ANTI-FAT BIAS AS A BARRIER TO GENDER TRANSITION CARE

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Abstract

This study investigates how trans people experience anti-fat bias as disruptive to accessing gender transition care from psychological, medical, or surgical providers. Based on previous work on health barriers for fat and transgender populations and intersectionality theory, the author predicted that fatness and transgender status would give rise to healthcare access barriers specific to fat transgender patients. Access to transition care in particular was examined as a site where such barriers would be highly visible, if present. Thirteen public texts about trans people's experiences of fatness and gender transition were examined using qualitative content analysis methods. Most subjects described barriers to transition that were related to anti-fat bias. Barriers were primarily cultural. Anti-fat bias discouraged care-seeking behavior and gave rise to denial of care. Gender performances and identities were treated as less legitimate, both before and after gender transition, with respect to fat people of all genders. Based on the findings, there is reason to suspect that people who are both fat and transgender or gender-nonconforming may face increased difficulty accessing other types of healthcare as well.

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Contents

Introduction

Cultural conceptions of fat and trans bodies as public problems give rise to similar experiences of marginalization, especially in healthcare. One important similarity is the way fat and trans marginalization are socially justified according to health claims. The very existence of trans and fat people is politically contentious; in both cases, there is active controversy around whether it is possible to be both healthy and fat or to be healthy and transgender. Critics define fat and trans bodies as intractably ill, with the only solution to stop being fat or transgender; advocates claim that wellness is possible for fat and trans folks but in many cases only with considerable medical assistance. The emphasis on medicalizing fat and trans subjects strongly links these populations with the medical and surgical interventions designed to treat them: weight-loss pills, bariatric surgeries, hormone replacement therapy, and various “sex reassignment” or “gender-affirming” surgeries (sometimes abbreviated SRS). Ironically, widespread barriers to appropriate and compassionate medical care for both groups accompany this highly medicalized status.

Interdisciplinary Literature

The literature framing this topic is unusual for several reasons. First, there is substantial literature on trans and fat health, but relatively little work investigates health care *barriers* for people who are fat or transgender, and virtually none of the literature addresses the intersection of these two populations. Most of the literature on health care barriers and inequalities impacting trans and fat populations comes not from the social sciences, but from medical journals. The literature that does approach these issues from a social science perspective is most often situated within queer studies, transgender studies, or fat studies. These movements are constructed as interdisciplinary or “post-disciplinary.” As a result, much of the existing work in this area often falls outside

sociology. In the context of a largely un-sociological body of literature, a reader may ask on what basis should the present research be considered sociology. The answer is in large part a matter of theoretical perspective.

Intersectionality

While researchers contributing to identity-specific or medical research generally investigate one type of marginalization at a time, the theory of intersectionality proposes that experiences of multiple marginalization are not simply the experiences of each combined, but a unique and often magnified form of marginalization (Crenshaw 1993). This theory emerged to address gaps in anti-discrimination protections for Black women and is most often deployed to study the intersections of race and womanhood, but has been adapted for other marginalized groups, including intersections of trans and disability status (e.g. Puar 2014) and intersections of gender and fatness (Ailshire and House 2011). Using an intersectional approach allows researchers to understand the specific challenges of particular multiply marginalized populations.

To that end, the present research seeks to understand how anti-fat bias produces health care barriers for trans individuals, and how those barriers are understood and experienced. Trans-only and fat-only studies of health care disparities often make policy recommendations for health care providers, but they do not address intersectional issues and thus these recommendations may not address the needs of patients affected by intersectional marginalization. The present research seeks to create a basis for more informed policy addressing the health needs of people who are both trans and fat.

Access to Care

Tracing the steps any patient takes to access care, there are many stages where barriers can occur. For a person to receive the medical care she needs, she must believe that she has a problem that can be addressed medically, that she could find a doctor or other health professional who would be willing to provide appropriate care, and

that she could actually go to the appointment in practical terms (e.g. she can afford care and has transportation to reach the care facility). On the provider side, appropriate care depends on factors such as willingness to render care, appropriate training or expertise, and compassionate treatment of this type of patient.

Even if a patient seeks care and a trained, compassionate professional is willing to give it, institutional barriers can block access to appropriate care. Access to care is determined by law and policy at many levels. State and federal law, insurance policy, hospital or practice policy, and best care recommendations by medical associations can all impact who can receive certain medical services, when, and at what cost.

Thesis Outline

The research is presented in several sections. Following this introduction is a background chapter introducing transgender and fat populations through the lens of diversity-positive transgender and fat theories. The purpose of the background section is to establish that “transgender” and “fat” both describe marginalized populations. Because these populations are frequently moralized as deviant and treated with a low degree of empathy, I will explicitly demonstrate the outcomes of marginalization as an injustice. This section also provides notes on language use and definitions for terms appearing throughout the thesis.

The third chapter outlines methods. I employed content analysis to examine existing public writings published online by trans people struggling with issues relating to body size and transition. Authors included men, women, and nonbinary individuals. Public narratives included published personal essays, editorials, public blog posts, and advice columns. Whether self-published or part of a formal publication, these are public narratives and are not human research as defined by the UCSB Office of Research. Narratives were analyzed according to qualitative content analysis methodology.

The next two chapters describe the results of the study. The results were divided chronologically, between barriers arising before the patient decided to seek medical care and barriers arising later. I found that subjects most often talked about social barriers rather than practical barriers such as affordability, local availability of services, or refusal of care by providers. The most dominant theme was the legitimacy of gender identity and performance. The question of legitimacy was closely tied to fatness in every narrative.

The final chapter presents conclusions and discussion. Here, I compare the findings of this study with an existing model of health care barriers. Creating a model of sequential barriers to care for fat transgender patients implies that interventions for improving care should occur significantly before patients ever meet a provider. I recommend strategies for improving access to care and directions for future research.

Background

Language surrounding body and gender diversity is highly politicized, and conventions vary widely within relevant communities. In deference to diversity-positive activist uses, I use *transgender* (or trans) and I use *fat* rather than obese, overweight, or any of the many euphemisms used for fatness. In keeping with diversity-positive conventions, I use both "trans" and "fat" as value-neutral descriptive adjectives.[1] Because this research is situated within an interdisciplinary body of literature and considers sources outside queer, trans, and fat studies, the language of the present study is often different from language appearing in cited sources. I preserved self-descriptive language in data and sources by trans authors, but other-descriptive language from academic sources outside is usually paraphrased according to the conventions of fat and trans studies.

One challenge of language in the discussion of trans identities in academic writing is pronouns for hypothetical persons. Neither the conventional generic "he" nor the feminist generic "she" will suffice. "He" centers men, who enjoy disproportionate representation in general, while "she" in this context centers trans women, who enjoy disproportionate representation in transgender narratives. The construction "he or she" is appropriate only for binary-gendered subjects, while the singular "they" can give rise to syntactic ambiguity.[2] More complex constructions like "he/she/they" are cumbersome and nonetheless marginalize pronouns used by many trans people.

To include the full range of possible gendered subjects with optimal clarity, I employ a variety of pronouns for hypothetical subjects, including neopronouns.

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1 Some people who fall within the operational definitions of "transgender" or "fat" would not self-describe using these terms, possibly including some of the subjects of this study.

2 The singular they is also, despite its reputation, perfectly grammatical (Merriam-Webster 2016).

Neopronouns are invented gender-neutral or gender-inclusive pronouns. These pronouns tend to follow the declension patterns of “he” and “she,” but for clarity, I have included footnotes on the first use of each pronoun indicating its full declension (e.g. they/them/their/themself) and the year of origin, in known. Including pronouns that may be unfamiliar to the reader has the additional felicity of bringing pronouns which are often erased into sociology and trans studies.

Who is Transgender?

A transgender (trans) person is someone whose endorsed gender differs from the one assigned to aer[3] at birth. A trans woman is a woman who was assigned male at birth. A trans man is a man who was assigned female at birth. I also use the terms “transmasculine” and “transfeminine” to indicate people whose transitions orient toward more masculine or more feminine (respectively) genders than they were assigned or socialized as. These terms include trans men and women as well as people who transition but do not identify as men or women.

A person who is not transgender is cisgender (cis). Broadly, a cisgender person is someone who identifies as the binary gender assigned to him or her at birth, but there are some cases which complicate this definition. For example, intersex people (those born with ambiguous sex characteristics) sometimes self-identify as transgender even when they have not undergone a voluntary transition process. There are also cases of children being raised as a gender *not* assigned to them at birth and later transitioning back to their originally-assigned gender.[4] They may likewise be considered transgender despite identifying as their assigned gender.

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3 e/em/eir/emself (1990)

4 Most famously David Reimer, who was raised as a girl after his penis was destroyed during circumcision.

Binary trans people understand their gender as occupying a discrete and usually fixed position within the male/masculine and female/feminine binary. There are also *nonbinary* (NB or enby) trans people, who may additionally identify as agender (having no gender), bigender (having two genders), genderqueer (having a gender which "queers" or challenges the gender binary), genderflux or genderfluid (having a flexible or fluid gender), or many other gender identities.

Many trans people use more than one term to capture their self-concept. For example, someone might self-describe as a nonbinary trans woman. Identity terms may also be compounded or modulated with prefixes and suffixes (e.g. biflux, a genderflux identity with two specific gender aspects, or demigirl, identifying somewhat but not completely as a girl). The wide variety of terms reflects a value within the trans community for having expansive language to capture subtle differences in the way individual people experience and express their genders.

Transgender people often (but not always) undergo gender transition. Gender transition is a deliberate renegotiation of a person's gendered social position. A transitioning person alters hir[5] social identity, legal identity, gender expression, and/or body to better align with hir subjectively experienced gender identity. Trans people and their health care providers usually describe transition as having several modular elements or subtypes. Social transition includes changing thon's[6] name of use, pronouns, and clothing; legal transition includes changing thon's legal name and gender marker; and medical transition includes hormonal and surgical interventions designed to change the body itself (Shultz, 2015). Not everyone goes through all changes; differences in preference, knowledge, "starting point" such as initial name or

5 Ze/hir/hir/hirself (1996)

6 Thon, thon, thons, thonsself (1858)

appearance, and resources can all influence the makeup of a person's transition. For the purposes of this study, transition care refers to surgical, medical, and mental health care relating directly to processes of gender transition.

Public discourse about transition both within trans spaces and in broader cultural contexts frequently understands medical transition and "passing" as the central and defining goals of transition. Passing, in this context, refers to a person's intelligibility as their gender. For binary trans men and women, this means being recognized as a man or woman by others. This idea of transition tends to associate surgical transition and passing with legitimacy, which may create social pressure to pursue certain elements of transition independent of individual trans people's needs. According to the World Professional Association for Transgender Health (WPATH) Standards of Care (2011), the goal of gender transition care is to help trans people achieve "lasting personal comfort with their gendered selves" (p. 1). This may or may not mean passing. Transgender identity can also be accompanied by gender dysphoria, which WPATH (2011) defines as "discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth" (p. 2). One purpose of transition can be to alleviate dysphoria, but the Standards of Care emphasize that a person may alleviate dysphoria without medical interventions and without passing (p. 5).

There is disagreement, even within trans communities, about how broadly "transgender" should be defined. Nearly all the trans-identified scholars whose work I reviewed acknowledged this disagreement and provided lengthy justifications for their definition of transgender, usually at the very beginning of the publication (Wright-Shultz 2015:xi-xii, Stryker 2008:19, Prosser 1998:176, Feinberg 1996:x).[7] For the purposes of

7 An interesting outlier is Jay Prosser, whose work focuses on transsexual embodiment. Prosser assumes a reader who is already familiar with the transgender "figure" within queer theory. Instead of including

this study, a trans person is someone who has undergone, is undergoing, or wishes to undergo any form of gender transition, including both binary and nonbinary trans individuals. This definition is not meant to endorse an ideological position on who "counts" as trans, but to capture the subset of trans persons to whom access to transition care would be most relevant. In the context of this study, "transition care" includes formal psychological, medical, and surgical care intended to affirm the patient's gender, treat gender dysphoria, or otherwise support the patient's transition.

Who is Fat?

Just as there are different ideas of who counts as trans, there are different ideas of who counts as fat. According to the Centers for Disease Control (2015), an adult is obese or overweight if cir[8] weight in kilograms is at least 25 times the square of cir height in meters. One criticism of BMI as a measure of fatness is that people with very different body types may have similar BMIs, illustrated in the images below:

Lance Brooks (left) and Donald Trump (right), both medically obese.

Donald Trump received criticism throughout his 2016 presidential campaign regarding his weight, often specifically citing his BMI. At 6 foot 3 inches and either 236 or 267 pounds, Trump's BMI is between 30 and 33, at the low end of medical obesity

a straightforward definition in the introduction or first chapter, Prosser addresses the complexity of the term in an etymological aside about two-thirds of the way through his book.

8 ce/cir/cirs/cirself

(Quinn 2016). Olympic athlete Lance Brooks has a similar BMI—about 31—but he would not be socially defined as fat ("Lance Brooks"). Although BMI standards vary only between adults and children, social standards of fatness are highly contextually sensitive. Differences appear between men and women, gay and straight men, and people in different social and professional roles. As Marilyn Wann (2009) argues,

> In a fat-hating society, everyone is fat. Fat functions as a floating signifier, attaching to individuals based on a power relationship, not a physical measurement… A young woman who weighs eighty-seven pounds because of her anorexia knows something about fat oppression. (p. xv)

For the purposes of this study, a fat person is anyone whose body is problematized as being too heavy either by perself[9] or by others. This includes medical definitions of "overweight" and "obesity" as well as people who experience social stigma or self-stigmatization based on body size. If a person talked about experiences of fat marginalization, about denial of care (real or imagined) based on hir weight, or about friction between fatness and gender legitimacy, ze is fat for the purposes of the study.

9 per/per/pers/perself (1972)

Literature Review

Literature on fat and trans people is often focused on medical practices, reflecting their highly medicalized statuses. However, there is also a large body of work addressing economic, social, and medical inequalities both groups experience. Much of the available literature addressing either gender variance or fatness with regards to health care and other inequalities comes from outside sociology; it often originates in medical science, nursing, and social work. As a result, the following literature review casts a wide net, including work from sociology and other social sciences, but also from the medical sciences. Since public constructions of fatness and transgender status are influential to stigma (and policy), I include occasional consideration of popular media as well.

Much of the literature on fat or trans people is situated within theoretical perspectives which define these populations by their need for medical intervention (Shultz 2015, Prosser 1998, Wann 2009). Arising in response to these perspectives are two critical bodies of literature, fat studies and transgender studies. Both perspectives are rooted in critical gender theory. These perspectives understand fat and transgender bodies as natural forms of body diversity, and affirm that these groups should have access to medical care but resist the pathologization of fatness and transgender status themselves (Feinberg 1998, Wann 2009). In keeping with feminist methods, these perspectives center fat and trans voices, arguing that medical perspectives fail to capture fat and trans experiences and may promote goals that conflict with the interests of the people they are intended to serve (Prosser 1998, Wann 2009).

This section outlines patterns of marginalization that trans and fat people (respectively) experience. However, side-by-side comparison of fat and trans marginalization is insufficient to understanding the experiences of people who are both fat and trans. Intersectionality theory provides a framework for studying the meeting

point of two or more marginalized categories. While literature on fat-only and trans-only marginalization is well established, very little work examines the effects of both in concert. However, studies exist which examine trans or fat marginalization intersectionally with *other* traits (e.g. race). Findings from such studies demonstrate that trans status and fatness intersect with other marginalized statuses multiplicatively. These findings suggest that trans status and fatness will interact similarly with one another.

Fat & Trans Marginalization

Fat and trans people are subject to marginalization across virtually every area of their lives. Economic marginalization limits access to resources. Social marginalization leads to rejection, harassment, and violence. Medical marginalization precludes appropriate and compassionate care. Together these result in poverty, compromised physical health, emotional distress, and even suicidality.

Economic inequalities. In the US, neither body size nor gender identity is a protected status in terms of federal law. This means discrimination against fat and trans people in hiring, pay, housing, and other resource distribution is usually legal. According to the ACLU (2016), 18 US states and the District of Columbia have passed some kind of discrimination protection for transgender people. Anti-fat discrimination is illegal only in one state and a handful of additional US cities (Vade & Solovay 2009). In most of the US, anti-fat discrimination is legally ambiguous, with courts finding it objectionable only where fatness is interpreted as a disability (Elser 2012). A recent resolution by the American Medical Association (2013) specifically discouraged interpreting fatness as a disability, which could undermine disability-based discrimination claims going forward. However, this is unlikely to improve employers' evaluations of fat workers.

Given the absence of consistent legal protections, employment discrimination and unequal pay are predictably common. Gallup found that BMI is positively associated

with long-term unemployment (Crabtree 2014). A meta-analysis of twenty-nine studies found that women earn less as their weight increases, with wages discounted as much as one fourth compared to the earnings of thinner women (Cawley 2000). The National Center for Transgender Equality (2016) finds that employment and pay inequalities exist in trans communities as well; trans individuals are twice as likely to be unemployed as the general public, and almost half report adverse treatment such as hiring discrimination, being denied a promotion, or being fired because of anti-trans discrimination.

Beyond employment and pay inequalities, fat people face “fat taxes,” which are moralistic or opportunistic increases in the cost of goods and services marketed to fat people. Proponents in the popular press defend fat taxes on food (Rampell 2009), clothing (Fierce 2010), and airfare (Stephenson 2015). One author explored a clinician’s call for a “fat tax” on the cost of health care to force fat patients to “take responsibility” for their financial burden on society; the same clinician said he would also like to stop hiring fat people (Leonhardt 2009). In some cases, the aim of a fat tax is punitive, designed to disincentivize fatness; Rampell (2009) notes these penalties do not actually have the effect of spurring weight loss.

Medical inequalities. Marginalization gives rise to medical inequalities at every level of care. Biased policies at both the institutional level and the provider level make appropriate health care less available, less affordable, and less effective for trans and fat patients. As a result, trans and fat patients have worse experiences in healthcare settings, worse health outcomes, and less trust in the medical industry than their cisgender and thin counterparts.

Institutional bodies including federal and state governments, professional associations, insurance companies, and hospital boards create policies which define who can receive care, on what timeline, and at what cost. Institutions such as medical

schools and law-making bodies also determine who is educated about certain types of health needs and what they are taught. Institutional barriers to health care are the most far-reaching and in some ways the hardest to negotiate. As a result, these barriers often attract the most activist attention.

In terms of US law, health care policy has become more inclusive for trans patients in recent years. Until 2010, insurance carriers could limit coverage for procedures according to sex. This means a trans man could be denied coverage for a mammogram or Pap smear, while a trans woman could be denied coverage for a prostate exam.[10] The Affordable Care Act made this type of policy illegal, but in practice insurance companies still deny claims based on incongruence between patient gender and services (Gillespie 2015). This forces trans patients to either pay out of pocket or spend additional time appealing the decision. It remains legal for insurance companies to deny coverage of transition-related expenses ("Transgender Health Care"). New efforts to repeal the Affordable Care act could remove even these limited protections (Lang, 2017).

While US health care policy has become marginally more welcoming to transgender patients in recent years, is has become more hostile to fat patients. The declaration by the AMA that fatness is a disease but not a disability could remove the thin employment protections that exist, while also ensuring that additional state support available to disabled people is *not* available to fat people. An emerging paradigm for fat health care, piloted by the Endocrine Society (Apovian et al 2015[11]), endorses a policy

10 Intersex people, who are born with ambiguous sex traits, also suffered because of this policy.

11 Apovian and her colleagues published several papers outlining their recommendations; the one cited was published slightly after the critical articles because the first paper is not available. Apovian et al have published a statement explicitly standing by their recommendations in the face of criticism, so I take it that this version is adequately similar to the original to associate with their earlier criticisms.

that Tucker (2015) summarizes as “treat the weight first”—which critics worry will encourage clinicians to prioritize weight loss above other health concerns. This controversial policy discourages clinicians from prescribing drugs to fat patients if the drug can cause weight gain (including drugs like insulin, antidepressants, and antipsychotics), even if the drugs are already working well to manage the patient’s health problem; it also encourages the use of weight loss drugs whose safety, critics say, is not well-established (Apovian et al. 2015, Tucker 2015). Fat health activist Regan Chastain (2015) criticizes the policy for establishing “that only thin people should get evidence-based treatment for their health issues” (par. 5).

The problems do not stop at policy. In practical terms, the US healthcare system is acutely underprepared to render care to fat and trans patients. Health care providers are given very little training in treating either fat or transgender patients, leaving them unable to render competent care. Health care providers self-report low levels of confidence in their ability to render care to fat and trans patients and are not sure where to find better information (Jay et al. 2009, Snelgrove et al. 2012). Additionally, clinics may not have equipment appropriately sized for fat patients, may not have bathrooms suitable for trans patients, or may otherwise have clinical environments that are inhospitable (Phelan et al. 2015, Thornhill & Klein 2010).

Lack of training and unwelcoming clinic environments communicate to both providers and patients that trans and fat patients do not belong; overtly biased treatment is highly normalized. A study of provider attitudes found 45% of health care providers reported responding negatively to fat patients (Jay et al. 2009). A study of fat patient experiences found that a similar proportion of fat patients identified experiences of anti-fat stigma at the hands of a medical professional (Mold and Forbes 2013). Trans patients face “outrageous frequencies of anti-transgender bias in care” (Grant et al.

2010). Lambda Legal (2010) found that over 70% of fat respondents had experienced some form of health care discrimination.

Bias sometimes escalates to the level of harassment or even violence. Puhl and Brownell (2006) found that more than half of fat women experienced harassing comments from their doctors. The most recent National Transgender Discrimination Survey found that 19% of trans people reported being refused care as the result of their trans status. 28% reported experiences of verbal harassment in care environments, and 2% reported physical attacks (Grant et al. 2016). Where care environments are usually ill-equipped and often hostile, patients may take on an educator or advocate role with clinicians, or they may postpone care (Grant et al. 2010, Drury and Louis 2002).

Social stigma. Violence, harassment, bullying, and exclusion are common experiences for trans and fat people. The National Transgender Discrimination Survey (2016) found that almost 80% of trans youth experienced harassment at school and 35% experienced physical assault. Fat researchers find that weight-based bullying is extremely common and socially normalized, but exact rates vary (Weinstock and Krehbiel 2009, Puhl et al. 2015). Both trans and fat people experience escalated risk of sexual violence and less access to police support (Grant et al. 2016, Royce 2009). Almost two thirds of trans people experience some form of family rejection (Grant et al. 2016).

Social marginalization for fat and trans people is intersectionally influenced by gender and sexuality. Among cis people, fatness is tolerated most in straight men and queer women, but least in straight women and queer men (Whitesel 2014). Fat and trans people are desexualized (Asbil 2009, Whitesel 2014, Stryker and Whittle 2006). Yet they experience fetishization and elevated rates of sexual violence compared to thin and cis people (Royce 2009, Grant et al. 2016).

Outcomes of marginalization. Different modes of marginalization work together to disrupt the life chances of fat and trans people. Employment discrimination and pay inequity partially explain increased rates of poverty among these demographics (Grant et al. 2016, Levine 2011). Social and family rejection are deleterious to mental and physical health (Wann, 2009). Family rejection and employment discrimination contribute to high rates of homelessness, drug use, and sex work among trans people (Grant et al. 2016). All of these combine to higher risk of suicidality (Wagner et al. 2013).

Theoretical Context

The present study is broadly situated within critical theory, drawing on the specific contributions of trans theory, fat studies, and intersectionality theory. Trans theory and fat studies are both interdisciplinary critical approaches emerging out of feminist theory; trans theory also draws from queer theory. They share similar foundational assumptions: first, that body diversity is a natural and value-neutral or positive feature of human populations; second, that the perspectives and goals of mainstream society and especially industrialized medicine are often in conflict with the interests and dignity of trans and fat people (respectively). Intersectionality theory posits that vectors of marginalization combine in multiplicative ways, such that a person who experiences multiple types of marginalization experiences them in a way unique to that intersection, rather than experiencing each in a separable way.

Trans & fat studies. Just as they share many experiences of marginalization, trans and fat populations share some methods of addressing marginalization. One method is the development of diversity-affirming theory that challenges stigmatizing notions of fat and trans identities. Fat and trans theories present viewpoints critical to mainstream social ideas of fat and trans as deviant. These theories challenge oppressive practices and viewpoints and center fat and trans voices (respectively).

One of the things critical theory does is challenge popular assumptions about causation. This features heavily in fat studies. Fatness and transgender status are both associated with poor health, leading many to conclude that being fat or transgender are inherently unhealthy or that these statuses are themselves diseases. A critical interpretation would be that since fat and transgender people are marginalized, and marginalization is almost always associated with negative health outcomes, health inequalities are likely explained in large part by factors such as prejudicial medical care, income inequalities, stress, and social stigma (Ernsberger, 2009).

Fat and transgender studies also challenge more basic assumptions about fat and transgender narratives. Both fat and trans identities are frequently defined as medical problems. Fatness is "solved" through weight loss, often with medical or surgical intervention, while gender dysphoria is "solved" by passing, usually as the result of medical and surgical gender transition. Fat studies and trans theory point out that these goals are not universal within their respective populations (Wann 2009, Mattilda 2006). The pressure to "solve" body size and gender identity can mask more pressing problems and generate pressure to conform to or endorse goals a patient does not actually have in order to avoid stigma (Burgard 2009).

Intersectionality theory. The marginalization of fat and trans people is similar in striking ways, raising the question of how these two vectors of marginalization interact. The thematic similarities suggest some outlines for what kinds of experiences a fat trans person might experience, but looking at each piece separately falls short of capturing the full complexity of intersectionally marginalized experiences. The lived reality of occupying a space at the intersection of multiple marginalized groups is not additive but multiplicative; not just the degree, but the *nature* of marginalization can change when new forms of oppression are introduced (Crenshaw 1993).

Intersectional theory (or intersectionality) emerged in the late 1980s to examine this function of marginalization (Cho et al. 2013). The classic position of intersectionality posits that Black women do not experience anti-Black and anti-woman marginalization separately, but in a way that is multiplicative and unique to Black women: when a Black woman experiences sexism, it is influenced by racism and when she experiences racism it is influenced by sexism (Crenshaw 1993). She experiences marginalization as a Black woman, not as only Black or only a woman. Intersectionality frequently focuses on the experiences of women of color, but this framework has also been adapted for use examining other intersectional identities including other genders, queer sexualities, disability status, and fatness.

The Intersection of Fat & Trans

Literature specifically focused on the intersection of gender variance and fatness is very rare. One such study focuses primarily on law, but focuses in large part on the shared pressure on fat and trans people to assimilate and participate in fat and trans oppression and uphold norms that mark them as outsiders (Vade and Solovay 2009). The authors present a list of “unspoken, false beliefs” which fat and transgender people are asked to support: “there is exactly one good, natural, and healthy body size (thin),” “when a person behaves correctly, by consuming a reasonable amount of calories and exercising appropriately, a thin body will result,” “there are exactly two good, natural sexes/genders (female and male), which correspond in a direct and linear way to exactly two types of sexual organs (vagina and penis),” “when a person behaves correctly, a gender presentation that is obviously and exclusively female or male will result” (Vade and Solovay 2009, pp. 168-169).

Vade and Solovay’s analysis of legal cases in the US shows that trans and fat people who fail to support these assumptions have less access to social support in the form of legal protection. Fat and transgender people seeking access to legal protection

are consistently asked to testify that they would rather be thin or cisgender; their protection is contingent on their consistent attempts to conform to thin and cis norms, even if those attempts ultimately fail “to transform themselves sufficiently to avoid discrimination” (Vade and Solovay 2009:173). The implication of these expectations is that fat and trans people have a social debt to not be fat or trans, but they may be forgiven if they make sufficient effort.

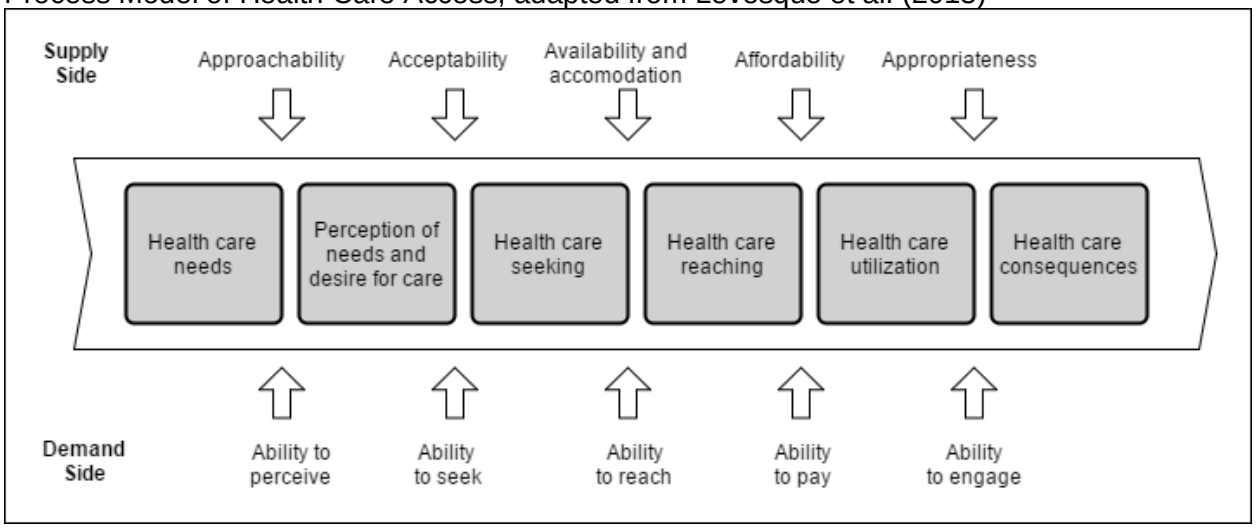
In *Trans/Portraits*, Jackson Wright Shultz (2015) presents a rare emic narrative of fatness in trans experience. Body diversity is not a central theme of Shultz’s work, but several of his subjects discuss weight and fatness. Their stories frequently feature frustrations with medical care. One theme of these narratives is medical gatekeeping preventing accessing care, especially transition care. Shultz’s subjects reported being told by providers that their surgical results would be bad because of their weight or that they had to lose weight to access care (p. 149). Another theme is eating pathologies; some subjects conceptualize disordered eating as a means of controlling their bodies, either symbolically or (in one case) as a means of passing as female. One subject describes avoiding treatment for her eating disorder because she cannot access transition care. “I’m still fighting to get on hormones, so I’m trying to pass as a woman without any help. When I’m thinner, it’s easier to do that” (Shultz 2015:94).

Shultz’s work is more biographical than scientific in nature and only a few of his subjects described struggling with fat marginalization. Nonetheless, his work provides a glimpse of one possible area of intersectional marginalization for people who are both fat and trans. Specifically, it suggests that anti-fat discrimination in medical environments impacts trans people’s access to transition care, and that this in turn encourages maladaptive coping strategies like self-starving.

Process Model of Access to Care

Access to care is an unexpectedly complicated idea. In a 2013 synthesis of literature on concepts of healthcare access, Levesque, Harris, and Russell modeled health care access as a sequential series of steps from the need arising to the ultimate consequences of health care. The authors define access as "the opportunity to have health care needs fulfilled" (Levesque et al 2013:4). In their view, "access is seen as resulting from the interface between the characteristics of persons, households, social and physical environments and the characteristics of health systems, organizations, and providers" (p. 4). The process captures "supply side" and "demand side" features that influence these opportunities starting with the health care need arising and ending with the outcomes of care.

Fig. 1
Process Model of Health Care Access, adapted from Levesque et al. (2013)



Levesque, Harris, and Russell expanded on an existing process model of health care access by articulating ways that complementary supply-side and demand-side features can facilitate or disrupt access to care at each stage (illustrated in figure 1). In order to realize access to care, a patient must overcome or avoid potential barriers at each sequential stage. The authors note that previously, barriers were understood in terms of only some of these stages, corresponding with "health care reaching" and

"health care utilization" in their model. A key feature of this model is its expansive view of health care access and barriers to care.

The unusual expansiveness of the process model means that some factors may be unfamiliar as "barriers" to care. Underserved populations may experience familiar barriers such as high cost and inappropriate provider behavior, but other barriers to care emerge before patients even seek care. Recent population health research on transgender medical access in particular mirrors this expansive view of health care barriers (Roberts and Fantz 2014, Unger 2014, Zieger 2016). Though these authors do not conceptualize barriers in a process framework, they do articulate barriers that fall outside conventional access models. These examples appear in the following discussion of the process model as it applies to transgender healthcare access.

The process model conceptualizes healthcare access as an active process starting with the healthcare need arising. Once a health care need arises, the potential recipient of care may not recognize it as a remediable medical issue. Recognition can be facilitated or disrupted on the provider side through *approachability* and on the patient side through *ability to perceive* (p. 5). In order to receive transition care, a person must recognize that she *is* transgender, know that transition care exists, and feel that transition care would be beneficial (ability to perceive). She must further recognize that a particular provider offers that care and believe that the provider would be able and willing to treat her (approachability). One way for providers to facilitate approachability for transgender populations might be listing transition care on practice websites. A corresponding approachability barrier would be making information about transition services available only by patient request.

A person with an acknowledged health care need may still not seek are due to cultural or social factors. Levesque, Harris, and Russell (2013) describe this barrier point in terms of *acceptability* and *ability to seek* care (p. 5). A patient who personally holds

anti-transgender values or whose family or friends hold such values may be less able to seek care because the care is not socially acceptable. Transgender children in particular usually depend on the support of their parents in order to seek care. A major cultural barrier described in research on health care access for transgender populations is a hesitance to disclose trans status (Unger 2014, Roberts and Fantz 2014). Facilitation of acceptability and ability to seek includes efforts to reduce trans and fat stigma, while anti-transgender and anti-fat cultural movements reduce acceptability and ability to seek.

Once the patient has overcome any acceptability and ability to seek barriers, she faces the issues of *availability and accommodation* on the provider side and *ability to reach* on the patient side (Levesque, Harris, and Russell, p. 6). In contrast with the previous stages, which focus on cultural features, this stage focuses on very practical considerations like location, transportation, and details about the facilities. One accommodation barrier for transgender populations is the absence of welcoming bathroom facilities in health care environments (Roberts and Fantz 2014, Unger 2014). One type of accommodation barrier for fat patients is medical equipment or furniture too small or unstable to fit or support patients' bodies (Phelan et al 2015). Long waits can also be an accommodation barrier (Erickson-Schroth 2014). In one extreme example, *The Guardian* reported in 2016 that the only surgeon in New Zealand who specialized in transgender care retired, leaving behind a thirty-year waiting list for would-be patients (Roy 2016). Some New Zealanders can seek care abroad, but others cannot; this imposes a significant barrier to care that disproportionately affects lower-wealth New Zealanders.

The New Zealand example illustrates the tie between availability barriers and the next stage, *affordability* and the corresponding *ability to pay* (Levesque et al. 2013:6). Affordability includes both direct costs such as the copay or out-of-pocket cost and indirect costs such as airfare, lodging, missed pay, and child care for a New Zealander

seeking care outside her own country. Ability to pay is the result of factors including income, social capital, and insurance. Although linked, affordability does not equal ability to pay. Life circumstances and indirect costs could make even “free” care too expensive for some patients. Cost appeared as a barrier to care for transgender patients (Zieger 2016) and for fat patients (Drury and Louis 2002).

If a patient is able to reach a provider, there is a final barrier point, which Levesque et al. (2013) call *appropriateness* and *ability to engage* (p. 6). This means the care available is adequate in terms of what services are available and in the quality of service; the provider is appropriately trained; and the patient is able to participate appropriately in treatment decisions (p. 6).

Some of the major themes from literature on marginalization for trans or fat people are economic marginalization, social stigma, quality of care, health care avoidance, and health care consequences of inaccessible care. These themes tend to correspond with the last stages of this model, but Levesque et al. (2013) emphasize that barriers are *sequential* (p. 7). If only the last few barriers are understood or addressed, the would-be patients who are blocked from care at earlier stages will remain unknown and underserved.

The present study uses qualitative content analysis of personal narratives about gender identity, transition, and body image to investigate how anti-fat bias disrupts access to gender-affirming psychological, medical, and surgical care for fat transgender people.

Methods

This study employs qualitative content analysis methods to examine public data in the form of personal narratives posted online. A unit of data was a single narrative, whether a one-sentence blog post or a five-page editorial. The unobtrusive method of data collection was chosen for several reasons. In her book on Internet methodology, Hine (2015) identifies unobtrusive data collection as ideal when subjects might be hesitant to talk about a topic directly, or when it is mundane in a way that they might not remember to mention it in a formal interview or survey. Both conditions apply to experiences of marginalization, as stigma can be both sensitive and highly embedded. Subjects may have discussed issues of stigma more openly in an (often anonymous) Internet environment than they would in interviews. At the same time, some of the narratives reflect passing slights and insecurities that may have been forgotten later.

Sample Demographics

Subjects were transgender individuals who have publicly shared narratives of fatness or body fat as relevant to gender transition or advice for trans people navigating fatness and transition. Because the unit of analysis is not a person and sources were sometimes anonymous, it is possible (although unlikely) that the same subject authored more than one sample. Subjects were found in multiple ways. General web searches for "trans+fat," "transgender+fat," "transgender+weight," and similar combinations of terms associated with gender and size diversity turned up blogs, editorials, and peer-to-peer transition resources. On Tumblr I looked for trans-specific pages and then searched for fat-related tags or topics within them (e.g. "fat," "weight"). Groups or pages where membership is limited to certain users were excluded.

The unit of analysis was a complete article or blog post, the demographic characteristics of which appear in Figure 2. Of 13 total writings, two came from personal blogs, four from support blogs, and six were formal articles. Four of the articles were

written for general audiences. Six samples were written for trans audiences. The remaining three samples were intended for specific audiences outside the trans umbrella. Content was drawn from only a single post or article by the subject, but demographic information was sometimes drawn from outside the article itself, but demographic information (discussed later in this section) was collected from other sources, including “about the author” blurbs after articles and separate “about me” pages.

Fig. 2
Characteristics of Samples (Total 13)

Type		
	Personal Blogs	2
	Support Blogs	4
	Formal Articles	6
Intended Audience		
	General	4
	Transgender	6
	Specific Others	3
	Eating Disorder	2
	LGBT	1
Approach		
	Personal Narrative	9
	Advice	4
Length		
	Blurb	4
	Short Form	7
	Long Form	2

The majority of the samples, nine, were structured as personal narratives, focusing on the life and experiences of the author. Four were structured primarily as advice, with less attention paid to the author’s personal history. These differences in approach represent a continuum rather than polar opposites. Some of the personal narratives were addressed to other trans people as an object lesson, while advice pieces sometimes drew from authors’ own identities and experiences.

Length varied considerably, from 82 words to 3,438. However, the sample lengths fell into three distinct clusters. I identified these ranges as “long-form,” “short-form,” and “blurb.” Seven of the samples were “short form,” with a very narrow range of between 1000 and 1335 words. The range for the four “blurbs” (shorter than short-form) was also narrow, ranging from 82 to 128 words. The two “long-form” pieces were 1,618 and 3,428 words.

Author Gender, Race, and Class

In brief, there were 14 total authors.[12] The authors were a roughly even mixture of men, women, and other genders. They seemed to be predominantly white, with one Black author, one Latina author, and one author who identified as "biracial, Métis[13] and white." Race information was not available for all authors. The original coding design included gender and race as single categories, but the information I found about author demographics was complex and frequently ambiguous or incomplete. For example, one subject describes a masculinizing transition process in terms suggesting a binary male identity, but the blog containing the sample article makes it very clear that the subject is actually agender. A limitation of unobtrusive data collection is that it was not possible to straightforwardly verify author demographics. More often than not, identifying a specific gender or racial identity required interpreting information like photos, which may not accurately capture the author's identity. In a study where identity is central to the research questions, conflating investigator-assigned and subject-reported identities would be methodologically suspect.

To address this, I coded these demographics a second time to specifically identify the source of the information as self-reported or implicit and to capture the nuances of gender information as it appeared in the samples. An overview of authors is shown in figure 3 (next page). Bold represents explicit information; dashes represent missing information.

12 One piece had two contributors.

13 Mix of Canadian Indigenous and white ancestry.

Fig. 3

Author Gender and Race

Name	Gender Identity	Assigned Sex	Transition Trajectory	Nonbinary?	Race
"Malcolm"	**man, boy**	female	masculinizing	**yes**	white
"River"	-	female	-	yes	-
Wiktor	**agender, boy, dude, man, cub**	**female**	**masculinizing**	**yes**	white
Ashleigh	**non-binary**	**female**	**feminizing**	**yes**	**black**
"Alex"	-	-	-	yes	-
"Sam"	-	-	-	yes	**biracial, Métis/white**
"Lauren"	**woman**	**male**	**feminizing**	no	-
Katelyn	**woman**	**male**	**feminizing**	no	white
Jen	**woman, girl, genderqueer**	**male**	**feminizing**	**yes**	white
Jude	man	**female**	**masculinizing**	no	white
Mey	**woman, girl**	**male**	**feminizing**	no	**Latina**
Nicholas	**man**	**female**	**masculinizing**	no	white
Ryan	**man**	**female**	**masculinizing**	no	white
Faith	**woman**	**male**	**feminizing**	no	white

Bold indicates explicit information; dashes (-) indicate missing information.

As observed in previous qualitative studies on transgender experiences, the gender identities of subjects were frequently multifaceted (Shultz 2015). Gender coding expanded from one category to three: gender identity terms (e.g. “woman”), transition trajectory (masculinizing or feminizing), and whether the author is nonbinary. The sample had a fairly even gender balance by all three measures. Speaking in broad terms, the sample included five men, five women, and seven nonbinary subjects, with three subjects coded both as nonbinary and as either men or women. In addition to the terms “man” and “woman,” subjects used several other gender terms to describe their identities. They used “girl,” “boy,” “dude,” and “cub” in combination with “man” or “woman.” “Cub” is a masculine gender identity aligned with a specific gay role. The terms “agender,” “genderqueer,” “transmasculine,” and “nonbinary” also appeared as gender identity terms. Three subjects did not use specific identity terms to describe their

identities. Five subjects underwent masculinizing transitions, six underwent feminizing transitions, and three did not indicate a transition trajectory. Half the subjects were coded as nonbinary. Four explicitly stated a nonbinary identity, and an additional three were coded as nonbinary for other reasons. Two of these published on nonbinary-specific platforms, and one used they/them pronouns.

Race was rarely mentioned explicitly, and while some authors provided photographs, others represented themselves through drawings (which may not accurately reflect the author) or provided nothing at all. Depending only on explicit race information would render an inaccurate summary of the data, as only three subjects explicitly mentioned race. All three of the people who explicitly named their race were people of color; one self-identified as Black, one as Latina, and one as biracial, Métis and white. Unsurprisingly, all eight of the people whose race was inferred from visual representations were coded as white. Living in a society where white is treated as the default, they would not be as inclined to name their race or experience race as relevant to their experiences of gender. No race information was available for the remaining three authors.

Class was not part of the initial research question or protocol but nonetheless appeared as an important feature of the subject group. The visible impact of this feature on the results necessitated inclusion. Socioeconomic status (SES) appeared most vividly in the high educational attainment of the subjects. Of fourteen subjects, six authors either had or were pursuing a graduate degree, and another three were identified as college students. Education information was not available for five subjects, but these subjects frequently employed an academic writing style implying that at least some of them had also received formal education. Data regarding subjects' educational attainment were collected after primary coding was complete.

Part of the trend of high educational attainment is no doubt explained by the study's inclusion of professional bloggers, journalists, and activists, but some studies show that in general, transgender people are unusually well-educated compared to the general public. A 2008 report by the Transgender Law Center found that trans adults in California were *twice* as likely as cis adults to hold a bachelor's degree or higher (Hartzell et al. 2008). The authors of this study linked this unusually high rate of educational attainment both with economic pressure and qualitative findings suggesting that universities provide an optimal environment for gender transition. Nevertheless, this relatively privileged sample likely excludes healthcare barriers that more economically disadvantaged trans people face.

Ethical Considerations

Given that I used only public materials that were accessible to anyone, this research fell outside the scope of human research according to UCSB's Office of Research. Nevertheless, the sensitive content demands certain care. Where narratives were clearly designed to be consumed by a wide audience—periodicals, resource sites, and more professional blogs—no special care was taken. Where narratives were taken from personal blogs, authors were anonymized. Some authors were also anonymous in the original format of the piece. In both cases, authors were assigned pseudonyms.

Coding

Samples were analyzed using qualitative content analysis methods. Content was evaluated for information on beliefs about fat, especially as it relates to gender and gender transition; on the source of such beliefs; and on the impact (if any) on access to or quality of medical care. Certain demographic information, if available, was also collected. Specifically, I recorded the presence of gender and race markers. I also recorded information about the sample itself: length, approach, type of source (e.g. blog, article), and intended audience.

I used multi-level thematic coding to structure data analysis. First-level codes were determined in advance, and second-level codes emerged during analysis of early data. After the coding scheme was fully developed, early data was re-coded to ensure validity. I identified four first-level codes: “health and health care,” “body,” “barriers to transition,” and “conceptual.” There were 21 second-level codes.

Under “health and health care,” the second-level codes were “desired transition care,” “realized transition care,” “coping,” “support,” “depression and distress” (e.g. emotional suffering with or without formal pathology), “gender dysphoria,” “suicidality and self harm,” and “eating pathology.” This includes health needs and symptoms, formal care, and informal care. These health care concepts were explicitly or implicitly linked with transition, transgender status, and/or fatness. Health concepts appearing in the texts that were not linked with transition, transgender status, or fatness were not coded.

Under “body,” the second-level codes were “physical parts” and “abstract and descriptive terms.” Abstract terms (e.g. “beauty”) and descriptive terms (e.g. “beautiful”) were initially coded separately, but I ultimately determined that this was unnecessarily complex. I wanted to distinguish between bodies and how people talked about bodies, but based on the use in context, separating these two formulations was not useful given the specific research questions of this study.

Under “barriers to transition,” the second-level codes were “gatekeeping” (i.e. someone directly blocking access to care), “violence,” “rejection and validity,” “attractiveness,” “agency,” “passing,” and “own concept of gender” (i.e. how the author defines or understands gender as an abstract idea). This category reflects themes that authors implicated or explicitly described as barriers to transition. As with “abstract and descriptive terms,” “rejection” and “validity” were initially coded separately but combined because these concepts appeared to be extremely closely linked and sometimes inseparable.

Finally, under “conceptual,” the second-level codes were “sources of information and belief,” “norms,” “values,” and “causation.” Sources of information included individuals such as specific health care providers, groups such as peers or family, or institutions such as the academic field of trans studies or “society.” Causation explored explicitly described causal explanations.

The code book can be found in Appendix A.

Barriers Arising Before Care Seeking

All of the samples described barriers to transition and the vast majority of these, eleven, described multiple barriers. While some described institutional barriers like cost and refusal of care, most accounts of barriers to transition fell in the earliest stages of the access process, before the patient sought care. These barriers were conceptual and cultural. Two major themes emerged as barriers to transition care that clearly related to fatness and appeared prior to care-seeking: abstract concepts of gender and predicted outcomes of transition. Both were closely tied to perceptions of gender norms and experiences of (or fears about) social marginalization.

Gender Concept as a Barrier to Care

The first barrier to emerge was the person's own concept of gender. Gender concept had a range of features including internalized definitions of "man" or "woman," awareness of transgender identities, knowing that transgender people *of hir own gender* exist, and awareness of nonbinary identities. As a whole, gender concept issues respond to the questions of whether a person could be transgender and whether the person could transition in a legitimate way. The way individuals answered these questions required navigating their own beliefs about gender (and later those of their social environments). Of the thirteen authors who discussed specific barriers to transition, six discussed barriers relating to internalized gender concepts.

Gender concept is defined as a barrier to transition care because it was discussed that way by the subjects. In the medical process model, this barrier fits the stage Levesque et al (2013) describe as "ability to recognize," but this designation is not universal for all transgender people. Experiences of gender incongruity and symptoms of dysphoria cannot be understood as a health care need in all cases, because transgender identities are not always medicalized. However, these experiences straightforwardly represent the initiation of the access process for those to whom an

access process model would apply (i.e. those who desire, seek, or receive care). For people who transition (or hope to transition) with the support of psychological, medical, and/or surgical health care providers, experiences of gender incongruity and symptoms of gender dysphoria *do* represent the health care needs transition care is designed to address. Since the subjects in this study have initiated transition or plan to initiate transition, experiences of gender incongruity and gender dysphoria are treated as health care needs.

Awareness of trans identities. Knowing about trans people (or trans people of the appropriate gender) emerged as being directly related to fatness for women, but less directly related to fatness for men. For Nicholas and Ryan, learning about other trans men immediately provided the conceptual tools to handle the challenge of navigating a dominant gender construct that equates gender role to genital morphology. Neither discussed fatness in relation to this conceptual problem, but fatness was connected less directly for Ryan.

Ryan identified as a boy very early in life, but lacking a conceptual framework to validate his feeling of who he was, he continued presenting as a girl. Ryan describes experiences that align with typical descriptions of gender dysphoria, including strong negative feelings about his secondary sex characteristics. Lacking awareness of transgender identities and gender dysphoria, Ryan interpreted these feelings as being about fatness. He explains, “I decided that all of my discomfort in life would go away if I just lost weight.”

Ryan developed a serious eating disorder, which helped him cope with his dysphoria but made him very sick: “A part of me liked my eating disorder because my body quit menstruating, my breasts were almost non-existent and I could wear boy’s pants that hung off my body.” Without knowing that transgender men existed, Ryan needed a way of understanding why he was struggling with his body. Cultural messages

about girls' bodies emphasizing the values of thinness and normalizing self-hatred in fat girls provided an explanation (and a solution) Ryan could access. Reducing body fat was a coping strategy for Ryan and several other transmasculine authors in the sample. This strategy most often appeared when transition was unavailable. In Ryan's case, this coping strategy meant a five-year struggle with severe anorexia.

That struggle ended when Ryan discovered a book about transgender men. He writes, "looking at their bodies and reading their stories I immediately knew why I was struggling with my own. I am transgender." That this realization appears as a dramatic epiphany rather than a gradual process highlights the significance of conceptual tools in gender recognition. Ignorance of transgender identities appeared as Ryan's most important barrier to transition. The account of reading this book immediately precedes a description of taking "steps to transition," indicating that simply not knowing about about transgender men was *the* factor that had been holding Ryan back. Ryan describes his recovery from anorexia as beginning at the same time. Throughout the piece he asserts that misinterpretation of his identity was the root cause of his eating disorder, and this moment of discovery stands as the pivotal moment where misinterpretation ended and transition began.

Other narrative clues further support the interpretation that Ryan's most important barrier to transition care was conceptual. The story of overcoming the conceptual barrier is followed by an account of social marginalization and family rejection, which emerged as important barriers for other subjects. However, Ryan dismisses them as unimportant, saying he no longer makes choices "based on what makes other people happy." He frames social barriers as relatively unimportant but internal conceptual barriers as being incredibly important.

Nicholas also presents learning about trans men as a central barrier to transition. Though he displayed gender-nonconforming behaviors from age 4, Nicholas began to

identify as a boy at 13, the same age at which he discovered that other trans men existed. As a preamble to the story of struggling with his assigned gender from early childhood, Nicholas notes, “before I was 13, I… didn’t even know that being a trans man was possible, even though I somehow knew that trans women existed.” The author’s aside is offered as an explanation for why he did not transition sooner. Using lack of knowledge of trans men as his explanation for not transitioning indicates that Nicholas understood this as the central barrier to transition.

The importance of conceptual barriers to transition is further illustrated in what Nicholas does *not* mention. Though he came to understand his transgender identity at 13, Nicholas did not begin to transition medically until age 17. No account is given of the reason for this delay. He had clearly been presenting as male during the intervening time, writing that he had “been binding [his] chest since puberty” and describing an experience of transphobic violence at 15. Whatever barriers delayed Nicholas’s medical transition did not appear in his transition narrative, but he took care to explain the impact of not knowing about trans men before age 13. This may be analogous to Ryan’s explicit dismissal of social barriers.

Nicholas and Ryan both framed their critical discovery as being about trans *men* specifically, and Ryan noted that he had previously been aware of trans women. The awareness of transgender women but not men could be the result of transgender women’s greater degree of visibility in popular culture. However, awareness alone did not necessarily translate into a more accessible concept of transgender identity for trans women in the study. Jen’s understanding of trans women, rooted in stereotypical media representations, prevented them from recognizing themself as transfeminine. “I had seen the requisite episodes of *Maury* and *Jerry Springer* and *Jenny Jones* to realize that

[trans women] were weird,"[14] they said. Because these representations were intended to be outrageous and othering, Jen did not recognize their own gender incongruence as aligning with those portrayals.

Jen indicates that their transition was "a long time ago. Before Cox. Before Manning. Before Bono. Well before Jenner."[15] They explain their inability to recognize their transgender identity as a result of the absence of relatable transgender figures in the cultural landscape. Their implication that they would have been able to recognize themself in less stereotypical images of trans women aligns with the recognition stories of Ryan and Nicholas. Like them, Jen located the beginning of their transition at the point that they first encountered representations of relatable transgender identities. Jen read "many books about gender and feminism and sexuality and the intersections thereof" and came away with the realization that they are transfeminine and genderqueer. Relatable representation also appeared in Jen's story in a positive way. Jen had decided not to transition because of family pressures, but they met someone whose father cross-dressed. Jen found their friend's acceptance of her father's gender-nonconformity encouraging. They came out to their friend, the first time they had openly acknowledged their gender in years.

The similarity of Ryan, Nicholas, and Jen's stories illustrate the first potential transition barrier as a failure to recognize gender incongruence as a transgender identity. For these authors, even when gender incongruence arises very early in life,

14 These tabloid talk shows exhibit transgender women as dishonest sexual predators and the butt of jokes. Segments with trans women often involve revealing a woman's transgender status to her partner, sometimes resulting in mocking and sometimes even on-screen partner violence.

15 Laverne Cox, a transgender activist and actress; Chelsea Manning, a transgender intelligence analyst who transitioned while in prison for espionage; Chaz Bono, a transgender advocate and author, and the child of Sonny Bono and Cher; Caitlyn Jenner, a transgender activist and former Olympic athlete.

dominant portrayals of gender caused them to conceptualize their experiences in other terms. In order to recognize themselves as transgender, these subjects needed to see transgender people they could relate to.

"Women can't be fat." Not all the conceptual barriers to recognition were limited to concepts of transgender identities. Some subjects' internalized definitions of womanhood prevented them from recognizing or accepting themselves as women. Fatness compromised the ability to recognize transgender identity for several transfeminine subjects. Lauren said very straightforwardly, "to me, women can't be fat." Her ability to recognize her gender identity was complicated by "internalized fatphobia" and misogyny which told her that a fat woman is not really a woman. If she could not be thin, then, she could not be a woman. "Who's ever heard of a 6'2" 320 pound woman, right?" Before Lauren could come to terms with her identity as a woman, she had to renegotiate her internalized definition of what a woman is—not in terms of genitals or chromosomes, but in terms of size.

Faith described a similar definition of women in a different way. Where Lauren felt that her view of fatness prevented her from recognizing her femininity, Faith cultivated her fatness as a way of preventing herself from acknowledging her femininity. Faith writes that she recognized at a very young age that she was "more female than male" but felt that she could not transition because of her conservative family. She used fatness as proof that she was not transgender. She said that people would sometimes notice her "feminine side" and assure them that "there was no danger of [her] ever transitioning. 'There are enough fat ugly women in the world without me adding to it!'" Like Lauren, Faith felt that fatness was essentially opposed to womanhood. She was not able to accept herself as a woman and initiate transition until she challenged her "internalized weight stigma."

Surprisingly, fatness appeared as the *primary* incongruity between several trans women's internalized concepts of womanhood and their own bodies. Only one transfeminine author discussed navigating gender validity around genitals and chromosomes (and then briefly), but transfeminine authors often described fatness as a challenge to their femininity. Faith, Jen, and Lauren especially emphasized fatness as *the* challenge to coming to terms with their trans identities, not an *additional* challenge. Other transgender women discussed dysphoria relating to their chests, voices, body hair, or other secondary sex characteristics, but none of these features even appeared in Faith or Lauren's narratives. They could have discussed gendered fat stigma as *complicating* the challenge of coming to terms with other features of their bodies, so it is telling that they did not. For Faith and Lauren, the perceived incompatibility between fatness and femininity was the central issue.

Racialized gender norms. For Ashleigh, femininity was compromised by fatness and blackness together. Ashleigh shared other subjects' sense that fat women are considered illegitimate as women, but her experience of being "denied femininity" was compounded by racialized sexism. She experiences others interpreting her body as masculine both because she is fat and because she is Black. She writes, "as we see in the media and within our interpersonal spaces, femininity is significantly scripted through whiteness and thinness." Ashleigh interprets feminine gender norms as centering white and thin women. A similar view of gender norms as thin- and white-focused appears in other texts in the sample; Malcolm (white-appearing) and River (race unknown) both offered encouragement to trans people whose gender presentation does not align with "skinny white trans" people.

Ashleigh's efforts to recognize and embrace her nonbinary, Black, fat, femme identity illustrate how formidable conceptual barriers can be for people with highly intersectional trans identities. Coming to terms with her identity meant challenging

cultural messages about the genderedness of her body in terms of gendered fatphobia, gendered racism, and the gender binary. The struggle to interpret and "craft" her experience of gender led Ashleigh to reject the nonbinary gender norm of using "neutral" pronouns. She writes, "I do not believe there is neutrality in my gender, nor do I believe they/them is… appropriate for MY Blackness" (original emphasis). The purpose of the piece is explaining why Ashleigh does not use they/them, and her explanation centers her experiences of gender policing "through a violent lens of whiteness" and "a lens of fatness as a gender-nonconforming quality."

In order to conceptualize their own gendered experience as transgender and recognize a need for transition care, people must have access to a transgender concept that can include them. In this study, making a transgender concept relatable could involve gender, race, body size, and departure from gender (including transgender) stereotypes. The conceptual barriers to self-recognition reveal implicit but widely understood standards of gender legitimacy. Although the subjects frequently recognize that standards of normative masculinity or femininity apply to everyone, the culturally precarious position of transgender identities means that normative expectations present a more robust challenge to the legitimacy of trans masculinity and femininity. Thinness norms in particular had a dramatic impact on how subjects understood their genders. The findings imply that fatness functions as a justification for delegitimizing the genders of those whose genders are already marginalized.

Predicted Outcome of Transition

In addition to impairing recognition of transgender identity, normative gender standards influenced how people imagined their transitions. The imagined outcomes of a desired gender transition appeared as a barrier to transition in nine of the narratives, even more frequently than gender concept barriers. Subjects described transition outcomes in terms of *attractiveness* and *passing*. Both of these concepts refer to having

a post-transition body that conforms to normative gender standards, but they are not interchangeable. Four people discussed passing and eight people discussed attractiveness; two mentioned both. Most of the people who talked in terms of passing were transmasculine, and most of the people who talked in terms of attractiveness were transfeminine. Attractiveness seems to be a specific type of passing.

Passing. Passing refers to having a gender expression that others correctly interpret. Passing may also refer to being interpreted both as the correct gender and as cisgender. Passing is more obviously applicable to binary trans people, as nonbinary gender expressions are not codified in a way that would make them widely intelligible. However, of the four people who mentioned passing, two have nonbinary identities. For Wiktor, who is both agender and transmasculine, passing means having their masculinity acknowledged, but it may not mean being interpreted as a man or as cisgender.

Some trans people regard the concept of passing as problematic. Janet Mock (2014) equates the concept of passing with the idea that trans people are engaging as "trickery and deception." Others criticize passing as centering cisnormative constructions of gender and devaluing people who cannot be or do not prefer to be mistaken for cis (Talusan 2015). However, passing is not just a matter of aesthetic preference. Being visibly transgender can make a person more vulnerable to transphobic harassment and violence. Even critics acknowledge that passing confers substantial benefits (Mock 2014, Kosciesza 2015).

This complexity was present in the data. Even though passing appeared in several narratives as a potential barrier to transition, criticisms of the idea were also present. Two transmasculine subjects argued for the validity of transition (and transition care) for men who do not pass. Malcolm addresses non-passing trans boys who "only see positive feedback on… boys who were able to 'pass' a couple of months after

starting on [testosterone] (or before).” Their piece is intended to validate trans boys whose gender expression falls outside normative gender standards in a variety of ways. Their engagement with the idea of passing illustrates expectations about transitioning they see in their interactions with other transmasculine people. Malcolm indicates that trans men and boys are expected to be recognizable as masculine at or very close to the beginning of their transitions. As encouragement to boys who do not pass within a few months of starting hormone therapy, Malcolm tells them, “your trans-ness is no less valid.” Passing is linked with the validity of a trans person’s gender. Malcolm’s focus on “positive feedback” suggests that validity affects social support, but this standard of validity may also influence whether a trans person is able to access care. Wiktor complains that providers define “good results” of transition around the notion of passing, and suggested that they decline to treat patients who do not pass even without intervention. Their experience of being denied care will be discussed later in this chapter.

Another trans man, Jude, acknowledges criticisms of passing but defends his passing-centered perspective. His piece, advising trans men on how to lose weight in order to pass better, explicitly positions passing as better than not passing. He notes, “while there are those who refuse to conform to a cis-normative appearance, there are still just as many that do strive for that level of presentation.” By describing non-passing trans people as “refusing to conform,” Jude asserts that non-passing trans people could pass if they wanted to. This aligns with Vade and Solovay’s (2009) summary of one premise fat and trans people are asked to support in order to maintain social resources: “when a person behaves correctly, a gender presentation that is obviously and exclusively female or male will result” (p. 169). Jude declines to defend non-passing trans people because he believes that they could choose to behave in a way that would result in passing. He does, however, assert that everyone has “the right to look, feel, and

live however they want," indicating that he may not feel that this imagined behavior is the only "correct" way for a trans man to behave.

Katelyn, the only woman who discussed passing, defended passing in terms of safety but also criticized the pressure to pass.

> For transgender women, society's policing of female bodies is especially problematic. The intersection of fat and transphobia is a very dangerous one. If trans women are deemed to manly to be women, it spawns the hateful "man in a dress" trope from society. The ability to pass… is one of the most basic considerations that any pre-transition trans person makes. Passing privilege is safety for a trans person. Safety from harassment and safety in using the correct restroom. Getting clocked as transgender oftentimes leads to abuse or violent confrontation. Visibly trans bodies are considered unworthy of dignity or respect and are marginalized from society in many of the same ways that fat bodies are… Society says to just eat right and exercise and then they'll consider your feelings or respect your bodies. Society demands transgender bodies look like cis bodies and then they'll consider you a "real woman" or a "real man."

This one passage addresses many of the major themes of the research as a whole, demonstrating how closely these themes are related. The majority of the passage addresses Katelyn's ambivalence about the concept of passing. She is critical of the social norms that make passing advantageous to trans people, but nevertheless accepts that passing is an important consideration for transitioning people. The passage starts and ends with discussion of fatness. The juxtaposition implies that Katelyn perceives fatness and passing as being related, but she does not explicitly address the connection. She may expect the reader to understand how the concepts are linked, which would suggest a widespread conceptual link between passing and body size. This

interpretation is supported by Jude's approach, suggesting weight loss as a means of passing.

Katelyn explicitly links transphobia with anti-fat bias and plainly articulates a connection between conforming to appearance norms, including body size norms, and gender legitimacy. She shows that this legitimacy can be a transition barrier when she says, "the ability to pass… is one of the most basic considerations that any pre-transition trans person makes." The implication of this statement is that pre-transition people who do not believe they will pass may be too afraid of violence and marginalization to transition. Nicholas did not describe this consideration as a barrier, but the association between passing and safety nevertheless appears in his transition story. He describes fears of being beaten or raped if anyone finds out he is trans.

Katelyn's statement about passing as a "basic consideration" is phrased in a gender-inclusive way, addressing the experiences of trans people in general rather than trans women. It is striking that Katelyn is the only woman to discuss passing, and she frames it in terms that include all trans people. In contrast, Malcolm, Jude, and Wiktor discuss passing in terms that focus specifically on masculine transition trajectories. In all cases, passing is a defining feature of a "good" transition by mainstream standards.

This passage also vividly illustrates the typically academic and feminist language throughout the sample. Katelyn talks about the "policing" of bodies as "problematic." She personifies "society" as an agential force making demands on women. She names the "intersection of fat and transphobia," referencing intersectionality theory. These terms were very typical. Katelyn speaks somewhat formally, saying "violent confrontation" rather than "violence" or "attack." The purpose of her piece was to communicate her own transition story, but this entire paragraph relates to theoretical concepts of gender and society.

Attractiveness. Attractiveness appeared as more straightforward, more intimate, and more emotionally charged than passing. Attractiveness also references embodying gender in an acceptable way, but where passing is mostly focused on strangers, attractiveness is often focused on the most intimate relationships. Attractiveness sometimes appeared to be interchangeable with other terms, most often desirability.

Katelyn explained that the focus on attractiveness is common among trans women. “I would see the very same words from my internal dialogue popping up in many [forum] posts. ‘Too fat,’ ‘too bald,’ ‘too something’ to be a pretty woman. Always pretty or cute or beautiful.” This reflects the ways attractiveness appeared in other narratives. Lauren expressed feeling like she looked “disgusting” and would never be “cute enough or pretty enough for anyone to love.” Other women said very similar things about their bodies.

Fatness also appeared as an antonym to attractiveness in some women’s narratives. Jen describes a very straightforward vignette of finding her imagined transitional body unsatisfactory and delaying transition as a result, but she never mentions attractiveness explicitly. Jen says she was standing in front of a mirror in a dress and makeup, and describes hating her body. To express her feelings of unattractiveness, Jen says, “I was over 400 lbs. I would never be the young woman I wanted to be.” Youth and thinness are closely tied with feminine beauty. Jen is able to talk about her attractiveness by reference to these features even though she does not mention attractiveness or desirability directly. As a result of imagining her transition into a woman who is too fat and too old to be beautiful, Jen threw away her feminine clothes and postponed her transition by another four years.

Mey also links fatness and attractiveness very clearly. She discusses the link as being socially constructed and a feature of the policing of women’s bodies. Mey complains about the impossible demands on her body as a fat, trans woman.

> It's tough as hell dealing with so much that tells you that you're not being a woman in the right way. If they're not attacking you for what's in your pants or in your genes, they're attacking you for your height and your waistline. And then, when they *will* accept fat women, they say that they better have curves in "all the right places" and be a perfect hourglass figure. Well I'm not... It's hard to love my body sometimes, but it's still beautiful. (original emphasis)

This passage suggests that body policing is felt in a series of sequential challenges to Mey's legitimacy as a woman. She characterizes the message of body policing as being about "not being a woman… the right way." Her structure suggests a hierarchy of disqualifying factors that, surprisingly, has trans status itself at the very bottom. She acknowledges challenges based on her genitals and genes, but quickly moves past them to focus on rejection based on fatness.

The sequential legitimacy challenges Mey articulates connects with the even more basic experience of thinness as defining womanhood appearing in Lauren and Faith's accounts. Lauren and Faith both experienced fatness, rather than their trans status itself, as the feature that most challenged their femininity. This suggests that trans women (or trans people more generally) have to first overcome the idea that their bodies can be consistent with their gender in terms of their genitals or genes, and *then* in terms of their body size. The experiences captured here suggest that for trans women, this second boundary is very difficult to overcome.

All three of these women experience the equation of thinness with womanhood as a challenge to their womanhood, but they encounter it at different points in their transitions. Lauren and Faith encounter this definition of womanhood within themselves, causing them to delay their transitions. Mey was surprised to encounter this definition in her interactions with others. Mey had not internalized thinness as the definition of womanhood but she struggles with others enforcing this definition on her body. Mey's

experience shows that she transitioned *first* and experienced this definition of womanhood *second*. As a result, she experienced it as a source of social marginalization rather than as a barrier to accessing transition care. All three women were fat before they transitioned, but it was only a barrier for the women who understood fatness as antithetical to womanhood. Even though Mey does not experience attractiveness policing as a barrier to transition, her insights illustrate how other women do experience it as a barrier.

Mey's mention of specific body parts reflects a common feature, but her reference to genitals was very unusual. Overwhelmingly, authors worried about body features that, unlike genitals, are highly visible and have an impact on communicating their genders. They talked about their faces, their height, their chests, and their shoulders. Trans women sometimes talked about big feet making it difficult to buy shoes—again, something that directly impacts their ability to communicate their gender.

Mey's feeling that her "fat thighs" compromise her femininity is also revealing. While listing the ways his body failed to display masculinity, Nicholas also named his "too thick" thighs. This similarity highlights the logical weakness of gender legitimacy hinging on thinness. Authors often describe the belief that sex differences in fat distribution mean that being thinner will help them pass or be attractive, but they do not share a sense of how different body parts are gendered. Fat thighs appear as unfeminine *and* unmasculine.

Gaining fat as part of transition. While most of the authors frame fat as opposed to transitioning, there were a few notable exceptions. For some masculinities, fatness appears as a benefit or even a requirement. Wiktor describes being told they were not fat enough to be a "cub" in the gay community. The idea of not being fat enough challenged Wiktor's previous experiences of having their body judged "too fat" for their assigned gender. This seems to align with transfeminine authors' experiences that fat is

coded as masculine and thinness is coded as feminine, but fatness also appears as a challenge to masculinity.

Jude, who is the least critical of body norms, states that putting on body fat can help some trans men pass better. “Putting on a little extra ‘stock’ will help some trans guys develop a more ‘masculinized’ appearance. Some guys… may start to notice that the stockier you get the easier it is to conceal your chest.” Concealing a trans man’s chest and developing a more masculinized appearance straightforwardly describe passing, but Jude makes it clear that this is nonetheless not a legitimate approach.

One way Jude frames weight gain as unmasculine is in his use of passive language, saying “one ‘solution’ is to allow the weight gain to take over so that the belly overcomes the chest.” Agency is transferred from the man to the weight and the belly, rendering the man either an onlooker or the object of his body’s independent behavior. Jude’s recommended course frames the man as decisively acting upon the world (and his own body)—a more gender-typical construction of manly behavior. Jude’s use of quotes around “solution” further indicates his distaste for this approach. His contempt for fat trans men suggests that passing as a fat man is not really passing as a man. This shows that fatness is illegitimate not only in its effect of compromising gender intelligibility, as it appears in most of the narratives about passing and attractiveness; fatness is illegitimate in itself. The value of achieving an intelligible masculinity is not enough, in Jude’s view, to make up for the unmanliness of the fat itself.

Jude’s construction of masculinity and fatness suggests that fatness challenges masculinity according to a different logic than fatness challenges femininity. Transfeminine authors show that fatness is opposed to femininity because women are supposed to be small and pretty. Ashleigh explains this in terms of the sexual objectification of women, defining smallness as a woman being “attractive” and “controllable.” Being legitimately feminine means having a body that another person

desires and can control. This is consistent with the framing of many of the transfeminine authors and several of the transmasculine authors (before transitioning).

Implicitly, largeness would be associated with masculinity and power, but this generally appears in transfeminine author's explanations of their non-conformity with femininity norms. Ashleigh describes her fatness as being "read as masculine," but Jude and other transmasculine authors experience fatness as unmasculine. By framing passing through fat as both illegitimate and passive, Jude posits that the masculine corollary to "women are supposed to be controllable" is "men are supposed to be in control." A definition of masculinity in terms of power and control is hardly novel, but Jude's construction shows that this is specifically felt as a *body* norm. Masculine power and feminine passivity are *both* expressed through low body fat and compromised by high body fat.

Later-Stage Barriers

Seven of the narrative pieces were centrally arranged around a chronological account of the author's struggle with their gender identity. In these accounts, first accounts of seeking or accessing transition care appeared very late in the text, typically about three quarters of the way in. Only two authors reported accessing transition care in the first half the text. The space authors devote to the time before they sought care demonstrates how difficult this period was. The first experience of seeking care frequently led to a brief summary of what services were accessed and a transition into more abstract discussion. The portion of transition following care-seeking generally appeared as uneventful, while the portion of care access preceeding care-seeking was frequently an ordeal.

Nevertheless, some barriers to care did arise at later stages. This section addresses barriers arising at the remaining stages of care access, corresponding with Levesque et al's (2009) "seeking," "reaching," and "utilizing" care (p. 5). At the "seeking" stage, the transitioning person has recognized hir identity as transgender and decided to seek transition, but has not yet received care. Provider gatekeeping on the basis of body shape appeared both as a real experience and as apocrypha. Surprisingly, economic and location barriers were virtually non-existent, and were never associated with anti-fat bias.

Provider Gatekeeping

In the sample, gatekeeping on the basis of weight appeared most often in secondhand accounts. Authors referred to the practice as commonplace, but only one author reported actually experiencing provider gatekeeping. Wiktor first discusses provider gatekeeping as it appears in trans and fat academic literature and online resources for transitioning people. They explain that questions about whether a medical professional can or will advise patients to lose weight before prescribing hormones or

performing surgery are some of the “most popular” questions trans people ask about transitioning. Wiktor advises their readers that providers “almost always” advise patients to lose “as much weight as possible” before chest surgery. Wiktor criticizes the policy as biased, suggesting that providers would do better to consider each patient’s body before making such recommendations.

Jude also treats weight-based gatekeeping as commonplace, warning that “obesity could result in delaying top surgery.” Unlike Wiktor, Jude frames weight-based gatekeeping as a reasonable health limitation, saying that “one needs to be stable enough for major surgery” to imply that people who are denied surgical treatment could not withstand surgery. He also notes that “the more fit you are the better the surgeon can develop the chest.” Both of these explanations locate reasons for gatekeeping in the realm of the patient’s health, but the only person in the study to actually *experience* provider gatekeeping was not given a health reason. Care was denied on the basis of their weight, not their safety.

After learning about transmasculine identities and recognizing their own transmasculine identity, Wiktor saw a psychologist to begin transition. Mental health providers play an important role in early transition. According to WPATH (2011), mental health providers assist patients in “exploring gender identity, role, and expression; addressing the negative impact of gender dysphoria and stigma on mental health; alleviating internalized transphobia; enhancing social and peer support; improving body image; [and] promoting resilience” (p. 10). Medical and surgical care often requires referral by a mental health provider, giving these providers substantial power over a patient’s access to other forms of transition care (p. 14). Approaching the psychologist as a stepping stone to other transition care, Wiktor said, “I am a boy. I want to do a sex change.” The psychologist immediately dismissed Wiktor’s identity. Wiktor reports that the provider asked, “don’t you think you’re having these thoughts because of your

weight?... That you think you want to be a boy, because you are fat? Maybe… you're just a fat lesbian." Wiktor did not identify as a lesbian and was not exclusively attracted to women. The provider's construction of Wiktor as a "fat lesbian" represents his own interpretation of Wiktor's gender presentation. A fat lesbian was a legitimate gender possibility, but a fat trans boy was not.

When Wiktor asserted their trans identity and continued to ask for help, the doctor said "there's nothing to help you with. You should [lose] some weight." Wiktor's transition was postponed by several years, during which time they developed an eating disorder. Convinced that other providers would respond to their body in the same way but determined to transition, Wiktor starved themself and obsessively exercised. The link between a barrier to transition and the development of an eating disorder mirrors the one Nicholas experienced.

While only one incident of provider gatekeeping appears in the data, other authors also treated gatekeeping on the basis of weight as commonplace, either as a practice or as a concern. Even if the practice is not widespread, apocryphal accounts of provider gatekeeping on the basis of weight may discourage care-seeking by patients who suspect they would be too fat to receive care. Grant et al. (2011) found that about 19% of transgender people experience denial of care based on their gender identity, but even more, 28%, avoid care for fear of discrimination (p. 72). Some trans people experiencing denial of transition care based on their weight may result in even more people not receiving care.

Affordability and Location

Given the economic marginalization both fat and trans populations face, it is surprising that affordability barriers were virtually absent. The subjects experienced dramatic barriers to seeking care and several talked about provider gatekeeping, but almost uniformly they presented desired care as being very easy to reach and afford. In

most cases, subjects described cultural barriers to seeking care in great detail but mentioned actual care only in passing. Even people who transitioned as minors discussed care as if it was available at will. Subjects described nutrition counseling, psychological care, hormones, and sometimes even surgeries very casually. Access to nutritionists in several narratives is especially indicative that health services were generally reachable and affordable for the subjects.

Even Wiktor, who described the widest variety of barriers, displayed this attitude. “At the age of 16, having had already spent days and night online and offline reading on transsexuality and the possibilities of transitioning, by my mother’s request I went to see a psychologist in my hometown.” Wiktor’s mother initiates care access, showing that care was affordable for Wiktor’s family and that they enjoyed family support regarding their transition, making family resources available for transition care. These financial and social resources are not typical of trans teens. Many transitioning people face family rejection and poverty (Grant et al. 2011:8).

Nutritionists and mental health professionals typically appear robustly in the narrative, but the story is about the content of the appointment; being able to reach and afford care seems to be taken for granted. Hormones and surgery have an even thinner presence, with the providers typically not mentioned at all. Wiktor tells their reader that they accessed testosterone by describing its effect on their muscles. There is no mention of the prescribing physician or any steps taken to gain access to hormone therapy. Similarly, Nicholas simply says “I started taking testosterone at age 17.” Once barriers to seeking care were overcome, accessing psychological, medical, or surgical care typically appeared as a narrative landmark rather than a process.

Only two people mentioned affordability as a barrier to care. Nicholas framed his practice of chest binding in terms of his inability to afford chest surgery. Notably, he still mentioned hormones in a typically casual way. The difference is straightforwardly

explained by the fact that surgery is substantially more expensive than hormone therapy, even with insurance. Nicholas was the *only* person to discuss their own inability to afford care. The other mention of affordability was hypothetical.

Katelyn writes that trans women may put off transitioning "because transitioning into society's preferred appearance is 'too' expensive. We can't all be Caitlyn Jenner dropping millions on facial feminization surgery in Beverly Hills." The type of care she describes as being too expensive, however, is not even mentioned in other narratives. Facial feminization surgery (FFS) does not appear anywhere else in the sample as a type of care that a subject accessed, desired, or even considered. Katelyn is using FFS as a straw man; she mentions care as expensive and far away (Beverly Hills) to illustrate a *bad* reason to postpone transition, not to identify an actual problem in care access.

Economic and location barriers were rare and never described as being associated with fatness. Other barriers typically appeared as being associated with fatness in some cases but not in all cases. Trans women experienced a definition of womanhood that demanded thinness, which is associated with anti-fat bias, but they also experienced a definition of womanhood that demanded specific genitals and chromosomes, which is not. Economic and location barriers were not attributed to bias. Nicholas's inability to afford top surgery may be a result of anti-fat and/or anti-trans bias in hiring and pay, but he does not present such an interpretation of his circumstances.

Discussion & Conclusion

Prior research on marginalization, intersectionality, and health care access suggested that people who experience marginalization due to their trans status and due to anti-fat stigma, both of which give rise to health care barriers independently, may experience barriers to care unique to this intersectional identity. Narratives frequently described barriers to care, often multiple barriers. Some of these barriers were attributed to transphobia or to non-bias causes, but as prior research predicts, subjects also described multiple barriers to transition care based on anti-fat bias. Surprisingly, these barriers were not primarily found in patient interactions with providers. Instead, they were concentrated at the earliest stages of transition care, before subjects sought care.

Anti-fat bias most vividly impacted subjects as they came to terms with their own transgender identities, first as they attempted to interpret their gender incongruity and then as they imagined what transition might mean for their bodies and lives. One person who sought transition also experienced barriers to care arising from the anti-fat bias of a healthcare provider, and others believed that such experiences were commonplace. These three barriers were closely related, though they appeared at different stages of the access process.

Fatness Threatens Gender Legitimacy

Throughout the data, the overwhelming theme was a sense that fatness could compromise the legitimacy of a gender identity and presentation. This theme bridged all of the major barriers and appeared even outside the context of a specific barrier to care. Whether this message came from the person’s internalized beliefs about gender or from other people, all of the major barriers arising in the data seem to arise from dominant constructions of gender that were robustly shared by the subjects and the social context in which they live.

Notably, the specific expression and content of body norms was more clearly associated with fatness than transness. When trans women imagined that fat women are not real women, they did not specify *trans* women. Their judgement applied to *all* women. Similarly, subjects who were fat before transition sometimes reported stories of having their *assigned* genders delegitimized. The apparent universality of the relationship between thinness and gender legitimacy suggests that experiences of gender "denial" may be shared by cis people as well. Transition care may simply be a social site where gender policing according to body size is highly visible or where such policing has a more tangible effect.

The overwhelming theme of gender legitimacy recalls Vade and Solovay's (2009) findings that fat and trans people are asked to uphold and endorse norms that marginalize them. Vade and Solovay's "unspoken beliefs" about good and natural bodies appeared throughout the research as authors struggled to conform to or overcome them. Many of the authors endeavored to transform themselves to avoid discrimination, reflecting the social debt not to be fat or trans Vade and Solovay (2009) described. The pressure to be thin was especially salient for transfeminine subjects with respect to their post-transition lives, and for assigned-female subjects with respect to their pre-transition lives. In other words, subjects felt pressure to be thin more intensely while presenting or being read as women and girls.

Previous research found that gender and sexuality influence the acceptability of fatness. My findings suggest that the patterns Whitesel (2014) described regarding cis fat policing did not extend to trans subjects. He found that straight women and queer men experience more pressure to be thin than queer women and straight men (respectively). While few of the authors discussed sexuality directly, those who do suggest that Whitesel's findings do not generalize to trans people. Body policing was incredibly central to the narratives of queer women, and the only man to discuss feeling

pressure to put on *more* weight was queer. However, the differences in body policing before and after transition suggest that the effect of sexuality may also be more complicated in trans populations than in cis populations. I would recommend research comparing pre- and post-transition experiences of body policing that controls for assigned sex, gender identity, and sexuality.

Another finding, not obviously pertinent to the research question, supports the idea that gender legitimacy is connected with thinness across genders. Almost half of the subjects struggled with eating, but the logics underpinning their sometimes compulsive body manipulations varied by gender. Female-assigned subjects tended to maintain dangerously low weights to escape "feminine" curves and menstruation, while male-assigned subjects gained hundreds of pounds as a method of denying their femininity. The transmasculine subjects who reported developed eating disorders lost weight to achieve a gender-affirming body, while transfeminine subjects gained weight to *avoid* a gender-affirming body. In both cases, thinness was constructed as affirming to their (different) genders.

Implications of Early-Process Barriers

The process model of access to care articulated by Levesque et al. (2013) arranges possible barriers to care in sequential stages. In the chronological narratives especially, this concept of sequential barriers was clearly present in the authors' framing of their own experiences. The authors devoted the majority of their attention to barriers corresponding to the very beginning of the access process, before the patient seeks care. The most obvious implication of this finding is that interventions intended to increase access to transition care should include strategies to address cultural barriers to transition care. Interventions intended to improve clinical environments and provider sensitivity only benefit those patients who overcome earlier barriers.

The clustering of barriers at the beginning of the care process raises an important question about why there were not also later barriers. One possibility is that authors were discouraged by early barriers and became less likely to seek care in the future. Most of the barriers were framed as past challenges that had been overcome, but authors may have chosen not to include information about ongoing struggles. Most of the authors had accessed some form of transition care, but few had accessed surgical care, and none indicated that they had received all the transition care they desired.

Another likely explanation for the clustering is that the authors were predominantly white and high socioeconomic status. Patients with greater access to economic and social resources are less likely to experience affordability or location barriers, and less likely to experience harassment and denial of care. However, barriers to care arise sequentially. The infrequency of later barriers such as cost and location may be a function of the subject group's high SES, but the presence of earlier-stage barriers is very likely shared with less privileged subgroups.

Limitations

One limitation of the study is its unobtrusive approach to data collection. This gave rise to ambiguities in terms of author identity and full impact of barriers to care. Future research could benefit from data collection methods that provide more clarity regarding these features. In-depth interviews would be especially well-suited to collecting data on complex and often excluded information like race, gender identity as it shifts over time, and the gap, if any, between desired transition care and attained transition care.

This possible gap connects with an inherent complication of fitting transition care within a care access framework. Transgender identity is not medicalized for all trans people, and some transgender scholars and activists are critical of medicalization. Transgender identity is not in itself a remediable medical problem. Transgender identity

may be accompanied by gender dysphoria (which is medically defined), but even the presence of gender dysphoria is not an uncontroversial sign of a medical need. In the context of pitched cultural, philosophical, and medical debates about the nature of transgender identity and transition care, it is difficult to decisively identify a medical need relating to transition care. This study addressed this difficulty by interpreting a medical need only in cases where a person actually sought transition care. This approach identifies delays in care resulting from barriers, but it necessarily excludes people who were completely dissuaded from seeking care.

Features of sampling affected findings in some known ways, and likely in unknown ways. The highly privileged and largely homogeneous subject group did not report certain experiences, such as significant economic marginalization, that are known to be common in broader trans populations. This suggests that findings present a limited picture of transgender experience.

Another possible result of sampling was a highly binary approach to gender concept, even among nonbinary subjects. Subjects tended to discuss body size as validating or invalidating to masculinity or femininity regardless of their actual gender. An obvious limitation to this understanding is its binary nature. Some of the subjects who conceptualized thinness as affirming to their masculinity or femininity were nonbinary, but none of the subjects articulated thinness as affirming to a nonbinary identity as such. This may be a result of the small sample size. It is likely that other nonbinary trans people have articulated experiences of gender affirmation in more explicitly nonbinary terms.

Recommendations

The findings support interventions to increase transition care access that are grounded in increasing public awareness about and acceptance of transgender people. Increasing the visibility of relatable transgender figures, including transgender people of

a variety of genders and body types, may increase care seeking. Addressing gender diversity in K-12 health classes could help increase recognition and decrease stigma. The findings also support later-stage interventions in the form of provider education to reduce transgender and fat stigma in care and encourage increased approachability. The widespread concern about provider gatekeeping suggests that active outreach into transgender communities may be necessary. Increasing transparency about screening and care could reduce patient anxiety about provider bias.

Moreover, the barriers arising in the study were rooted in sexism. Eradicating anti-fat barriers to transgender health care is likely dependent on eradicating sexism and gender policing more broadly. In addition to interventions specific to transition care, broader programs advancing intersectional feminist positions on gender and body diversity would likely reduce the effects of anti-fat transphobia.

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Appendix A: Code Book

Source:
1. Publication
2. Blog (personal, activist, organization/group)
3. Forum

Intended Audience:
1. General
2. Specific (trans)
3. Specific (other)

Author Information:
1. Gender
2. Race
3. Educational Attainment

Content:
1. Health and Health Care
    a. Desired Transition Care
    b. Realized Transition Care
    c. Coping (e.g. informal self-care strategies)
    d. Support (social, family)
    e. Depression and distress
    f. Dysphoria
    g. Suicidality and self harm
    h. Eating pathology
2. Body
    a. Physical parts
    b. Abstract and descriptive terms (e.g. “beautiful,” “flat,” “hairy”)
3. Barriers to transition
    a. Gatekeeping (by provider, parent, or other person)
    b. Violence
    c. Rejection and validity
    d. Attractiveness
    e. Agency
    f. Passing
    g. Own concept of gender (in the abstract)
    h. Cost of transition care
4. Conceptual
    a. Sources of information and belief (e.g. provider, peer, family)
    b. Norms
    c. Values
    d. Causation (e.g. “I am fat because…”)