Standards of Care, WPATH, p. 34).

Increasingly, there is indication that transgender individuals do not wish to be diagnosed with gender dysphoria as a prerequisite to obtaining hormone therapy or surgery, and do not wish to complete therapy as a requirement to transition (ICATH, 2018). There is also a growing body of literature indicating that despite these WPATH standards of care, experiences are highly variable and often negative, and many transgender people continue to be unable to gain access to hormone therapy or surgery. Giblon & Bauer (2017) studied the inequities of healthcare use among transgender and cisgender people in Ontario and reported that transgender individuals avoid using healthcare due to a range of barriers from lack of provider knowledge to refusal of care. Rotondi and colleagues (2013) found that a quarter of transgender individuals in Ontario using hormones have at some point obtained them through a non-prescribed source (which is to say, a friend, family member, internet source, or stranger). Of that quarter, 6.4% continued to do so up to the time of interview or survey. The researchers conclude that past negative experiences with providers, along with limited financial resources and a lack of access to transition-related services, may contribute to non-prescribed hormone use as well as self-performed surgeries in a small minority.

Informed consent is an emerging alternative to the Standards of Care put forth by

WPATH. There is a small but important and growing body of literature suggesting that it is a safe and effective model of care that re-emphasizes the individual's agency and choice around medical transition, and de-emphasizes the necessity of diagnosis and of mandated therapy. Schulz (2018) writes, "Historically, researchers and clinicians have viewed the transgender experience through a narrow diagnostic lens and have neglected to acknowledge the diverse experiences of those who identify as transgender. This model shows promise for the treatment and understanding of the transgender experience outside of the lens of medical pathologization". Deutsch (2012) surveyed twelve American clinics who provide informed consent and found that no cases of malpractice claims or judgments relating to regret about the use of informed consent were reported. Only 4 of 12 sites required any contact with a mental health provider prior hormone therapy. A minimum number of visits prior to beginning treatment was required by only 5 clinics.

Contemporary Approaches

The WPATH model. Perhaps the largest worldwide organization advocating for high quality, accessible transgender health care, the World Professional Association for Transgender Health (WPATH) continues to promote standards of care that centralize the role of the mental health practitioner to assess and diagnose gender, and serve as access points to treatment. While recognizing the important work of the organization, many activists, researchers, and service providers argue in favour of a model that avoids such pathologization of normal experiences of gender identity. As a result, there are now — in principle — two options of pursuing transition-related care for transgender individuals: the WPATH model and the Informed Consent Model. Despite growing consensus concerning the benefit of the Informed Consent Model (detailed below), many sites

across Canada continue to only offer the WPATH model of care provision. This means that transgender people across the country, depending on location, could experience two very different streams of healthcare. In the traditional model, people may be required to attend therapy and to spend time living as the “opposite gender” before they are able to access health care, or to effectively “prove” to the therapist that they meet whatever standards are put in place to meet criteria. The traditional model also tends to dictate a binary model of trans male versus trans female, leaving non-binary and genderqueer people to risk “failing” their gender assessment — or to perform a gender narrative to the therapist that may not be authentic — simply to gain access to treatment. Ultimately, this model puts the decision-making in the hands of the mental health professional, and transgender people must seek permission and eligibility before accessing treatment.

Informed consent. In response to this model of gatekeeping for access to treatment, in recent years some cities have adopted a different model of access than what is officially endorsed by WPATH (Cavanaugh, Hopwood,, & Lambert, 2016). While the WPATH guidelines for access to hormones require an assessment by a mental health professional, and the endorsement by the mental health professional that the individual in question meets the DSM criteria for Gender Dysphoria before the individual may be prescribed hormones or referred for surgery, an alternative does exist. The Informed Consent Model permits access to transition-related care without any formal assessment for, or diagnosis of, gender dysphoria (Schulz, 2018).

The Informed Consent Model may include some counselling and some informative sessions which detail the effects of hormones or surgery on the body, such as the timeline of effects one may expect or the dosages of hormones that are typical, but,

unlike what WPATH recommends, there is no assessment that details the individual's childhood or past relationship to gender, or an assessment which details the individual's mental health unrelated to their experience of gender and being transgender. While this model is still emerging, recent research (Schulz, 2018; Deutsch, 2012; Shuster, 2019; Saad, Blackshaw, & Rodger, 2019) has suggested that this model is effective and provides care without medicalizing the transgender identity, and is more in-line with how transgender individuals see themselves; that is, as someone whose gender is not a diagnosable mental illness, but rather a condition that may require sex hormones or surgical interventions to relieve the distress associated with living in a world that does not recognize one's gender or living in a body that does not match one's gendered sense of self (Ashley, 2019).

As observed by a number of transgender scholars and activists, under informed consent, transgender people are given agency to decide when and how to transition, and are not made to seek permission or convince a professional of their eligibility or of their diagnosability (Levine, 2018). As a result, new service providing and advocacy groups have recently formed to spread awareness of the demand for this new model of care, such as ICATH, or Informed Consent for Access to Healthcare. This project argues that:

The ICATH model reflects the basic human right to self-actualization... Informed Consent is a standard of care that is acknowledged and honored by medical providers around the world. ICATH promotes a departure from a system that uses the Gender Dysphoria diagnosis, formally known as Gender Identity Disorder, as a means for accessing gender-confirming health care. (ICATH, 2019)

That said, there is a gap in the literature both on the use of informed consent broadly in

Canada, as well as the experiences of accessing transition-related care specifically in Nova Scotia. While qualitative research out of Halifax, such as Vermeir's (2016) study, suggests that barriers to care exist for transgender individuals accessing any kind of healthcare, the current study aims to specifically examine the process of interacting with healthcare systems with the goal of gaining access to hormone therapy or surgery in Nova Scotia. Since the WPATH standards of care work are flexible and allow for variation in care, it is worth asking how these standards are working in Nova Scotia, and if there is an argument to be made that Nova Scotia should move in the direction that some American clinics and forego the WPATH standards of care for the Informed Consent model of care.

CHAPTER 4 | Private Transition-Related Care in Nova Scotia: Three Case Studies

The following chapter provides an in-depth narrative exploration of the experiences of three participants. Mapping their processes from start to finish, this chapter offers insight into the varied, yet common, experiences of accessing transition-related care in Nova Scotia. While these three narratives stand out for their complexity, they also reflect a number of key findings from the study's larger sample, and moreover, the analytical insights of the existing grey literature and academic scholarship. This chapter, then, contributes to that literature and scholarship by offering in-depth ethnographic detail of the Nova Scotian context, which, as discussed in the previous chapter, is poorly represented in the scholarship as a whole. This chapter also helps to contextualize the analysis provided in chapters 5 and 6 by providing an overview of the process of accessing hormones or surgery, as well as deviations from that process.

Another critical aspect of these three narratives is that each participant primarily accessed private care in completing the assessment. While this distinguishes them from those (a larger part of the sample) who were only able to pursue treatment through publicly funded Community Mental Health, and as such may reflect class privilege and access to resources, their narratives more importantly offer insight into the tensions and complications that follow from the partial commodification of these services. Indeed, as is revealed, these young people did not necessarily have an easier time, nor was their access to the care they required expedited. Instead, in their efforts to avoid the wait times anticipated of the under-funded, multi-purpose public system, they encountered new barriers that followed from the private therapists' discretion — notably, protracted therapy that exceeded their needs, gender assessments that forced them to conform to

rigid notions of “male” or “female”, and the revisiting and reliving of trauma in the context of the therapeutic relationship.

The detail offered below is intended to provide a “thick description” of these experiences — that is, and following in the anthropological tradition of Clifford Geertz (2008), an in-depth account of the phenomenon in question read through the systems and structures that shape it. In this regard, the larger system and structures are those that splinter mental health services between public and private systems — mapping onto, broadly speaking, the social and economic context of Neoliberalism (Alfredo Filho & Johnston 2005; Lazzarato, 2009). What is important for the analysis that follows (chapters 5 and 6) is that the consequence of this splintering is not improved service. This is not to suggest perfect uniformity; individuals with resources are able to exercise more choice, and, to an extent, can navigate these systems more efficiently. But rather, as detailed below, playing off anxiety generated by the slow-moving public system, the private system syphons off people who are desperate and does not necessarily offer improved outcomes.

Liam (he/him)

Liam has a unique story. His narrative offers insight into not only inter-provincial variability, but the ways in which care is not easily transferred from one health authority to another. Liam’s experience also demonstrates how having certain advantages can lead to a smoother and more positive experience: the ability to travel between and throughout provinces, the capacity to take on the role of self-advocacy and education, having access to both public and university services, and the ability to pay for private assessments all impact the experience of accessing transition related care in Nova Scotia.

Though originally from a small town in Nova Scotia, Liam was living in Alberta where he was attending university when he first accessed transition-related care. After realizing his identity as a transgender man, and telling family and friends, Liam made an appointment with a doctor at his university clinic's walk-in service. Liam saw several doctors at this clinic over the span of year , several of whom were uneducated or unsure about the routine process. Liam persisted and continued to see other doctors through the clinic, and finally one informed him that he must be referred to a public psychiatrist. Liam reported that this doctor was rude and abrupt in saying that seeing a public psychiatrist was the "only way" he would gain access. In Alberta, similar to Nova Scotia, transgender people must either be assessed through a private or public mental health provider. In Alberta, however, according to Liam, use of the informed consent model was permitted per the discretion of a physician who had sufficient knowledge or experience around transgender health. After meeting with a third doctor at the university clinic, the doctor was open to a surgical referral but hesitant to prescribing hormones. This doctor first asked Liam himself to find the names of surgeons in Alberta, and she completed his referral to them under an assessment of gender dysphoria. Liam's doctor also referred him to the psychiatrist for the assessment for hormone therapy, for which he waited about eighteen months. While he waited, Liam said that he began to educate his doctor about hormone therapy. Liam had connections to a family member, a doctor in Toronto, who told him about the way that Toronto does it under the informed consent model. Liam gave his doctor in Alberta this information, and provided her with a website that physicians could use to become qualified to prescribe under informed consent. According to Liam, "she tried really hard to get me hormones under the informed consent [model]. It

was a little bit less than 12 months [later], she called me into her office and she was offering me hormones under informed consent.” Liam prompted his doctor’s willingness and capacity to self-educate and use this model, rather than simply direct Liam to follow the standard mental health assessment that is offered in Alberta. Instead of waiting eighteen months to meet and be assessed by a public psychiatrist, Liam’s university clinic doctor was able to learn about the informed consent model and provide a prescription in just twelve months. Following this, if another patient were to see this doctor inquiring about transition-related care, the patient would not be required to wait eighteen months for a psychiatric assessment, but perhaps only to have a few meetings with the physician to complete the informed consent.

At the same time of his surgical referral and prescription for hormones with his university doctor, Liam was under considerable stress in his personal life, especially with university. His upcoming university graduation also meant that he would lose access to this doctor who just prescribed under informed consent. In light of this upcoming change to his access, Liam decided not to begin the hormones at that time. He recalls, “I [would] have to get this needle every two weeks and she won’t be the one doing it. I wasn’t ready to start it. I was so tempted to say yes. But in the back of my head I knew it was best for me not to start. That really is an important thing to highlight because a lot of people say that you need to go see the psychiatrist because you’re just rushing into it. But no — we know when it’s right for us. We know exactly when it’s right for us. So, I said no.”

Liam graduated from university in Alberta, and he then returned to his hometown in Nova Scotia. During this time, he was still on the Alberta waitlist for publicly funded surgery, as well as the psychiatrist appointment for a surgical assessment. Several months

later, Liam flew back to Alberta for surgery. He first met with the psychiatrist for the assessment for gender dysphoria required for surgery. The psychiatrist gave approval for his surgery shortly before the date of the surgery, which was also completed in Alberta. After some recovery, Liam flew back to Nova Scotia and decided to remain in Nova Scotia and continue living in his hometown. Shortly after his surgery and now living in Nova Scotia, Liam decided he was now ready to begin hormones. He called his university clinic in Alberta about his prescription and was met with some complications; he asked to be given his prescription, and to pick up his hormones in Nova Scotia, and was told that the clinic was not able to send him the prescription (and that he needed to be present to receive it). But since he was now living in Nova Scotia, and was no longer a student with the same university, he was unable to simply return to the clinic in Alberta, and so was effectively barred from the prescription that he was initially given several months prior (but made the decision not to start). Despite having completed several steps in the process — the informed consent with the doctor at this clinic, the mental health assessment for surgery, and surgery itself — he was unable to transfer this prescription to Nova Scotia, and had to effectively restart the process in order to regain access to hormones.

Liam began by making an appointment with a sexual health centre in Halifax, travelling about 100 km from his hometown by car. He reported a very different experience as compared to Alberta: “...they were phenomenal. I was so blown away because I was like ‘it was so hard in Alberta — it’s going to be ten times harder Nova Scotia.’ Everyone was perfectly accepting on the pronouns, totally understood that it was just me wanting [hormones]. I saw a walk-in doctor, and she was phenomenal. She just looked me right in the eye and said ‘I understand how much you need these right away,

we're going to be doing everything we can to get them for you'. That right there, having a doctor who just understands the need, even if they're just legally bound to the system, changes everything. You're not hearing, 'no, the system won't let you', you're hearing 'I understand you need this. I want to help you. Here's what we're going to do to get you there as fast as possible', and that just changes the entire experience from day one."

Liam gave this doctor the form he received through the informed consent process he completed with his doctor in Alberta. He also had a letter of support from a university psychologist he was seeing for his mental health. In Halifax, Liam's doctor refused the informed consent prescription he had received from his doctor in Alberta, and insisted her follow the Nova Scotia system. As Liam explained, "Nova Scotia would simply not take informed consent. This doctor said she didn't feel that she could [prescribe under informed consent]. The sense that I got from her was not that she wasn't willing to do it, but that she legally couldn't do it." While Liam felt as though the doctor and the clinic in Halifax was more supportive and understanding as compared with Alberta, the system itself was more restrictive in the sense that assessments must be completed according to WPATH standards of care and not through the informed consent model.

While his doctor in Nova Scotia said that she would "take into consideration" his informed consent form as well as his letter of support, she did require him to provide a letter from a WPATH-certified mental health professional as well. Liam was hoping to do this as soon as possible; in order to secure a letter quickly, he would not have been able to go through the public system, but instead would have to find a private practice with some flexibility. The clinic provided Liam with the names of private WPATH providers in the province, and he reluctantly began to search for anyone with an available upcoming

appointment. As he called, he began to remove names from the list, and noted that the list seemed to be out of date as several people were not reachable or had left the practice that he had contacted. Liam also met with some resistance from the providers he was able to speak with, as he was intending to meet with someone as soon as possible, and to get his assessment finished in as few appointments as possible. He noted that many said that they did not have any appointments available, but that he was also told by several people that his timeframe and goal of having the assessment completed in just a few sessions was not realistic, and something that “would never happen” according to how the practice operates.

Liam finally found someone, a social worker who ran a private practice, about 50 km from his hometown. Liam said that the social worker was a little hesitant because he was asking to complete the assessment immediately, when, according to Liam, the protocol seemed to require several sessions in which the provider “gets to know” the individual, as well as significant time to write the letter of assessment. Liam brought the informed consent form and the letter of support from his old therapist and completed a two-hour session costing a total of \$360, for which he did not have insurance coverage. Liam recalls, “I gave her the whole story from scratch and then she gave me a twelve-page questionnaire that I had to fill out — spill my guts out on it. So I hand-wrote this whole thing about my experience and sent it off to her and then she gave me the WPATH-certified readiness letter.” Liam then took this letter back to his doctor from the sexual health clinic in Halifax — again travelling about 100 km. Liam recalls, “I don't think my doctor even read it [the letter] — she just looked at it and she was like ‘perfect you have a signature, let's go’. So that was it and then she gave me my prescription.”

Despite the complications and delays he encountered, Liam reflected positively on his experience in Nova Scotia: “As much as that process isn't great, at least it was accessible; it was informed, and it was — there [was] a way you can get there. In Alberta it was pretty much like no doctor knew anything, there was no information online, you were jumping around. At least that was good about Nova Scotia, there was information available, doctors were informed about how to go about it.”

Liam also reflected on the process of making your own decision within a system that is supportive: “I literally had to look at it from a different perspective. Because when I was out West it was ‘this is what I want, and you're telling me I don't, and I'm going to tell you that I do,’ and I didn't get much time to think about what I would want if someone was just saying ‘yes’. When I got to Nova Scotia and someone looked at me and said ‘yeah we're going to do this for you, you can have it as soon as you want,’ I had to go ‘am I ready for this?’ and not just think about fighting to make sure I got it. So I had some interesting months where it was like really looking inward, really asking myself, ‘Am I ready for this? Is this the commitment that I want to make to myself? Do I even need hormones?’ As soon as someone said, ‘Here they are’, I was like, do I need hormones to feel fully valid in my gender identity? It was like — okay, now it's really up to me, and that power is incredibly insightful in knowing what you want.”

Liam's experience demonstrates a lack of consistency across provinces — in that an individual can have all but completed the process to be prescribed hormones and then be made to redo the process, in a slightly different manner, in another province simply due to attending school away from home. While Liam was clearly able to travel extensively and pay to propel the process ahead (the sexual health clinic, private practice

assessor, and his home town being in all different parts of the province, while his psychiatrist for surgical approval and his surgeon being in another province), had Liam been unable to do so, the experience may have been far more drawn out and potentially negative due to extensive waiting. It is however interesting to note that despite the fact that Nova Scotia continues to use the WPATH standards of care, according to Liam he felt far more supported in Nova Scotia as compared with a province that does provide an alternative model of informed consent (based on the doctor's willingness to self-educate).

According to Liam, his doctors as well as the nurses at the sexual health centre seemed far more knowledgeable and genuinely empathetic — despite being held to the WPATH system — compared to doctors in Alberta, who technically could follow the informed consent model of care, but were unwilling to do so. The support and access he received actually assisted him in making a better-informed decision, as compared with a system where he had to educate the doctors and fight for access in the first place. Simultaneously, Liam did not engage with Nova Scotia's public system of mental health care — who provide the hormone assessments for free — as he was seeking as immediate access as possible, and as such did pay insured therapy fees on top of travel in order to expedite the process, simply because neither his Alberta doctor nor his Alberta therapist had WPATH-specific training that a doctor in Nova Scotia could accept.

Rachel (she/her)

Rachel lives in Halifax and initially began the process of accessing hormones when she made an appointment at her university's mental health clinic. After deciding she wanted to go on hormones, she asked her counsellor how to do this. While the counsellor was helpful regarding her general mental health, Rachel said that the

counsellor was unable to assess her for hormones, and did not know who Rachel should be referred to for the assessment. Rachel said that this stalled the process for nearly a year and a half and she over time stopped attending sessions as she became more focused on accessing hormones: “I stopped going to those because it was sort of running into roadblocks about me being like ‘show up to talk about my gender feelings and my gender feelings were like “I want to get on hormones” and that was sort of it’. I have since found therapy afterwards but it's like at a certain point then it was just like, “well yeah, I’ve got one thing I want to do, and I don't really want to talk about anything else until that’s happened.”

Rachel mentioned that, following this, her mental health declined and she became suicidal. At this time, Rachel decided to search the internet about the possibility of ordering estrogen pills to be sent to her, as she had done this before in the past with other non-prescribed medications. About the process of ordering hormones online, Rachel said, “It is apparently incredibly easy to get estrogen off the internet and get testosterone blockers off the internet. So I was I was in such a bad place, I was like ‘I don't really care if this isn't how you're supposed to do this. I'm just going to try it and see what happens. Like worst case scenario I'm like suicidal already so this isn't going to make things worse. So I got them off the internet, it took about two months because the first place was awful and sketchy and did not respond to emails, and the second place was much nicer and just sent me them within like two weeks of me asking for them.”

After having taken estrogen and testosterone blockers for a period of time, Rachel said that her mental health greatly improved and it got to a point where she was no longer suicidal, but was something she would like to continue. She talked about the fact that

when one takes non-prescribed hormones, one should ideally practice considerable self-monitoring, particularly in light of the fact that one does not have access to blood tests or a doctor: “I'd been sort of doing it by feeling and I have all these notes and stuff. The side effects were that I was really tired the first week. I took way too high a dose in retrospect. When I was on the higher dose my side effects were really bad. Later I started writing down mood things because I was trying to figure out if me being tired all the time was just me looking for patterns or whether it was actually every day I was tired, in which case it was probably the testosterone blocker, and [in] which case I should bring it down. So I was trying to judge my doses based off that and apparently I wasn't that far off when we did end up going to get my blood tested. I was kind of at the time very concerned that I was completely off base in terms of what I was taking.”

Rachel then began the process of getting assessed for a readiness letter for hormones. She reported some confusion with the public process, leading her to seek out private practices: “I don't understand how you get to the public one. Because when I was trying to look at the public one, I could understand how you could get on the waitlist if you were a youth but I was no longer under their definition of youth and so I was like I guess there just isn't a public one [for adults]. I think she [university counsellor] was like saying ‘oh yeah you should look it up, we can't do that here, you should look that up’. It's really hard to look it up because it's like even if you try to search it up it's like the people who do it aren't good at advertising. There's no place you can just go where you can call and ask them for an assessment and so it sort of took me being in school again and trying to get things going. But I was willing to sit down and go through a big list of therapists and their specialities and go to each website and be like who does what and then call

around.” Rachel also mentioned that, at the time, the sexual health centre did not openly advertise that they provided services around transgender health, but that she was told to simply call and ask anyway, and to specify that she was self-medicating, as it was considered a risk (and therefore a reason to prioritize getting her an appointment). Rachel then called around to several private practices and got an appointment with a therapist, who then began to ask her general questions about her identity: “We started out with him just being like ‘oh so you think you're transgender, why don't you tell me about that’. When I was going through the summary of my history of various gender feelings, [I] got to the end and was like ‘yeah, last summer I started self-medicating’ and he was like ‘oh, okay I think that counts’. He got kind of panicked actually and it was like ‘okay, so if you come again, we don't actually have time to write you a letter now, come in again, I will write you a letter the first thing. For now, call the sexual health centre, tell them you’re self-medicating, ask if you can get in so you're no longer taking random medications off the internet. Then also tell them that you're seeing a therapist and we'll have a letter within a week’.”

After Rachel’s initial appointment with the therapist, she then called the sexual health centre for an appointment with a doctor: “My impression is that there's a kind of harm reduction because when I called the sexual health centre, they were like ‘we can put you on the waitlist’ and ‘do you have a letter?’ and when I started explaining that ‘no I don't have a letter yet but the guy I'm seeing says he will give me a letter and he said that I should call them because I'm self-medicating’ and when I said that the nurse on the line was like ‘hold on a minute’ and apparently talked to somebody. I assumed it was just like they had to talk to one of the people more in charge about what to do. But then they were

like ‘okay we can get you in like 2 weeks’.”

Rachel then asked if she should stop the hormones she had been taking, and the centre informed her that she should continue, as there is a risk to suddenly stopping the medication, especially since what she had been taking was not officially documented. When she got in to see the doctor two weeks later, the doctor told her that they would first do a blood test at her current dosages before writing her a legitimate prescription. She reflected on her experience with the doctor: “I went in to see the doctor and she was super like calm and just like ‘that makes sense, and we’ll get you a blood test and see where it is’. My impression [is] that this is super common, to self-medicate. I actually have a lot of friends who are transgender in the US and it’s super common among them. A lot of the times it’s just because they can’t afford a doctor or their insurance doesn’t cover like trans medications, and like once it starts being more expensive to do it officially it gets sort of hard to justify that.”

Rachel then had a series of blood tests to determine how best to adjust her levels of estrogen, testosterone and progesterone: “There was a series of like blood tests, where we tried to figure out what was an appropriate dosage, and there was issues with the progesterone, which was super high, but everything else was like more or less where it should be. Until we messed around with stuff to try to lower that, I’d been having a bunch of negative issues from, we found out, from the cyproterone [testosterone blocker] causing a similar kind of suicidality. That stopped as soon as I got off of it, I switched to spironolactone. I was having a lot of really pressing issues and it was just as soon as I got off it, they just stopped.”

Rachel also noted that at the sexual health centre her doctor downplayed the

necessity of an assessment letter: “I didn't actually bring in my letter until like my third appointment, I had gotten hormones and it was like, she was like, ‘oh, I was looking over your file and apparently we don't have a letter for you so you should bring that in’.” Similarly, Rachel noted an overall attitude of openness and support, rather than control: “She [the doctor] seems super willing to let slide a lot of things. There was one time briefly where I messed around [with] the doses without her telling me to. Then I came back and was like ‘here's what I did’ and she was like ‘okay we'll make a note that you did that. When do you think you started it, and did it affect you?’ My experience with the doctors there has been fine.”

On feeling as though she had to self-medicate, Rachel reflected: “I always feel like it's something that I wouldn't want it to not be an option. I just want it to not be a necessary option. I guess I feel like I always ought to be able to self-medicate if I want to, but I shouldn't have had to. It shouldn't have been like this is the easiest option, to self-medicate. I feel like it's not that hard to get drugs off the Internet. It's not hard to get psychedelics off the internet and those are very controlled. It's not even that hard to get opioids off the internet. So putting all these barriers up means that it's going to end up being the easiest option.”

Rachel also discussed how the way the system is set up benefits those who are well-connected and marginalizes those who are not: “I was also not in any trans facebook groups at the time. I didn't have any trans friends that at that point. I'm, so it was like, if I had known someone who was already on hormones, it would be super easy because I would have just done what they did. And that's made things a lot easier now in terms of getting on other waitlists for like surgery and things like that. I know I can just ask

someone and be like ‘what did you do? How long did it take?’ This is the thing I don't like about trans healthcare stuff. It's the same thing about when I tried to get into the sexual health centre I was told by the therapist like ‘call and say that you are self-medicating, say that you wanted an appointment with this doctor’. You need to know what to say. I shouldn't have to do that. I checked the website — no mention at all of trans stuff. I was like ‘Why couldn't you have just had that on your website? Why do you need to know secret code words and who to ask?’”

Rachel's experience demonstrates the potential consequences of mental health professionals who are not knowledgeable about the system to access transition-related care. Rachel is an example of someone who had mental health challenges, sought out therapy for that along with her gender identity, and was met with not only a lack of knowledge but a lack of willingness (from healthcare professionals) to find the answers, which instead put the onus on the client to do the research. While Rachel clearly monitored her self-medication very well, this lack of straightforward access from a mental health professional, along with with one's own internet research not leading to clear results, coupled with a lack of contact with other transgender people who may be able to guide or give support, all combine to result in increased risk and worse experiences for transgender individuals seeking hormone therapy. Rachel's experience, however, also points to a strong and supportive system with both her private assessor, who quickly wrote her the letter and told her how to get in with the sexual health centre as quickly as possible, as well as with the personnel at the sexual health centre — who did not seem to stigmatize or further control Rachel's actions, but rather worked with her to rework her hormone levels and medications under somewhat atypical circumstances

(when typically, one would have a baseline hormone level to work with). Rachel's experience points to how much simpler the process would be for someone with support and clear ties to the transgender community, as well as if there was better knowledge across mental health and primary health care professionals and online. As Rachel puts it, "my problems could have been solved if I had just been at the very outset been given a little pamphlet that was just like 'so you want to be a girl? Here's the steps: here's how you get on hormones, and where you call, and everything'."

Noah (he/him)

Noah's story highlights the highly variable nature of the private mental health system, which he accessed over the course of five months in order to receive a letter of readiness for hormone therapy. Especially as a non-binary individual (at the time of his assessment), Noah received care that was rooted in a binary understanding of gender, and a framework that positioned the mental health provider as the knowledge source and gatekeeper, and framed the client as the one to be scrutinized and controlled. At the same time, Noah's story also outlines the experience of gaining access to top surgery in Nova Scotia — either waiting eighteen months for another mandated assessment through the public system before being referred out to a clinic in Montreal, requiring travel and recovery out of province, or, for those with sufficient financial resources, having surgery within a few short months and receiving care and results that surpass the public system, while also remaining in your home city among your family and friends to recover.

Noah is agender and a transgender man. At the time of pursuing his assessment for hormones, Noah identified as non-binary. Noah approached his mother — who is also involved in the LGBTQ+ community — and, after speaking with her friends who also

have transgender children, she recommended that he see a private psychologist. This was due to the wait time associated with the public community mental health system, as well as because their health insurance had excellent coverage — 100% coverage for twenty sessions. Noah said that he heard from his friends that many could get their assessment finished in around three sessions, and he assumed this would be the case for him as well. As it turned out, it took him about five months of weekly therapy to “convince her that I [he] was trans enough to get on hormones”, which took up virtually all of his full twenty-session coverage through his private health insurance.

Noah reflected that the psychologist was not used to working with non-binary people. When he first began to see the psychologist, he was still discovering his identity, and he presented as having long hair, androgynous clothing, and using they/them pronouns. Noah reflected that “she wasn't against learning and working with a non-binary person, but definitely a lot more wary than she would have been with her other patients that were binary trans people.” Noah said that he initially identified as non-binary because he “would be very dysphoric and the next day [he] would feel like everything is fine. [He] would go back and forth and didn't really understand what I was feeling or why.”

The psychologist asked Noah a lot about his childhood, which Noah said “irked” him and made him uncomfortable. Noah said, “I didn't consistently refuse to wear dresses, so she basically used that as a point against me. She said, ‘you didn't refuse dresses, you did play with Barbies, you don't hate the colour pink, so I don't think you're ready for hormones’.” Noah was met with the continual question of why he did not know, or report this, when he was younger, which he took issues with, as he felt he was raised

with gender-neutral toy and clothing options, as well as the fact that he did not have the language to convey how he felt as a child.

Noah felt that he continually had to prove himself, his confidence, and his knowledge level to the psychologist in order to gain her approval for the letter. When the psychologist provided Noah with details on the side effects and transition timeline of hormones, the psychologist was surprised to find that not only had he researched this already, but he could answer all of her questions as to what would happen to his body if he began hormones. Noah remembered, “she took the sheets away from me and started testing me. I knew everything right off the bat and she almost didn't believe me. She was very wary of whether or not I was ready, but I knew absolutely everything. I was telling her things she didn't even know that hormones would do to your body. I know that [she's] trying to do [her] due diligence and make sure that [she's] only writing letters for the right people, but I know what I want.”

Noah felt as though his sessions were more about proving himself to the psychologist: “It was never about me and my unique experiences, it was always ‘do you meet these criteria? Do you fit into the boxes?’ and that I guess bothered me, because it was very much geared to female to male or male to female, and it was still a binary.” Noah said that the psychologist put a lot of pressure on him to conform, and to consider things he would not have otherwise considered. First, she wanted him to try using he/him pronouns instead of they/them. Next was the pressure to freeze eggs before hormone therapy, since, according to her, hormone therapy will affect fertility. (Noah later supplied her with evidence that it does not.) Noah noted that in large, bold print on his letter was a warning to doctors about the fact that Noah expressed a desire for children

some day and to strongly take that into consideration before prescribing hormones.

Noah reflected on much of his experience with the psychologist as a negative one, and one that actually worsened his experience of gender dysphoria: “I think [the experience] made me more dysphoric because she was weighing me against standards. When I went in there I wasn't weighing myself against any standards, I was just experiencing my gender the way it was playing out. But she was like ‘this is what I'm expecting of you’. So when I went in I was like only slightly dysphoric and by the time I left I was super dysphoric. She was like ‘this is what masculinity is and if you want to be a man and be on testosterone this is what I'm expecting of you.’ So I kind of internalized that in order to be a man I have to bind, pack, wear certain clothes, have my hair a certain way. In order to get on hormones I kind of changed my presentation to meet what she was expecting of me. I feel like if she had just said ‘okay, cool, you can go on hormones’ I'd probably be a lot different than the way I am now. Maybe I would have gone on [testosterone] for a year and then stopped. I would have just been like all over the place with gender. I would have been a lot more dresses one day, suits the next day. I would have been very fluid. But because of having to meet those requirements I kind of forced myself into a masculine role.”

Noah expressed feelings of regret over not feeling permitted to fully explore gender, especially as he began to self-enforce behaviours and clothing associated with men, and to rid himself of anything feminine: “I would be a completely different person, and I don't think I really realized that until you asked. If it hadn't been for therapy, I probably still would have had surgery and gone on hormones, but like the clothes and my mannerisms would probably be different. I self-police my own mannerisms all the time.”

After about five months of therapy, the psychologist at last agreed to write the letter, but said she needed a month to do so while he continued the weekly appointments. Noah commented that the language in the letter was stigmatizing and outdated. His chosen name was in brackets and his legal name was used through out, and he was referred to as a “natal female”. At first he reasoned that despite the language, the letter is meant for future physicians and other health professionals he may work with in the future, and will use precise medical language, and not the language he would prefer. But Noah then questioned why the letter would outline the kinds of toys, clothing, and activities he preferred as a small child, and how this related to a young adult’s decision to pursue transition-related care.

After the psychologist gave him the letter, Noah noted that she was unsure of the next step. Noah said that the endocrinologist she used to refer out to had left the province, and so the psychologist told Noah that he would need to figure it out himself. Noah contacted the sexual health centre in Halifax for an appointment with their doctor, and was met with a three-month wait, since intakes are completed four times a year, and he had just missed the cut-off. After waiting the three months, he met with the doctor for two appointments before receiving his prescription. He reported that other than managing to receive his letter from the psychologist, the remaining experience with the sexual health clinic was smooth, especially relative to some of his friends’ experiences: “they take so much better care of me than my friends who have gone through the children's system. So many of my friends have gone through the [children’s hospital] for hormones and they get blood work every 6 months or something and I get blood work every 3 months without fail. I've been treated so great by them, I know that's an experience that

not a lot of people have, so I'm pretty happy with that part.”

When Noah met with a doctor for his hormone prescription, the doctor also offered to send a referral to community mental health (public option) for surgery. Shortly after this, Noah received a letter stating that he would have approximately eighteen months to wait before an appointment to meet with another assessor through community mental health in order to then be referred to surgery out of a public clinic in Montreal (which is where all transgender people seeking top surgery are sent in Canada, other than those in Ontario). Noah was told that despite having the private coverage to get the surgery letter and have MSI cover the surgery, MSI required a letter from a particular psychiatrist out of community mental health. At the time of his interview with the researcher, it had been well over eighteen months, and he had still not received an appointment for the surgery referral. During this wait time, Noah had decided to get top surgery via a private plastic surgery clinic in Halifax. Noah said that not only was he unsatisfied with the potential long wait time, but that he did not like that he had no choice of surgeon, and that he has seen the results from the Montreal surgeon and that they were “comparatively mediocre”, which he said he knew because he “shopped around” and researched online. He selected a particular private clinic in Halifax that was known for having the best plastic surgeon in the province, and while his website did not advertise any trans-related surgeries, they did advertise that they provided “male chest reductions”, which, Noah pointed out, was technically what he was seeking out. Having filled out one online form with a request for a consultation, in less than a month Noah met with the surgeon to discuss options. Noah noted some of his reasoning for going this route for surgery: “My family lives here — it was like, why would I fly to Montreal? Yes, they'll

pay for your expenses and stuff, but I'd have to go and put all the traveling time on my body and stuff when I could literally ride the bus 6 minutes down the road or something. Why would I not just do it here and save travel costs and go home and rest with my family?"

Noah said he was met with some hesitation from the surgeon, but that it was not significant, and that there was a minimal process of assessment or gatekeeping: "He was like 'okay you've not been on hormones very long, you're really speeding through this. Are you sure you want to do it?' and he was like 'okay if you're sure then alright'." Noah also pointed out that he "literally said 'if you change your mind after the surgery we can always give you breast implants' and I looked at him like, cool but you have nothing to worry about." Noah said that in that meeting he was booked for a surgery date, with no process of mental health assessment, which was affirming for someone who previously had to continually prove their gender to another health professional: "He's like, it's a bit soon after starting hormones but you know you're paying me so I don't care if you're the girliest chick on Earth and you don't want boobs, if that's what you want to do." Noah then went on to say that he was able to schedule the surgery during the school holidays in December to ensure that he did not miss classes or exams, and not need to take any time off school in order to recover.

The total cost of the surgery was \$8,500. Noah reflected on his privilege of being able to afford this surgery at his young age, especially with the support of his family: "I was very lucky that I had my own savings. I had my father and mother who are separated, my grandmother, and my aunt, and a lot of people in my family all contributed a bit towards my surgery." Noah noted that his surgery was on the costly end of top surgery,

and that his results are better than he has seen out of his friends and of people's results from online: 'I can genuinely say that I have some of the best results I have ever seen. I am very, very happy with my results and I think it's better than what I would have gotten in Montreal.' He also reported being treated very well at the clinic, and never misgendered — while he had heard of his friends' experiences in Montreal of being misgendered by nurses who were assisting with recovery. He also appreciated being able to meet in person with the surgeon — who could physically examine him in person — whereas going the public route involves phone calls, pictures, and video.

Noah commented on the lack of accessibility of the surgery he was able to obtain: "it's unfortunate that it's not accessible for so many people because I have friends who were out way before me who are still waiting for surgery. I had a lot of privilege guilt because so many people need this and I kind of skirted the system by doing it privately. I wish that everybody would have that opportunity. I had a lot of guilt because my friends all watched me go through that and they're still not there yet." Noah also mentioned that he as well as his family have historical and current ties to an LGBTQ+ organization in Halifax, and that his level of connection within the community, as well as having many friends who are transgender and have already gone through the process, had helped him to navigate the system better and provided him with overall greater support than another person whose parents may be unsupportive or simply not know where to direct their child, or who does not have friends who transitioned first.

Noah's story is distinct in both his experience of therapy and assessment with the private psychologist — which took five months and what would have been over three thousand dollars in fees if it had not been for Noah's full coverage health insurance. His

experience with the therapist while, at the time, identifying as a non-binary person attempting to explore his identity, also stands out and underlines how the mental health system may mistreat and attempt to re-label those whose gender exists outside of the binary. While many of the participants reported feeling positive or ambivalent about the therapy or assessment for the readiness letter, Noah's experience clearly highlights the negative impacts of therapy that places the expectations on the client to conform and prove themselves in order to gain access to transition-related care. Noah's experience also points to the disparities in the current system of transition-related care, as someone who was able to afford to pay for top surgery within the province, as opposed to an extensive wait time through the public system for referring out to a public Montreal surgeon.

Instead of waiting eighteen months or longer for the assessment, and another wait time for the actual surgery date, Noah was able to meet with a surgeon in Halifax within a month, simply because he had the money to gain the access. As a result, Noah felt he got results that were far superior to those from the Montreal surgeon, and had the extra benefit of remaining at home to recover, without the added stress of travel. Noah's story is interesting because it demonstrates how financial privilege can completely change a timeline of transitioning (waiting a month, versus waiting years), but at the same time cannot guarantee positive and affirming care, especially as a non-binary (identified at the time) person who was made to fit into the "male" box.

CHAPTER 5 | Going Public: Navigating Access to Transition-Related Care

Chapter 4 offers three vignettes that illustrate the experience of accessing private transition-related care in Nova Scotia. Together, the narratives of Liam, Rachel, and Noah offer insight into the experience of having a mental health assessment made by a professional who runs a private practice and charges for hourly visits; accessing university-based primary or mental healthcare which is exclusive to students and staff of the particular institution; and pursuing surgery via a surgeon who runs a private plastic surgery clinic — all of which require access to resources. In turn, this chapter outlines the public health side of accessing transition-related care and examines participant experiences of navigating public healthcare in pursuit of transition-related care. The participants who mainly went through private lines of healthcare were, in a number of ways, different from the participants who went through the public system.

Unlike Liam, Rachel, and Noah, those at the centre of this chapter were not able to pay for access; they did not have private insurance coverage, nor did they the money to cover the high fees of healthcare professionals who run private practices. Their only option, then, was the public system, which, while covered through the public health authority, is not without other complications — notably, extended wait times, lack of choice in which professional to work with, and the potential requirement of travel. In addition to providing a roadmap to the public system of gender-affirming treatment in Nova Scotia, this chapter highlights several unexpected features of that system, which, while mapping onto widely offered critiques of neoliberalization, suggest that — in some instances — the constraints of neoliberalism might actually (if inadvertently) improve care. That said, and despite consensus that the public system is “better than anticipated”,

its process retains a number of harmful features which subsequently fail and further marginalize an already-vulnerable population. This chapter explores, then, both the positive and the negative aspects of the public system.

To gain access to hormones or surgery as a transgender adult in Nova Scotia via the public health system, a referral or self-referral to the health authority's community mental health services is required. Children up to age 18 would be referred to the children's hospital, which has a similar process in terms of mental health services. In both cases, similar to accessing a private practice, several appointments with a health professional are required to meet with a to receive a letter of readiness which states that an individual meets the DSM-5 diagnosis for gender dysphoria and the WPATH criteria for hormone therapy or surgery.

Public mental health services in Nova Scotia are known for their very long wait times, as resources in the community system do not keep up with the demand upon the system (MacLean, 2018). For participants able to access private modes of assessment through insurance or access to money, the long wait times of the public system were often the motivating factor behind doing so. Indeed, reflecting on Liam's experience, he anticipated extended delays within the public system based on his previous experiences in Nova Scotia. His expectations that public access would prove lengthy was not ill-founded. Brandon (he/him) describes his experience of being on a waitlist for public mental health services: "My doctor put me on a referral list for the free community mental health, but that waitlist is over a year. Several months passed, I was struggling with it and I really wanted to talk to someone. So I made an appointment to see a therapist privately on a sliding scale." Brandon's experience reflects a common one:

mental health is negatively impacted as individuals wait for an opening within the public system to become available. Desperate and without other options, the individual seeks out private care, even as accessing these services may leave them struggling financially and eventually in debt. Private practice, despite bringing with it its own complications and delays, provides (at least the sense of) immediate access to the assessment process required to begin transitioning via hormones or surgery. By the time community mental health services got in touch with Brandon with a cancellation appointment, he had already begun hormone therapy. Sage (they/them) echoed this understanding that people many avoid the public mental health services due to wait time: “I don't think I know of anybody who has gone through community mental health, just because of the waitlist. Like even to see a counselor there for anything is forever.” Here, concerns about the under-resourced public system circulate amongst people who — regardless of direct experience — come to understand that system as an obstacle to care rather than an access point. These people are then redirected to the private system, which (as explored in chapter 4) may only offer a partial solution to the experience of waiting. The otherwise accurate view that waiting is an obstacle within the public system, then, obscures the way in which waiting operates in the private system as a mechanism of profit for some private therapists. It also obscures the effectiveness and expediency of the public system once services have been accessed. This represents one of the more unexpected findings of this study: it reflects both the deep self-knowledge of transgender people, and moreover, it challenges taken-for-granted assumption that private systems of care are inevitably better.

Somewhat ironically, the public system's lack of resources appears to make it

more responsive to the needs of people accessing mental health service for transition-related care. Ironically, then, the neoliberal move away from long-term mental health services — an outcome of decreasing resources and growing demand, and an approach that may not benefit those who struggle with more complicated mental health issues — does benefit those seeking a mental health assessment for transition-related care, and this approach does seem to work. Importantly, such an analysis is not an affirmation of neoliberalization — far from it. Rather, it points to an unexpected consequence of the neoliberal insistence on “efficiency” and “efficacy” (Ferguson, 2010). Indeed, for those who went through the time-pressured, resource-poor public system, there simply were not the same kinds of opportunities to pathologize and/or medicalize their experiences. As elaborated below, rather than holding people in place to tap out their insurance coverage or to apply a protracted (and potentially problematic) assessment tool developed by a private therapist, people moved quickly through the public system, which deploys a standardized approach and limits the number of appointments per client, with the intention to cut costs and move people through the system quickly.

Public versus Private: Neoliberalism’s Silver Lining?

Once participants did, at last, enter the public mental health system to receive an assessment, their experiences seemed strikingly consistent and positive — especially compared to those who sought out a private assessment, most of whom had a varied experience in terms of cost, number of appointments, types of questions asked, and support received. Brandon reported completing his assessment for surgery in two appointments: “I did the whole assessment for surgery. It was an hour for the first appointment and an hour the second appointment. [The assessor] said ‘yeah I’ll write you

a letter, not a problem'. The whole process was actually pretty smooth.”

The wait list for community mental health services was also experienced inconsistently and with considerable variation. While some participants reported waiting over a year to be seen, others reported a couple of months. According to Amy (she/her), from the time she first contacted the clinic, the wait was just six weeks. Amy also had a fast and smooth experience once she had an appointment: “I got myself on a six-week waiting list for Community Mental Health. After a six-week waiting list, I got in contact with [the assessor] who was intent on knocking it out in one session. She booked a three and a half hour session because it was supposed to be two to three appointments of one hour in length. She was like ‘we can probably just nail it out really fast in one appointment’ and that's exactly what happened. We took maybe an hour and a half to complete it.”

While regarded critically in most analysis of mental health service provision in the province (King’s Investigative Workshop, 2018), for Amy and others, “knocking it out in one session” was ideal. Amy did not, following from what she already knew to be true about herself and her gender, require a protracted therapeutic engagement. Indeed, if her gender was the source of “mental ill-health”, it was only as an outcome of the misgendering she had long been subjected to, compounded by oppressive societal norms and their adjoining symbolic and material violence. Effectively accessing care to transition was, in her case — and in the case of several participants — was the most expedient way of addressing her mental health concerns. Amy also reflected on the assessor’s approach to the process: “she seemed to think that the questions [in the standard assessment tool] were kind of overbearing and invasive, so she treated it as kind

of like a bureaucratic thing that needed to happen, which was nice. The last question on that list she had just crossed out she was like ‘this is bullshit, don’t worry about this’.” This highlights an example of the professional’s use of discretion to modify the process, rather than adhere rigidly to an assessment questionnaire. In this instance (relative to what was happening for participants in the private system) discretion was used to hasten the process. Moreover, and perhaps more importantly, it reflected the practitioner’s sensitivity to the ways in which standard assessment protocols might reinforce the medicalization of transgender experience and life.

Other participants also noted that despite the long wait time, the assessment itself went by very smoothly and involved very few appointments. Furthermore, and mirroring Amy’s experience, the other participants noted that the assessors seemed to skim over or re-word questions in a way that reduce both time and potential distress or discomfort. Again, such an approach reveals an unexpected particularity that follows from what might otherwise be regarded and critiqued as the public system’s neoliberal turn. Favouring short-term intervention that prioritizes the resolution of discrete, immediately-presenting problems over longer-term intervention into a range of issues, gender assessment as it occurred in the public system moved people along quickly. The problem was identified (GID), and a solution was offered (access to treatment). While potentially problematic in the case of other presenting problems, in the context of medically assisted transition, this rapid, short-term approach was read by participants as more sensitive and responsive to their unique needs.

Despite its neoliberal overtones, such an approach appears to benefit those seeking assessments for hormone therapy or surgery. Indeed, the stated preference

amongst participants was always immediate access; even among those who accessed private care or saw their service provider sooner, most did not appreciate getting into detailed histories of childhood, relationships, or mental health history, and wished instead for a more practical approach of discussing current and immediately relevant issues, as well as the effects and timeline of hormone therapy or surgery.

What Does “Good” Care Look Like?

Multiple participants’ initial entry point into the process of pursuing hormonal transition began with accessing the Halifax Sexual Health Center (HSHC), a Halifax-based clinic that provides sexual health services and resources to their clients. As of 2018, “transgender health” is listed as one of their services on their website, stating that the center is able to assist individuals with all aspects of transition. Participant experiences with the HSHC were overall very positive. Recall, for example, Liam is from Nova Scotia, but living outside the province at the time he wanted to begin testosterone. After having a challenging experience in Alberta out of province, he made a second attempt once he returned to Nova Scotia. Despite his initial assumption that Nova Scotia’s system would be even more challenging, Liam outlines the extent to which he was impressed by the level of care and compassion he received by the doctor he met with:

When I was at the sexual health centre with the doctor, she delivered the slight sense that this may take longer than [I] expect but she never made me feel like I was going to be denied. She was very supportive and that meant so much to me because in Alberta I ran into doctors all the time that were like, ‘no, you're not going to get this.’ The experience I had at the sexual health centre was 100%

positive. The doctor that I personally had the experience with was phenomenal: clear eye contact, clear intent of [the doctor saying], ‘You need this. I understand, I hear you.’ Being heard can make a huge difference in the process. So that was so positive for me, knowing that she was on my side.

Liam’s experience demonstrates the importance of an engaged, empathetic and knowledgeable health professional. Prior to the HSHC, Liam faced many health professionals being either unsure of the process and unable to direct him in the correct direction, or unsympathetic to his desire to begin hormonal transition despite a complicated system of requirements. The rapport established between Liam and this doctor at the HSHC made a large impact on the experience. Liam still had to go on and complete his letter of hormone readiness, but unlike his previous attempts out of province, he was now being overseen by a supportive and well-informed doctor, who understands how essential it is to gain access to hormones efficiently. The HSHC seems to be well-positioned to continue to offer high-quality and supportive transgender health services as a clinic centering reproductive and sexual health in ways that general practitioners may be less equipped to do so due to lack of specialization and awareness.

Participants reflected on their experiences talking with mental health professionals in pursuing a letter of approval stating that the professional supports a diagnosis of Gender Dysphoria and endorses the individual beginning hormone therapy. This experience seemed to be highly variable, with participants accessing several different systems for this assessment: the public adult system (Community Mental Health), the public children’s system (the IWK Health Centre), or the private system (a privately-run practice offering psychological services). Sage’s experience stood out as

someone who pursued private therapy and reflected on the benefits of talking with a professional to gain insight and clarity into the decision of beginning hormone therapy:

I do think having somebody to talk to in the process is a pretty invaluable step especially because not everybody is as sure as some people are, some non-binary people in particular, and for other people it's a more complicated decision. I know that there are people who are way more sure about this than I am. But especially as a non-binary person there's a lot more questioning, "is this what I want to do?" I feel like I would have been too scared to do it if it had just taken a week. Having the step of being able to talk through that with somebody, I think, was a positive thing.

Sage's identity as a non-binary individual, meaning someone that falls outside of the male/female binary, impacted their experience in a way that was different from many of the other participants who were transgender men or women. As someone who desired having a discussion about identity and the effects of hormones, Sage was someone who found the requirement of meeting with a mental health professional to explore these topics to be a positive aspect of the process. Sage pointed out how many people are certain of their decision to transition well before meeting with a professional, but for them the decision was complicated and something they did desire talking through with somebody. At the same time Sage also reflected on having a very positive experience with the professional overall:

The stated goal was "I want to make sure that you know you want this." [The psychologist] was very adamant that she was not going to play the role of a gatekeeper and that her job was to make sure that I knew I wanted to do this, and

that if I wanted [hormones] she was going to write the letter — she just needed to make sure that I understood the decision I was making.

This again stresses the importance of a competent and supportive professional who understands how crucial access to transition is. In particular, professionals who are aware of the the history of gatekeeping access to transition and how the professional’s opinion was centered over the life of the transgender individual. Having a professional frame the discussion around guaranteeing access shifts the focus back onto the client’s feelings and decision.

Michelle is a trans woman in her 50s with a significant past of mental health diagnoses and struggles. She similarly reflected positively on her experiences during her assessment for hormone readiness. She appreciated the approach the assessor at a public mental health clinic took of unpacking the present issue, rather than focusing on her past. She said regarding the assessor, “She is awesome. Right from the get-go she said, ‘from this day forward it’s all looking ahead. We’re not looking at anything behind you’, and that was huge because any other therapy was always dealing with the past.” Michelle’s experiences contrast significantly with other participants who felt as though their childhood and previous experiences, particularly around mental health, were overly relied upon within the assessment process.

Experience vs. Expectation: Nuancing “Good” Care

In considering the ways participants viewed and described the public process as a positive, it is important to recall that these experiences were always framed in relation to participants’ existing expectations — expectations that followed from accounts they had heard from other transgender people and their own experiences of access health care

more generally. In other words, in stating that the experience was “positive”, most participants were signalling that it was “better than anticipated”, or, more accurately, “not as bad as they thought it would be”. Participants were also very quick to offer “luck” and “privilege” as factors influencing their “relatively good fortune” with the system. Here, timing, capacity to self-advocate, and referral to particular health care professionals emerged as particularly important. A number of participants also stressed that their individual experience was not — in their estimation — the norm. That said, such a caveat was commonly offered amongst those who did access care through the public system. Others pointed out that their motivation and excitement to begin hormonal transition outweighed any possible perception of the negativities of the process. Still, even as the experience was “better than anticipated”, there were moments beyond the initial wait that were challenging. That said, and as partially explored in chapter 4, negative experiences occurred across a range of systems. While focusing on the public system, in what follows, I explore and unpack a number of negative experiences in the public as well as private system.

Daniel is a young transgender man who was initially assessed by a psychologist from Nova Scotia’s children’s hospital. Because Daniel was eighteen he was given the opportunity to either be assessed through the public adult system or the children’s system. He was told at the time that to go through the adult system would be approximately a two-year wait for the assessment, and so he was instead able to meet with someone within a few months through the children’s hospital. Despite the faster access time, Daniel described his experience in negative terms: “I actually didn't have the greatest experience. I feel like the person I saw didn't listen to me. While she wrote a very long

and detailed letter, she got a lot of the details wrong that I'd be a little bit afraid to correct right now in case that means they would rescind the letter and I don't get top surgery. So I'm just kind of putting up with all of it. I just feel like she just didn't pay attention to what I was saying that much. I've been avoiding reading through that whole letter because it's kind of uncomfortable to think about how wrong she actually got everything.”

Daniel also spoke of his discomfort discussing his mental health during these sessions and feeling though he should conceal some aspects of his mental health from the assessors, especially as he did not feel it was relevant in gaining access to hormones: “I hid a lot of aspects of my mental health from them [assessors] because I didn't feel like I wanted to share that. I thought I was just going in for hormones. I didn't outright lie about anything but I didn't go deep into it. I didn't treat it like I would treat a therapy session. I treated it like, ‘I'm here to get hormones, you're the person I need to access these hormones’. I wasn't terribly comfortable with all their mental health questions, I understand the purpose for it, but it wasn't very comfortable.” Daniel later did go to the adult public mental health clinic for another letter and found there to be a stark contrast with his experience there as compared to his experience through the children's hospital. He said, “I genuinely felt like the person that I saw [at the public health clinic] for a letter for testosterone was genuinely happy for me when I got it which was really nice. She also wrote a very long letter but it was it was a lot nicer and a lot more accurate than [the previous letter at the children's hospital] and I appreciated the way that she handled the process. I feel like [the assessor] definitely tried to educate herself and it was really a good experience.”

Sage, who accessed a private therapist, said, “There [in the sessions] was a lot about my mental health history. I've been in therapy a lot of times. I didn't love that I had to spend a whole session talking about mental health history because I felt like it wasn't really relevant at that point. I couldn't get my letter after two appointments because I had a lot of other stuff she wanted to talk through. I have a lot of mental health history and familial history that I think she felt like we weren't done after two appointments. It was kind of open-ended when we went into it. It was like, ‘we'll be done when we're done’.” Sage’s experience also demonstrates how access to a private mental health system can be very untenable, especially when it is a system in which you are meant to pay for services up front and be later reimbursed, and how this can compromise your access. Sage said, “It took me probably more than a year to get the letter. I called everybody on the list and there was only one of the providers [who] actually got back to me and it was a private doctor. I was in school at the time so my school health care covered it, but it definitely would have been cost-prohibitive otherwise. So I did my first two appointments with her. And then I lost my job and my housing situation fell apart and it just turned into a really big mess and I couldn't afford it. You have to pay out of pocket and get reimbursed and I just couldn't do it at that point. And I wasn't in a mental place at that point either to be really thinking about it. I know other people have gone to the same person and had it in two appointments and then I think it probably would have only been three [appointments] if I had stuck with it the first time but because there was a year gap it took us some getting back into.”

Other participants found that while it was not necessarily mental health that was the issue within the sessions, but rather an inappropriate view of gender and sexuality.

Liam brought to his interview the questionnaire he was given by his private practice assessor to fill out at home and to return to his next session. He commented on some of the questions listed, “Don't get me started on some of these questions. ‘Any activities you did as a child that you as an adult now think of as cross-gendered?’ ‘What is a typical sexual fantasy for you?’ ‘Have you ever cross-dressed?’ It's not the greatest feeling in the world. Like okay, I need to tell you about my sex life and my fantasies for you to be like ‘okay you're a guy’.” Elizabeth’s experience closely mirrors Daniel’s in terms of the questioning around childhood and sexuality. She said, “I was very uncomfortable during the interactions. It was a lot of very leading questions trying to pigeonhole me into ‘I just wanted to wear high heels when I was a little child but no one would let me’. It was a lot of questions. I felt like a lot of things weren't very particularly relevant — like there was a lot of talk about my sexual relationships and trauma.”

Elizabeth’s experience is somewhat unique as she accessed mental health services through a university in Halifax, rather than strictly through a public or private system. The services were free to her, but largely operated as a private system since they are not available to everyone and are funded through tuition. Elizabeth was seeing a general counsellor who was not WPATH-trained. Since the university did not have any mental health professionals at the time who were WPATH-trained, it was decided that Elizabeth would work with this counselor, and that after a period of time, the university mental health clinic would bring in a WPATH-trained professional to complete the assessment for hormone readiness. This timeline, however, seemed to be entirely on the counselor’s terms, and not Elizabeth’s. She said, “It was about six months of just talking and spilling my guts and retraumatizing myself over and over in front of this cis white woman.

Essentially I was going to see her [the counsellor] for as long as it took for her to think that I was valid enough for her to contact an outside therapist to come in and officially diagnose and prescribe me. I had to lie to her about the length of time I was presenting as female publicly to get my hormones — I told her it was a year longer than I had been. She also made me come out to my family before I was ready to, with the threat that she wouldn't make the appointments. I shouldn't be threatened with withholding medical services just so I can do what she thinks is the right way of transitioning.” Elizabeth also provided some insightful analysis into her own experience as well as the experience of transgender people seeking transition related care in general: “I feel like having letters in the first place is a holdover from when trans identities were more pathologized. It's like we know what we want and we know what's best for our own bodies but you're still treating us like we're sick. And we are sick [but only] because you aren't providing us with the medical attention that we need. But then when we make steps to gain access to that attention, we are met with roadblocks, and then that just perpetuates the cycle of dysphoria and poor self-esteem and fragile mental health.” Similar to other participants, despite a long wait time, Elizabeth reported having a good experience, relative to the previous ones, in the public mental health system: “I had to wait two years to access Community Mental Health, which [ended up being] a really good experience despite the egregious wait time. The person that I'm seeing for the psychological readiness for surgery is great, I love this [assessor]. I was literally just like two sessions to get the letter.”

Jamie is a nonbinary and transmasculine individual who lives in rural Nova Scotia, several hours away from Halifax. Jamie described the process of gaining access to

hormone therapy outside of the city as essentially impossible, and felt that his time and effort was wasted by many mental health professionals in his area, having been told multiple times that they could not provide him with a letter for hormone therapy. According to Jamie, “it was a series of several years of bouncing back and forth between therapists. I had three or four people just flat out say ‘no, not my thing, not going to help’. I had others say, ‘okay I’ll listen I can totally write you a letter’ and after 6 months of going through appointments and initial assessments not getting a letter. It was gatekeeping whether it was ‘I don’t feel like you’re ready’ or ‘you’re not trans enough’ or ‘well maybe we’re not actually qualified to write this letter’, there was a variety of reasons.” After several years, Jamie got connected to the public mental health system in Halifax, and learned through an LGBTQ+ conference that they could make an appointment there, though they would have to travel over five hours by bus to do so. Jamie said, “I finally had to come to Halifax. I had gone through seven or eight different people before I got to that point of finding the right people. I was really surprised when I met with them the first time. We did the assessment and right after the appointment it was ‘okay, come back and see us in three months because we want to do a follow-up’, but there was a guarantee that the letter would be written.” While, once again, this participant had a relatively positive experience within the public mental health system in Halifax, Jamie’s experience demonstrates the urban/rural disparities in Nova Scotia — that people must travel long distances because a qualified person does not exist in rural locations, and that a hormone prescription requires this kind of qualified person to write a letter of permission.

While several participants seemed to have a relatively neutral or positive

experience within the public mental health system in gaining access to hormone therapy or surgery, the extended and variable wait times direct people into private systems of assessment — where experiences seem far more varied and negative. These experiences demonstrate a clear conflict between the transgender individual seeking access and the mental health professional carrying out the assessment. Many of the participants did not wish to be treated as mentally ill, and did not want their past leading up to self-identifying as transgender to be explored within the assessment. This can be understood as a process of medicalization — where transgender individuals’ desire to begin hormone therapy or have gender-confirming surgery is seen as something to be deconstructed and diagnosed as gender dysphoria (complete with an exploration of previous traumas and current relationship to gender), it is seen as a mental health concern to be dealt with rather than a personal step in the process of transitioning. Many of the experiences in both the previous chapter and this one demonstrate how the assessment process is largely determined by the agenda of the assessor, such as fitting in a particular gendered box or having to follow a path of transition the assessor saw appropriate, rather than one that is directed by the wishes of the transgender individual.

In some of the experience, the reality of being transgender and seeking out transition-related care is conflated with the individual’s mental health, sexuality, or childhood, which not only treats being transgender as something rooted in negative experiences rather than an internal positive sense of self, but also conflates gender dysphoria with other unrelated diagnoses. While the WPATH standards of care does require an indication that individual’s mental health concerns be “reasonably well-controlled” and that they possess the capacity to make a fully informed decision, it does

seem that some of the assessments that are taking place go far beyond the necessity to meet the WPATH criteria for hormone therapy, and these decisions to go beyond the requirements do not seem to benefit the transgender individuals, but rather extend the time and money associated with beginning hormone therapy, which generally leads to a feeling of being controlled and managed by the assessor to meet a predetermined understanding of what gender dysphoria should look like and how it should be managed.

All of these experiences contribute to the way in which being transgender and seeking care is being medicalized by the mental health professionals — that is, taking a largely non-medical concern, the state of being transgender — and become treated as a concern that must be explored, assessed, and diagnosed prior to the individual’s desired treatment. This is a medicalized process because, for the most part, the participants did not want to pursue therapy before beginning hormones or surgery; rather, this was a step required of them, to be diagnosed with gender dysphoria and to receive a letter of permission. A mental health professional allowing transgender people access to a kind of treatment that is not rooted in mental health, but is rather concerning hormonal effects on the body or surgical alteration. While these treatments may impact mental health, the current medicalized approach is to assume that a mental health diagnosis of “gender dysphoria” is a required prerequisite and for any other mental health diagnoses to be under control. It is quite striking that those who managed the wait time and entered the public mental health system universally had a smooth experience, an assessment of only a few appointments, and left feeling like it was a positive experience, while many of the participants who either accessed care through a private clinic, a university clinic, or the children’s hospital had a highly variable experience where they might have been made to

attend months of therapy and receive care that was inadequate or controlling.

The public system might have moved toward standardization of care in terms of mental health — an approach that may not benefit those seeking long-term therapy or help with complex problems, but this standardization does seem ideal for the mandated assessments to initiate hormone therapy or surgery — an assessment that must, according to WPATH, document a diagnosis for gender dysphoria, but is largely flexible in its requirements. This flexibility could be taken advantage of and used to require more sessions and more information than needed, especially around sensitive details many transgender people do not see as relevant to their experience of gender dysphoria and wish to medically transition, as seen in the private system. But, positively — though perhaps due to a lack of resources and a move toward solution-focused brief therapy and moving people in and out of the system — the “bare minimum” that the public system provides seems to not only provide transgender people with quicker access to care, but also does so (at least relative to the private options) in a way that does not expect a long client history or an exploration of “why” someone might be transgender and whether it was present in childhood — questions that many transgender people find offensive to contend with in the first place. As the public system continues to work, relative to the private system, ideally the wait times associated with getting an appointment are reduced and individuals feel less like they must seek out a private practice to get what they need faster. The conflict that is observed between transgender individuals seeking medical transition and the mandated assessment process is as follows: a process of medicalizing a physical health problem (transitioning via hormones or surgery) and turning it into a mental health problem (diagnosing gender dysphoria as a requisite to access).

CHAPTER 6 | Getting Past The Gatekeeper

While chapter 5 examines and analyzes the different experiences of accessing transition-related health care and receiving assessments for access to hormone therapy or surgery in the public and private systems, chapter 6 offers a focus on the participant's specific actions taken over their access to transition-related care. Through the lens of medicalization, this chapter considers the role of several factors, including the participants' role in self-advocacy, their resiliency, emotional labour, and affective experiences. Drawing on these, this chapter also provides a platform for participant reflections on the state of transgender health care in Nova Scotia. In this way, while the previous two chapters explored the experiences and trajectories of participants through gender-affirming health care, this chapter turns more closely to how those participants thought, felt, and acted while attempting to access either hormone therapy or surgery. Here, the intention is to highlight the ways that participants were active in their medical transition journeys and that — more than simply accessing one system rather than another — their agency, decisions, and capacities, in addition to other qualities, influenced their experiences.

Nearly all of the participants described engaging in research and self-education prior to beginning the process of assessment. The reasons for doing so varied, but often overlapped. Some participants engaged in this process as a way of preparing for their interactions with healthcare professionals; others did so as a means of managing their expectations, and subsequently, their experiences of the accessing care; still others sought to have a more complete picture of what the system looked like; and finally, some did so to education educate their healthcare professionals on the realities of being transgender,

or on the effects or outcomes of hormone therapy or surgery. That so many of the participants in this study did their own research prior the assessment process reveals a number of important insights. In the first instance, it speaks to the inherent expertise transgender people have concerning their own needs and experiences, and the extent to which many simply require a supportive environment that facilitates what they already know they require. In the second, however, it betrays the challenges transgender people anticipate as they move through the system of gender-affirming health care. These included a lack of professional understanding and capacity, and a very strong sense that they — as client or patient — would be at the mercy of the system and its gatekeepers. Indeed, in many participant narratives, self-education pointed to the profound lack of individual agency ascribed to clients throughout the process. Faced with a paternalistic system that sought to pathologize and manage their transition, many participants described having a lack of control over their transition.

Learning about the process in advance was one of the few ways they could gain some control over their own transition, which otherwise was largely shaped and directed by the assessor. Liam commented on his ability to find information, and how it affected his experience: “My ability to get on the internet, research, find links, ask people questions, push for answers, not taking simple answers, being like ‘tell me what else can I do’, that definitely helps... even kids today are going to be a lot more informed than half the therapists that are giving that are giving the therapy.” Liam's reflection that some transgender youth arrive to their therapy with more knowledge than the professional seems to point to an inherent flaw in the system. Posited as gatekeepers rather than facilitators, many of the professionals accessed by this study's participants had little

insight beyond the system's requirement for a medical diagnosis (that is, gender dysphoria), which served as the sole deciding factor for access, rather than viewing a transgender person as someone with a complete identity outside of this medical model. The role of self-education also suggests how the current system privileges both a medicalized and cisgender perspective when it comes to transitioning; despite the fact that the participants were aware of their gender identity and desire to begin hormones or have surgery, many expressed having to research the process in order to develop a better way of communicating this identity or desire to the assessor with the hopes that the process would be smooth and that the assessor would understand or be "convinced". This might look like having to reword feelings or retell experiences in a way that suited the perspective of the assessor, as opposed to corresponding to the actual experience and perspective of the client.

We can understand the requirement for diagnosis in several ways. First, we might look to the legacy of an enduring history of social exclusion and marginalization. In this context, isolated (and perhaps less aware or less able to articulate their experiences), older people suffering from depression, anxiety, and other mental health concerns, were accessing therapists for diagnosis and support who in turn would uncover their transgender identity and offer access to treatment. In contrast, nearly all of the participants interviewed for this study pursued medical transition only after their gender identity was very much clear to them. There was no professional-facilitated discovery of their gender identity; instead, they came to know themselves through processes of self-discovery that typically relied on supportive peer networks.

At the intersection of self-education and self-awareness, many participants

reflected on the requirement of self-advocacy. Of their experience, Jamie explains: “I consider myself probably one of the lucky ones because I've done a lot of research. Then of course being trans and having to be your own expert, you have to self-advocate. I think really the only advantage that I can say I have was that I put in so many years of knowing who I was, and I wasn't fitting into the boxes, but I had done research. So as hard as it was to advocate for myself, I was able to do it in some ways because I had that knowledge and experience.” The importance of self-advocacy again corresponds, at once, to the ways in which transgender people are their own experts, but also to the requirements and harms of medicalization. Here, self-advocacy can look a lot like having to “prove” one's gender to the professional. Put differently, being regarded as “untrustworthy” in their own understandings of their gender, participants felt that they had to self-advocate to ensure they could access the care they required. The system is, thus, revealed to responsabilize transgender people, while simultaneously de-centering their expertise. Here, the system becomes something to navigate and overcome, as opposed to something which facilitates access and care. This is further exaggerated when transgender people are faced with professionals who are not educated in transgender identity or in the exact process to access treatment. For example, Noah reflected on his experience of doing research and educating the private therapist he worked with and considering the effects of this: “I was saying [to the therapist], ‘in my research, that's not actually correct’. I eventually did end up educating her and sending her [the therapist] links and stuff and she said ‘oh okay, maybe I need to do a bit more research’. She was kind of under-educated or miseducated in the actual medical transition. I feel I paved the way for other trans people to see her because I've had people ask me ‘would you

recommend her' and I say 'not really', but I feel like I kind of opened her eyes to non-binary people's experiences, so maybe she would be more accommodating in the future for other non-binary people. I've helped her learn, and hopefully she can improve that for other people." Noah's experience (outlined in full in chapter 4), in which his therapist came from the position of not believing his gender, or being willing to recommend him for treatment until he conformed in ways she felt was necessary, clearly demonstrates how the professional's perspective is placed at the centre of the process, while the responsibility to direct the process toward what the client wants falls solely on the client. Noah's experience further demonstrates how transgender clients are made to work with professionals who are under-educated, and yet are placing gendered expectations upon those who may be non-binary or otherwise not conform neatly into the "transgender box" that cisgender assessors may have. These issues with the process further medicalize the experiences of those seeking transition, as they are unable to simply enter these sessions, authentically be who they are, and access the care they need, but are instead expected to conform their experiences into one that can meet the criteria for a diagnosis that misunderstands being transgender as a kind of dysphoria or distress that follows the expectations of the assessor.

Riley also reflected on being able to self-advocate and focus on getting to the end of the process, even in the face of the system's barriers. They said, "I don't get turned off of something very easily. When I kind of get fixated on something, I will do anything I possibly can to make it happen. I'm determined. I don't know how to not go hard. For folks who wind up getting discouraged for a whole lot of reasons, it would be a lot harder, because it's really easy to wind up at either finding a real roadblock or even

perceiving a roadblock. It would be pretty easy to get discouraged in this whole thing, either not having enough information, not knowing how to go about this process, or even just like having a bad experience from a gatekeeper and being like ‘I don't want to do this anymore, I can't put myself through this.’ So [my success is] a mixture of luck, and [the fact] that I go hard.” Riley describes an experience that is difficult, filled with roadblocks, and in which the average person may get discouraged easily, based purely on how complicated the process is. Riley’s and others’ experiences suggest difficulty navigating the convoluted, multi-step process of the current system, in which one must meet with multiple people such as family doctors who may refer to a mental health clinic, mental health assessors who provide a letter of recommendation, sexual health doctors who then write a prescription, surgeons, nurses who may educate on dosages and injections (or who might assist with surgery) as well as the many phone calls and appointments that need to be made. As Riley suggests, if you are not someone who can “go hard” and direct a lot of energy and effort into this process, you might be someone who is discouraged and their transition is delayed or never completed at all — which in turn could lead to worsening mental health or self-medicating, as seen in Rachel's story (outlined in chapter 4). Indeed, while this study interviewed those who ultimately managed to receive a letter of recommendation for hormone therapy or surgery — and many of the participants shared a capacity to fight through the system, not give up, and eventually be successful to the point of accessing care — it is important to think about who are those who were “unsuccessful” or unable to “go hard” and put up with the system as it currently treats transgender individuals. This population might be more vulnerable and in need of greater support than those who are able to do their own research, self-advocate, and get through a

system which is set up to favour those with money, time, education, and the emotional resiliency required to propel oneself through all the steps.

Several participants reflected on not only the degree of research and education they had to engage in, but also the level of emotional labour the process demands. Elizabeth described the level of labour and commitment it takes to move through the process, and how emotionally draining it can be: “The amount of times I’ve called MSI [Medical Services Insurance — Nova Scotia] and the amount of times I’ve called the sexual health centre, and the amount of times that I’ve called offices around this province is disgusting. Also dealing with the people it’s always really hard. Especially before I had my name changed to be like, ‘Hi, I’m [dead name] but that’s not my name, but that’s what it’s on file as. But use “she and her” — that’s not a request, that’s a demand. But also please do what I want.’ Having to stick up for yourself and be very, very firm but then also simultaneously having to suck these people’s dicks because they’re the only ones who can help you.” Elizabeth’s experience suggests how marginalized people within the healthcare system are not in an ideal situation to obediently follow the medical system while also making demands of how that system treats them. Transgender people are forced to navigate through paperwork and systems that only know them as their previous name, gender, and pronouns, and through people within the system who may not be aware of the best practices surrounding these. Elizabeth describes a double-bind situation, where either she is firm about who she is or she follows the system in hopes of accessing care. Doing both at once requires a lot of emotional labour of one person who is simply pursuing gender-affirming care.

Liam’s experience mirrors Elizabeth’s. He describes the amount of effort he put

into the process and how it ultimately affected him: “Tracking down the phone numbers for these people once the referral has gone through — you have to be on the phone, you have to get yourself through all of the receptionists, you have to be as kind as possible to whoever is willing to give you the information. Constant calling, especially with the surgeons and the psychologist waiting list, constantly calling every month asking “did my referral go through”, because you how many referrals doctors say they put through and then they didn't actually end up going through and people get stuck waiting an extra year because of that. I was not going to handle any of that, so I was constantly calling and asking for updates.” Liam’s experience suggests the possibility that if it were not for transgender people being on top of their own care, the system would not work as smoothly or as quickly as it seems to be working. Accessing care becomes its own job where the responsibility seems to fall once again on transgender people to ensure everything comes together — and for those who perhaps cannot make “constant calls” to medical offices, Liam points out that they end up waiting far longer than those who can monitor the process.

When asked about his comfort level during the process, Liam commented, “I think my level of comfort was vastly biased toward my desire to get to the end of the road. So, I was like, I *WILL* put myself in a position makes me uncomfortable, but I’m going to deal with it because I want the result. So, there was this mindset of ‘it’s ridiculous, I shouldn’t have to do it, but I want what I want, and it’s the only way to get there, so I’ll just put a cap on it and let it sit’. But that stuff affects you later. There would be days where I would wake up and be like, ‘I cannot take on the world today because of all the stuff I had to just get over’. You wake up in a state of complete emotional distress,

and you're like 'oh, it's because I had to sit in that room and have this person misgender me, or this woman talk at me, and this bias came at me, and I had to be the one to put the wall down, and protect myself from it', and later on your emotions come fleeting [sic] back. It's rough, totally uncomfortable in some settings, but you just have to accept it, and deal with it, and process it later." The level of involvement required for the process to go smoothly was such that it has affected Liam after it was over. People are willing to put their own comfort and their own wellbeing aside if it means getting to "the end of the road" and starting hormone therapy or accessing surgery. This act of putting aside one's own comfort to ensure the end result was something echoed by multiple participants. It suggests that the system is being tolerated, as opposed to functioning in the most supportive and beneficial way. Moreover — and representing the failures of the system — Liam's experience was clearly not therapeutically necessary, despite the amount of therapy that was required of him. Reflected in his narrative, the process — predicated as it is on the ideals and practices of the medical and diagnostic model, can actually induce feelings of distress rather than identify them, or exacerbate the distress associated with possibly being withheld treatment, while mistakenly assuming that the process is simply diagnosing gender dysphoria.

Emotional labour is typically known to be the process of managing one's emotions in a workplace or other professional setting — generally to fulfill the requirements of the job, such as maintaining a cheerful affect in customer service or placating bosses during difficult tasks. Emotional labour can be seen as the performance of particular emotions, but also as the suppression of internally felt emotions such as discomfort, anger, or fear. In several cases, the participants discussed how emotional

labour tied into the “job” of getting past the gatekeeper and through to the desired treatment. Participants like Liam had to suppress their discomfort to passively follow the steps to begin hormones. Others, like Elizabeth, had to perform acts of obedience and politeness, both of which reinforced the need to act out a gender that fit into a neat box of “female”. Rather than feeling open to explore oneself, ask questions, and seek support, the role of emotional labour through the assessment process is to ensure that the participants conceal their true feelings in favour of what is expected by the mental health professional, who ultimately has the decision-making power to open the gates to medical transition.

The role of emotional labour also suggests that this process may serve the professional’s interests and curiosities around what transgender people are supposedly like, rather than creating an authentic and therapeutic environment where the client’s true emotions can come through in the context of exploring the client’s identity and gaining support for transitioning — whether or not they are palatable to the assessor’s notions of being a certain gender. For instance, Daniel discussed how he entered therapy unsure of how “masculine” he wanted to be, and whether he even wanted to take on the label of being a binary man. Rather than feeling welcome to unpack these feelings in a supportive environment, Daniel was made to perform each masculine trait the therapist saw as a prerequisite to begin hormones, with the threat of not being provided access if he was not “convincing” enough to the assessor. Despite his efforts to educate the therapist, and his internal frustrations at performing gender in a way he was not ready for, the desire to begin hormones outweighed his capacity to explore his authentic gender expression.

Riley said of the current system that “This process shouldn’t exist. I don’t really

get why we have to go through such a rigorous process. You should totally just be able to give someone a sheet saying ‘this is how it [hormones] works, read it, let me know what you think’.” Once again, this suggestion is closely in line with informed consent. Riley continues and reflects upon how gender as a diagnostic criterion is inherently difficult to understand and work with in a medical framework: “Gender is weird, and I feel like it’s not something that you can really quantify in anything other than a discussion — you could probably write an entire paper on the pathology behind someone’s gender and where everything came from, but I don’t really want to have 60 pages. So at that point, you may as well just have an index card with a check box thing saying ‘this person is trans, check, send it’, because that would be sufficient. I think a lot of this process should be dismantled and slimmed down, and there’s a lot of steps and time in this process currently that don’t need to be there, and the very fact that I know so many people who have had to deal with gatekeeping.” This reflection brings up a very important point that gender, as an internal psychological identity, does not lend itself well to being described and summarized in the few pages of a recommendation letter, and attempts to do so will likely depend on a simplified and medicalized view of gender and its associated dysphoria. The current system seems to straddle a “middle ground” between a 60-page etiology of gender and a simple “check [in the] box” with the current “readiness letter” of a few pages, but Riley questions why either option must exist when a transgender individual is informed about hormone therapy and is consenting to that treatment option. Since the current system requires that the diagnosis of gender dysphoria be documented and each criterion be met, some information must be given to justify that decision — when in reality, transgender people might be better served if this diagnosis is bypassed,

and self-identification and informed consent is the primary requirement to access transition-related care.

CHAPTER 7 | Conclusion: Can We Assess Gender?

Many of the participants in this study had their own ideas of how the process could or should be changed in light of information they had received. Elizabeth said, “The language within the letters themselves are like really really weird and problematic and super patronizing. Like ‘this person (legal name in brackets) is a biological male who strongly feels that they would prefer living life as a female. This person has lived as a woman full time for the last x amount of time. They described enjoying wearing jewelry as a child’. It’s just so ridiculous. If the entire process was removed and I just went somewhere and I said ‘hey I want hormones’ and someone said ‘you know that’s not going to solve all your problems, right?’ and I was like ‘yeah’ and then they were like ‘okay I’m going to go book a specialist’ and that would have been perfect.” Elizabeth’s suggestions look similar to how informed consent has been introduced in other cities — rather than spending time on assessment and diagnosis, the client is told about what hormone therapy may do, and it is the client’s decision (and not that of a mental health professional) to begin this treatment. Elizabeth’s experience, and others’, pointed out how stigmatizing the letters of access given by the mental health professionals are, as well as how they completely misunderstand being transgender and are unaware of the respectful and appropriate language to be used; even if the assumption is that the letters are primarily for other healthcare professionals and not for the client’s own information, the language must be correct and consistent.

Other participants made suggestions that seem to be similar to alternative models of informed consent. Daniel said, “I feel like I handle a lot on my own, so I’m not too crazy about actually seeking out therapy. But certainly if someone had said ‘here’s a

therapy session you have to go to anyway. You might as well spill your guts and nothing will happen [to your access to hormones or surgery]’, I probably would have been a lot more open to the process.” Again, with the potential threat of being withheld treatment, and the mandatory interaction with a mental health professional who is meant to diagnose and not necessarily to understand, participants such as Daniel are not in a safe position to be their authentic selves and be open about their feelings and any struggles they might be facing. As transitioning is a large life change and brings with it many other potential struggles with work, school, family, and so on, a part of this assessment could be an exploration of supports and coping skills rather than focusing on past gendered behaviours and current displays of appropriately (or not) gendered norms — which the assessor, as a typically cisgender individual, will often reduce to stereotypes or transphobic archetypes.

Liam also reflected on potential changes to the current system of accessing transition-related care and said, “A lot of people say that you need to go see the psychiatrist because you’re just rushing into it. But no, we know when it’s right for us. We know exactly when it’s right for us. Just the actual grasping of the reality that I needed to pay a complete stranger for an hour and a half for them to give me a signature for what I know I want, that in itself is a negative experience. It would be nice to have a one-stop shop for transgender people, that way, doctors who aren’t comfortable, they can say ‘there’s this one-stop shop place you can go, here it is’, and then the doctors that are specialized in this field can get a job in this field and help.” Recall the fact that Liam, in another province, was prescribed hormone therapy via informed consent, and then he made the decision to not begin hormones at that time. In this other province, Liam did

have the “one-stop shop” of a doctor who both did the informed consent, provided the prescription, and would have been the person to oversee the injections of testosterone had Liam decided to follow through at this time. When Liam moved back to Nova Scotia, however, the concept of a “one-stop shop” was missing, in that he had multiple avenues of readiness assessment (i.e. private or public) and had to seek out a specific doctor through a sexual health clinic in Halifax.

Following from a different set of experiences, Brandon also spoke of the assessment as being unnecessary. He explains: “The whole process was more of a step. It’s always helpful talking to someone about anything you’re going through, gender dysphoria or other issues, so I guess in that respect it’s good. For me it was more just like a stepping stone to the end goal. Because I know what I want to do. If that step had been taken out I don’t think anything would have changed. It might be different for some people because I know some people go through it and they’re part way through their transition and they think maybe this isn’t for me. It’s hard to say, but for my experience, I don’t really need [the assessment].”

Rachel, who had self-administered hormones ordered from an internet website, reflected on how her decision to do so could have been avoided had the system been more clear and straightforward, rather than a multi-step process whose consistency is wildly variable depending on whether one knows the right places or people — often an outcome of accessing information through peer networks. She said, “Why do you need to know secret code words and who to ask? There should be more information about what you do. I feel like going on internet hormones would have been avoided if I had better information about how the process works. If there had been more information, I could

have started at the point of going into a therapist who could write me a letter. This is the thing I don't like about trans health care stuff. When I tried to get into the sexual health centre I was told by the therapist 'call and say that you are self-medicating, say that you want an appointment with this person'. You need to know what to say, and it's like, I shouldn't have to do that. I checked the website — no mention at all of trans stuff. I was like 'why couldn't you have just had that on your website?' [Problems from self-medicating] could have both been solved if I had just been at the very outside been given a little pamphlet that was just like 'so you want to be a girl, here's the steps. Here's how you get on hormones and where you call and everything'."

Similar to Rachel's suggestion, Noah said, "I honestly think that there should be some sort of guide, and it even would benefit parents as well as trans youth and trans adults. Like, 'Do you think you might be transgender? Do you want to see hormone replacement therapy? If so and you live inside the HRM or inside Nova Scotia, here's a list of clinics who can provide services for you. Here are people who [you] can [see] if you'd like to discuss your gender identity issues. You can see this attached list of doctors who are WPATH-trained'. Or something that says 'you feel this way — here's what to do'. I didn't know what I'm supposed to do, there was just no consensus on what my next step was, and just making it clear and streamlined would be so much easier. If there was some sort of guide or how-to, a [list of] frequently asked questions, just something to ease parents' worries, that kind of thing, that would be so much better and take a lot of the anxiety out of the process."

Cisgender Fairytales and the Role of the Professional

The notion of being able to "assess gender", or to know and determine another

person's gender and therefore diagnose a transgender individual with gender dysphoria, is a fundamentally flawed concept rooted in cisgender ideals of what it means to experience gender as a trans, non-binary, or gender-nonconforming person. Cisgender assessors cannot authentically understand what it means to experience a non-cisgender gender identity, and are compelled by the inherently medicalizing nature of the assessment process to view their clients' gender identity in terms of diagnosing dysphoria and describing lived experience in medicalizing terms. The current system of assessment, based as it is on the DSM-5 diagnostic criteria for gender dysphoria, also reduces transgender identity to a mental health diagnosis based in distress, discomfort, problems to be solved, and a desire for physical changes, rather than viewing dysphoria as one aspect of a multitude of transgender experiences and identities, all of which may lead someone to desire transition.

Gender euphoria (to contrast with gender dysphoria) is a recently coined term which aims to redirect the focus of being transgender away from a model of hatred to one of “comfort, certainty, joy, or excitement” about one's transgender identity, body, or mind (Fury, 2019). Gender euphoria does not necessarily imply a lack of gender dysphoria, but rather the recognition that being transgender is not wholly defined by pain or struggle, or by medical diagnosis, due to the day-to-day experiences of happiness within one's gender identity despite everything — an experience that Fury suggests that is “almost spiritual”, and one that cisgender people may not even experience. They write, “As being cisgender is the norm, my initial suspicions were that [gender euphoria] was a uniquely trans experience, because normalcy brings with it an innate mundanity ... I think gender euphoria is just the act of being seen — by yourself or by someone else.”

The current system in Nova Scotia, which forces transgender people to complete a mental health assessment and receive a diagnosis of gender dysphoria, is ultimately rooted in the assumption that transgender people experience gender in the same way that cisgender people do (or in certain ways that cisgender people assume transgender people do). The process depends on a “cisgender fairytale” narrative of what gender is and how it can possibly be understood, wherein a cisgender professional can identify, classify, and fix the problem, thus “saving” a transgender person from despair, provided that the transgender person can appropriately perform a gender in a way that is coherent to the professional — often, a stereotyped, binary, and preferably dramatic display of appropriate gender norms, ideally coupled with stories from childhood and adult sexual confusion or interpersonal trauma.

In reality, transgender people know who they are and what their gender is. Meanwhile, under the requirements of the current process, the control of knowing who someone is and what gender they are is placed in the hands of the professional, who is likely cisgender and only aware of transgender people in a medical context. Gender, however, is ultimately a social process, and not something that can or should be diagnosed. Within the constraints of the current system in Nova Scotia, those who are best positioned to facilitate access to transition-related care could in fact be other transgender people. At the same time, there are hierarchies within the transgender community, and regulating access to treatment to the hands of other transgender people may not solve these problems if transgender health professionals are largely white, gender-conforming, middle-class, or able to pass as cisgender.

If it is accepted that the role of the professional is to simply facilitate access to

treatment and not to gatekeep based on an assessment of gender, and that no one (not even other transgender people) should be given the power to decide who may or may not medically transition, the rapid development of the informed consent model in Nova Scotia may be the most equitable and anti-oppression course of action with regards to the future of transgender health and access to care.

Recommendations

In light of the experiences of transgender individuals, and of the changes to the assessment process in other cities (which has largely moved away from the WPATH standards of care), a number of recommendations for Nova Scotia's current system of access are described below.

Healthcare practitioners' awareness of all the steps required to initiate hormone therapy or surgery as a transgender person in Nova Scotia must increase, as well as their awareness of the effects/outcomes of both hormone therapy and of the various surgeries transgender people may undergo. The most frequent early access points (university counselors, family doctors, private practices) should be focused upon for this increased awareness. The Halifax Sexual Health Centre's capacity to assist in this and to prescribe hormones (although readiness letters are still required) as well should be more highly publicized — the HSHC likely has the best framework of care with transgender people to implement any changes in practice, such as the introduction of informed consent over the WPATH standards of care. Education campaigns could be done by a number of Halifax-based organizations, including the Youth Project, prideHealth, the Gender and Health Promotion Studies Unit at Dalhousie University, or other researchers at local universities.

As many participants mentioned needing early in their transition, a guide for

transgender people seeking medical transition should be updated or re-created. The current one from PrideHealth (via Nova Scotia Health Authority) was last updated in 2013, and is no longer accessible online (and may only be accessible in hard copy).

Public awareness campaigns need to rebuild the public's trust of community mental health as a viable, common, safe, and positive way to complete the required assessment to begin hormone therapy or surgery. Many people avoid community mental health in Nova Scotia because of the long wait times, lack of choice in providers, and the perception that the care is worse than the private system. However, as several participants in this study revealed, once one can get into community mental health, the experience is often positive.

Community Mental Health itself should aim to reduce the wait time associated with receiving an initial appointment for the readiness assessment; alternately, other measures should be put in place for people to complete the assessment outside of a fee-based private system. For example, the HSHC or another Halifax-based organization such as the Youth Project could hire a social worker who is WPATH-trained for clients to see at no cost outside of the community mental health system.

Within the system of private practice, there needs to be a push toward standardization of appointments and questions, as well as a standard letter of readiness format (perhaps with a guide of preferred language and language to avoid) in order to facilitate more positive and less varied experiences for clients. This might look, overall, like more WPATH-based training, or training from other transgender-specific organizations.

With several cities in Canada, Dalhousie University's health services, and some

Halifax-based private surgery clinics now using an informed consent model of access to care (rather than a mandated letter of readiness from a WPATH-certified assessor), informed consent is a growing alternative model of accessing hormone therapy or surgery in Nova Scotia that may be of benefit to all transgender individuals seeking medical transition, rather than the few who can access Dalhousie Health Services or a private surgery clinic. Since the HSHC's doctors already frequently work with transgender clients who do not have family doctors to prescribe hormones, the HSHC might be an ideal location to pilot this alternative model of care. Instead of turning clients away and referring them to first complete an assessment with a mental health professional for a gender dysphoria diagnosis, physicians would simply complete the informed consent by detailing the physical changes (along with their timeline) and other effects that each hormone therapy at varying doses will cause. Not only does this eliminate the issue of wait times, or that of the cost associated with a mental health assessment, but this is more in line with the way transgender people already view the need to physically transition; that is, a physical problem that has a medical solution, and not one that is necessarily rooted in a specific mental health diagnosis. Indeed, the World Health Organization announced in May of 2019 that "gender incongruence" has been moved out of the "Mental and behavioural disorders" chapter and into the new "Conditions related to sexual health" chapter, stating, "This reflects evidence that trans-related and gender diverse identities are not conditions of mental ill health, and classifying them as such can cause enormous stigma." (WHO, 2019)

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APPENDIX A
Recruitment script for online social media posting

Are you 18 years or older, speak English, and have received a gender assessment for hormone replacement therapy in Nova Scotia in the last two years? I am a queer, non-binary researcher and a Master of Social Work candidate. I am interested in interviewing you one-on-one about your experience of the assessment. Interviews will be conducted in the HRM within the next several weeks, at a time and place of your choosing, and will be audio-recorded as part of a research project aiming to explore individuals' experiences with these assessments. I hope to examine the benefits of the current process and explore its limitations, as well as consider how the process might be improved or changed to benefit the wellbeing of trans and non-binary people medically transitioning. Interviews are likely to take between one and two hours, during which I will ask you a series of open-ended questions about your experience. Your participation is voluntary and all information will remain confidential.

If this sounds like something you might be interested in or if you have any questions about the study, please email me at b.long@dal.ca for more information! Participants will be compensated \$30 for their time and offered bus tickets for transportation.

APPENDIX B | Forms

INFORMED CONSENT FORM

Assessing Gender: Exploring Transgender Individuals' Experiences of Assessments for Hormone Readiness in Nova Scotia

Lead researcher Bry Long Dalhousie School of Social Work B.long@dal.ca 902 449 9459	Supervising Researcher Dr. Marion Brown Dalhousie School of Social Work Marion.Brown@dal.ca	Supervising Researcher Catherine Bryan Dalhousie School of Social Work C.Bryan@dal.ca
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INTRODUCTION

You are invited to take part in a research study by Bry Long, a Master of Social Work student at Dalhousie University in Halifax, supervised by Dr. Marion Brown and Catherine Bryan. **Choosing whether or not to take part in this research is entirely your choice.** The information below tells you about what is involved in the study, what you will be asked to do and about any benefits, risks, or discomfort that you might experience. Please discuss any questions you have about this study with Bry Long; ask them as many questions as you like. If you have questions later, please contact them via email: **b.long@dal.ca**

PURPOSE OF THE STUDY

I aim to explore experiences of receiving gender assessments as a step in medical transition. I want to listen to your experience of this system as a researcher coming from within the Halifax queer and non-binary community who aims to work for change. The sooner we can learn directly from transgender individuals about their experiences within health care, the sooner improvements can be made to better the lives of those within this community. I want to explore the benefits of the current process as well as limitations. I want to consider how the process might be changed to benefit the wellbeing of transgender people medically transitioning.

STUDY DESIGN

If you take part in this study, you will complete an interview exploring your experiences receiving gender assessment for hormone replacement therapy in Nova Scotia. The interview is expected to last between one and two hours. This study is taking place in Halifax. A total of 6 to 8 people is expected to be participating in the interviews. You will have the option to meet with the researcher and discuss the findings from your interview,

such as the quotes I used from your interview if you choose.

To a maximum of two weeks, the researcher may reach out to you in order to seek clarification regarding content of your interview. Participants will be invited to confirm if this follow-up is acceptable.

WHO CAN TAKE PART IN THE STUDY?

To participate in this study you must:

1. Be 18 years or older
2. Have received an assessment for hormone replacement therapy in Nova Scotia in the last two years
3. Understand English
4. Be able to meet in the HRM.

WHO WILL BE CONDUCTING THE RESEARCH?

The study is being carried out by Bry Long, a Master of Social Work student at Dalhousie University, supervised by Dr. Marion Brown and Catherine Bryan at the School of Social Work. In order to receive more information about the study, please use the following contact information:

Bry Long
b.long@dal.ca
902 449 9459

WHAT YOU WILL BE ASKED TO DO

We would like to ask you questions about your experiences of receiving a gender assessment for hormone replacement therapy. The interview should take no more than two hours. You are welcome to ask for as many breaks as you like during the interview. If you agree, we would like to audio record the conversation. If you do not agree to be audio recorded, I can also take notes on what you say. We can carry out the interviews at an agreed-upon private location, such as an office or small classroom at Dalhousie University.

POSSIBLE RISKS AND DISCOMFORT

The transgender and non-binary community in Halifax is a small and tight-knit one, which results in an inherent risk to your confidentiality within the community, especially if your direct quotations are used in the final report, as well as if you are an activist or well-known community member and other community members who know you read the final research. While every effort will be made to minimize this by removing specific identifying information (such as names and locations), this remains a risk to your participation. Please consider this possible risk and you are invited to raise your questions or concerns with the researcher.

We can meet in a private location of your choosing. You do not need to consent to your direct quotations being used to be a participant in this study. If you prefer, the researcher will paraphrase what you say from your recorded interview in the final report. You do not need to consent to an audio recording of your interview either. If you prefer, the researcher will capture what you say by taking notes and use that information in the final report. You also have the opportunity to meet with the researcher to go over your interview and which quotations or parts will be used in the final report.

Risks also include the possibility that participants may find discussing their experiences upsetting. Participants will be respected and listened to with the utmost sensitivity. The researcher will be prepared to offer a list of resources for free or low-cost mental health supports to all participants.

POSSIBLE BENEFITS

There are no direct benefits to participating in the study. There may, however, be an indirect benefit in the form of feeling satisfaction with assisting trans-related research.

COMPENSATION

You will be thanked after the interview and offered \$30 for your time. Bus tickets are available for transportation. If you choose to end the interview at any time, this compensation will still be offered.

IF YOU DECIDE TO STOP PARTICIPATING

You are free to leave at any time during the interview. You are always able to skip a question if it makes you uncomfortable. You may end your participation in the study at any time without any penalty - no part of your interview will be used and you will still be offered bus tickets and the \$30 honoraria if you withdraw from participating. After you complete your interview if you wish to withdraw your interview, contact the researcher at b.long@dal.ca to do so, up to August 31st, 2018. After August 31th, 2018, your interview will have been analyzed and become part of the study.

CONFIDENTIALITY

We will do everything possible to maintain your confidentiality. Each interview will either be audio recorded or transcribed by hand (and therefore not audio recorded). A code number will be used on your transcript instead of your name. **Your name will not appear on the transcript or on any files other than the consent form.** The researcher will be the only person to read the transcripts. Recordings will be deleted once transcripts have been made. Transcripts will be encrypted and stored on a password protected USB, which will be locked in a filing cabinet in a locked office when not in use; only a password protected computer will be used to view your transcript and any paper copies

will be stored in a locked filing cabinet, and will be shredded once this research is concluded (which will be no later than August 31st, 2018). In reporting findings, all names and any characteristics that might identify you will be removed. You will be assigned a pseudonym (a fake name) within the final report; you can choose the gender of the name, and other preferences around the name that we assign.

IF YOU HAVE QUESTIONS

If you have any questions about the study, please feel free to email Bry at b.long@dal.ca. You will receive a copy of the consent form for your records. Participation is voluntary. You may withdraw your participation at any time.

In the event that you have any difficulties with, or wish to voice concern about, any aspect of your participation in this study, you may contact Marion Brown at marion.brown@dal.ca or Catherine Bryan at c.bryan@dal.ca.

If you have any ethical concerns about your participation in this research, you may also contact Research Ethics, Dalhousie University at (902) 494-1462, or email: ethics@dal.ca (and reference REB file # 2018-4434).

- A “male” name
- A “gender neutral” name
- Other preferences : _____

My pronouns are:

- She/her
- He/him
- They/them
- Other: _____

Date: _____

Receipt of Honorarium

Participant number: _____

- I have acknowledged that I have received a sum of \$30 cash from Bry Long for my participation in the research titled: **Assessing Gender: Exploring Transgender Individuals' Experiences of Assessments for Hormone Readiness in Nova Scotia**

Date: _____

Participant Information Survey

Participant number: _____

The following questions will help the researcher learn more about the participants in this study. Your name will not be linked to any of the responses you give. The survey is to provide a broader understanding of the participants as a group. Please skip any questions you do not feel comfortable answering.

How old are you?

- 18 - 22
- 23 - 27
- 28 - 32
- 33 - 37
- 38 - 42

- 43 - 47
- 48 - 52
- 53 - 57
- 58 - 62
- 63 - 67
- 68 or older

How would you describe your racial / ethnic identity?

What level of education have you completed?

- Have not completed high school
- High school diploma or equivalent
- Some college or university
- College diploma
- University degree
- Graduate school or professional degree
- Other: _____

Where do you live, in relation to the HRM (Halifax)?

- I live in the HRM.
- I live outside of the HRM.
- I live outside of Nova Scotia.

Where were you born?

What is your employment status? (May check multiple responses)

- Full time employment
- Part time employment
- Unemployed and looking for work
- Unemployed but not currently looking for work
- Student
- Retired
- Unable to work
- Other: _____

Which income group does your household fall under?

- Less than \$10,000
- \$11,000 - \$20,000
- \$21,000 – \$30,000
- \$31,000 to \$40,000
- \$41,000 to \$50,000
- \$51,000 to \$60,000
- \$61,000 to \$70,000
- \$71,000 or more

What is your relationship status?

- Single
- In a relationship
- Married or common law partnership
- Widowed
- Divorced
- Separated
- Other: _____

APPENDIX C | Interview Guide

Thank you for agreeing to participate in this interview. During the interview today, I will be asking you questions about your experience of your assessment for hormone therapy. Please feel free to ask me any questions during the interview and share whatever you are comfortable disclosing. That being said, if you are uncomfortable with any of the questions that I ask, please feel free to say “pass” and we can move on. You can also say “skip” and we may return to the question at the end. Your contribution today will help me gain a better understanding of your experiences and the benefits and limitations of the current process of assessments. There are no right or wrong answers and you are free to share as much information as you like. I am interested in your own unique experiences. The interview has approximately 10 open-ended questions and will last between 1-2 hours. You can choose to stop participating at any time during the interview, and you will still receive the honoraria and bus tickets (if requested) as a thank you. At any time during the interview, we can take a break - feel free to let me know if you would like one. Any questions before we begin?

Semi-Structured Interview Questions

1. Can you tell me a bit about yourself in terms of your gender and other identities or aspects of yourself that you want to tell me about?
2. Tell me about your experiences around pursuing a gender assessment or mental health services with the intent to gain access to medical/hormonal/surgical transition.
 - a. Take me through your experience from start to finish.
 - b. Which system did you access?: Community Mental Health, private practices, IWK, in Halifax, rural, etc.
 - c. Who connected you to the particular system? Self referral, etc.
 - d. How long of a wait was it to have your first appointment?
 - e. How many appointments overall?
 - f. How long from the first meeting to your letter/approval? Did anything seem to impact this, i.e. did they initially deny the letter/approval to you?
 - g. Tell me about the questions asked by the professional.
 - h. Describe your level of comfort in the interactions.
 - i. During your assessment, was there ever a time when you felt you had to self-advocate?
 - j. Describe any (if any) positive experiences around the overall process. Any (if any) negative experiences?
 - k. How did the process provide you with greater insight into yourself, your gender, your desires around beginning hormones or surgeries, or offer any

useful support in transitioning or any other potential struggles?

3. Can you share a time during this process when you felt reluctant to disclose an aspect of your gender, mental health, or other identities to the health professional? If you did disclose, how did it impact the assessment process, if at all?
4. Can you share a time when the knowledge or assumptions of the health professional impacted your well-being during this process, either positively or negatively?
5. Can you tell me about a time when you felt supported? Can you share a time when the health professional worked creatively or collaboratively within the constraints of the current system to provide you better care/services?
6. Can you share a time when you were confused or frustrated by the current system of gender-related health care services in Nova Scotia?
7. Are there any people, groups, websites, or organizations that helped you get connected to begin pursuing a gender assessment?
8. Can you talk about any barriers and/or any advantages (if any) that may have impacted your experiences?
 - a. What do you think helped you to navigate the system?
9. Tell me about the “hormone letter” if you received one in the end. Did you agree with the way in which it was written? What did you disagree with? Tell me about whether or not the letter assisted any other health professionals or physicians.
10. Based on your experience, are there any changes would you like to see with regards to transgender health care / mental health services around gender assessments in Nova Scotia? What are those changes?