The Stories We Tell: Making sense of gender, transition, and the centrality of relationships

by

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Abstract

What does it mean to be trans? What brings some of us to medically transition? This thesis contributes to a better understanding of trans lives. More specifically, my work attends to how we situate ourselves within others' stories to determine validity and humanity.

Motivated by my own experiences of making sense of gender and medically transitioning in my youth, my research considers how the dominant stories of gender inform how trans adults in North America make sense of their own genders and transition.

These stories and orientations are enmeshed with relationships and relationships vary. This variation is not because of any one identifiable thing. These variations tell us things about the way we see and think about gender, as well as our orientations to it. This thesis is a call for research on transition to return to considering what gender means, starting from the perspective of trans lives and voices.

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Preface

What does it mean to be trans and what brings some of us to medically transition? This thesis contributes to a better understanding of trans lives. More specifically, my work attends to how we situate ourselves within each other's stories to determine their validity and their humanity. Through narrative research with differently situated trans adults in Canada and the United States, I critically reflect on the stories trans adults tell about medical transition, about gender, and the social contexts in which these stories become possibilities.

I don't know many people who started their medical transition as long ago as I did or at the same age. I was meeting with doctors to get approval to start my medical transition when I was 17. I started taking Testosterone in the transitional time between being a teenager and an adult: I took my first dose of Testosterone on my 18th birthday. I felt too old to have been a trans child and too young to have the complexities of an adult life to consider. Now, at 27, I can see that how I make sense of my gender is very much influenced by my rural, conservative, Christian upbringing as well as the political and social discourses about trans people at the time of my transition. Then, the only media representation I could find about trans men was the movie, *Boys Don't Cry*. So, I expected violence. I expected to be murdered.

I had no awareness of the interplay of gender and race and the privilege my Whiteness gave me throughout my pursuit of medical transition. As a young woman, I had been bombarded with messaging that because of my perceived womanhood, I was the target of violence and always would be—that I was unchangingly vulnerable. It never crossed my mind that trans women existed and that trans women and trans feminine people experience the brunt

of the violent transphobia that horrified me, and it only compounded as intersections of class, race, and dis/ability came into negotiation.

I was consistently told that I had to prove that I *was* pathological and *suffering* because of my gender identity to get access to medical transition, but not so mentally ill that I couldn't self-regulate. Even though I paid for surgery privately and expanded my search across multiple provinces in Canada in 2012, this was the bind: as a trans person seeking gender affirming surgery, I had to be distressed without exhibiting any symptoms of distress. From the informal conversations I had in the Ontario trans community at the time, this was not a unique experience. Without exhibiting symptoms of distress, we were told that we couldn't *actually* be trans because being trans is distressing. But exhibiting symptoms of being distressed meant we were a liability and couldn't be sure that we were distressed because we were trans because being distressed means we're too emotional to make any sense.

I came up with this research project in the final year of my undergraduate degree. Or maybe it's better to say another version of it. I've been working with trans folks for around 10 years, first as a peer leader in my local trans community and now as a mental health clinician. It was 10 years ago this summer, in my final year of high school, that I started pursuing my own medical transition. Before I began the interviews that form the heart of this project, my supervisors asked me what biases I'm bringing to this project and what I hoped to find. I had thought that with my background in community activism and advocacy that somehow, I had managed to free myself from biases and assumptions about others. I confidently told them that I didn't have any. I naively told them that I was just asking people what their stories are. I imagined this project as a space where trans meaning-making could be shared without alteration.

But I began this project from a specific stance. I wanted to disrupt the 'wrong body' narrative that all too often gets ascribed to trans people. I wanted to shine a spotlight on the messiness of trans experiences as always butting up against a cis ideal that, from my assumptions, would always be beyond the reach of trans people. In beginning this project, I made sense of what it means to be trans as simply just not being cis.

When I came to know myself as trans, I already felt too old. Then, I started working with trans youth and that only made me feel even older. Then, I started university. Suddenly, I was surrounded by people who, like me, had grown up without knowing that being trans was a possibility. Unlike me, they were only just now, as adults, able to access the resources necessary to medically transition or had just got to a place to be able to start relating to gender differently than the cis folks from whom they had learned how to navigate the world, or so I assumed. I started to wonder about how if I already felt too old to be trans as a 17-tear-old, what's going on for people who began their medical transitions even older?

Once I actually got into doing this research, I was confronted with the actuality that I *had* made assumptions. I assumed that because I couldn't relate to how cis people spoke about gender, then it must be impossible for *all* trans people. I was operating from an understanding of being trans as being in opposition to being cis—that understanding gender as a cis person foreclosed the possibility of trans existence. That *my* story of transition was *the* story against the dominant narrative I couldn't find myself in: righter, realer, truer. Throughout this project, I worked to prioritize the stories of others while recognizing that my interpretations of them can only ever be just that—my own subjective efforts to find meaning. While at times their stories contradicted my own, causing visceral and difficult to navigate impacts to my own sense of self,

I attended to others and situated our differences as alternate possibilities amongst possibilities where the existence of one does not necessarily mean the nonexistence of another.

In each of my interviews, the person I was speaking to was trying to figure me out and what my relationship to this project was. Some of them would directly ask me if I was trans even though I clearly stated that I was in the recruitment materials for the project. Most would explain to me what a medical transition was. This often seemed more like something comforting and familiar for them to articulate than an assumption that I didn't know. It was as though they had learned to think about gender with another person through the routine of first educating and explaining. Some would coyly keep circling back to indirectly asking me about my own experiences with gender and healthcare. Others would share a fragment of how they understand gender and transition and then the floodgates would open once they got confirmation that I, too, had experience medically transitioning. That confirmation seemed, from where I was sitting, to allow for a more vulnerable openness and sharing grounded in an understanding that there are some parts of gender that come with a trans experience that can't be put into words yet – unspeakable but felt by both of us.

This thesis raises questions of agency and self-determination. Are trans people's stories simply misrecognized, or is there something deeper, inconsistent, and messier at work in which trans people are active subjects in building, framing, and telling our own stories? If so, how, in what contexts, and for what purposes?

[Interlude] My Story, Ten years in transition: A surgical referral

"I don't know what else I can do to prove to you that I'm a person" I tell her as tears well up in my eyes. I'm frustrated. I'm sweating. My heart is in my throat. I can see myself on the screen. My face is red and I look as tense as I feel. At least my apartment is clean. In the background, she can see the plants I'm nursing back to health and what kinds of tea I drink. I think I feel angry. No, not angry. I feel frustrated. I will always be occupying a conditional humanity that can be revoked. I think about what Sedgwick might say. I'm being paranoid. I'm going into this appointment already suspicious. I know I am, but it feels too vulnerable to be anything other than guarded.

"I'm kind of like a trans elder" she tells me within the first two minutes of meeting me. I ask her what she means because she already told me she isn't trans and it's my understanding that you can't be an elder of a group that you're not part of. I'm anticipating what she means before she answers. I am already preparing for the discomfort, the hurt, and disappointment that comes with having to placate another person gatekeeping my care that they're a good person in a bad system. I don't know how much of that I actually believe, but I adjust my body and my tone.

I've only ever heard the term "trans elder" applied to trans people like me: those of us who have existed as trans for a long time. "Well, I've been doing this for almost three years now… working at the trans clinic, I mean. I'll admit, I haven't met someone like you before. I just haven't worked with one of you." She's defensive. Someone like me, one of me, one of what? What am I? When I asked to be called another name from my given name in high school, I had to sit down with the schoolboard executives and they said that, too. "We've

never had one of you before" and it ripples through my body like ants crawling under my skin. One of you, one of me. I'm not "like you", I'm "Other". I've become something else.

"I'm working in a through-office so you might see shadows of people passing by." Why can't she just be truthful with me: She's working from home and there are others there. At least let me consent to the context of this appointment. When you're not human, your comfort doesn't matter. She tells me she's an ally. I don't think allies turn a 15-minute referral into an hour-long disagreement about who (and what) I am.

Her camera strategically points to a corner so I can't see anything other than her head. She is a disembodied person assessing how to treat the monstrosity of my transness. I am a monster and she's not wearing headphones—I can hear myself echo back. Whoever is there with her can hear me, too. I'm not human to her. I don't deserve that kind of care.

"Are you aware of your past mental health diagnoses?" I tell her that I am not, but I'm sure there are some in my file. I tell her that diagnoses and psychiatric interventions were like silencing weapons throughout my childhood. If you discredit someone's mental capabilities before they're old enough to speak for themselves, you're untouchable. "So, you don't like healthcare providers?" I tell her I'm skeptical of people who claim to be specialists in experiences they do not, themselves, have. "Well, you said you have a good relationship with your mother, so it couldn't have been that bad." I tell her that I am not sure what my childhood or my mother have to do with an approval for a surgery that I have already been referred for by my doctor, especially almost a decade after starting Testosterone. "Sometimes when we are teenagers, we have emotional problems, and we grow out of them. It sounds like you have."

"I'm not sure what else I can do or say to prove to you that I am a person deserving of care. I don't know what else I could have done to prove that I am trans. Decisions were made for me when I was younger. Stories were told about me that were not mine. Why are those what you have decided are truths about me when I'm sitting here telling you differently? This isn't about who I was as a teenager. This isn't a personal triumph. I didn't get a youth and I'm mad about that. And I want to be allowed to be mad about that. Of course, I'm scared of you. Of course, I don't like you. But since then, I have built a life that I'm in love with. I am a person I love. I'm a person."

I pause. She says nothing. The air is so thick with everything I hate about myself and my life that I can't breathe. I am choking on my grief. Or drowning. I'm not sure which. I'm berating myself for being emotional, for not being professional, for correcting her. I'm wondering what she's writing about me in her notes. I am worried that even after all of the changes to trans healthcare in Ontario that supposedly have made it more accessible, I will be denied. That no matter what, there's always the possibility that I'll be denied.

Chapter 1: Trans and Gender: Stories, Meanings, Truths… An Introduction

> The academic pursuit of gender as a category of analysis has long privileged embodied subjectivity… While we write histories about gendered discourses and tangible remains, we are quiet about what it felt like. (Gush, 2018, p. 57)

Stories are powerful. We inscribe who we are with every story that we tell about ourselves. Stories are emotionally charged ways of creating our own self-concepts and worlds. Stories help us to legitimize what we perceive as 'truth'. Stories are how we make ourselves intelligible to others and, in turn, relate to them. They communicate meaning. And because it is through stories that we become comprehensible as people, crafting these narratives unearths how we have come to understand the world around us and ourselves. The articulation of narrative is a significant way that we produce knowledge. Stories that are relatable—that is, stories that are able to show a causal or logical connection to something or someone else—become truths. When we see ourselves mirrored in how other people articulate their worlds, when their stories are relatable, it makes sense to conclude that it's not only their world or my world, but *the* world. These relatable, dominant experiences come to be understood as naturally and universally human because we make sense of them through our own perceptions of the world (Foucault, 2005). Relatable stories, then, are unmistakably part of 'human nature'. But what happens when our personal narratives don't fit with the dominant ones? Do we become less relatable? Do we become less human?

My research contributes to a better understanding of trans lives. More specifically, my work attends to how we situate ourselves within each other's stories to determine their validity and their humanity. My work contributes to research that is informed by the full and direct participation of those of us that are being spoken about. This work calls on social work scholars,

clinicians, and trans community members to pause and reflect on how our own assumptions and biases about others structure how we interpret them and delimit their possibilities by generalizing experiences as 'truths'. Through narrative research with differently situated trans adults in Canada and the United States, I critically reflect on the stories trans adults tell about medical transition, about gender, and the social contexts in which these stories become possibilities. My aim is to explore trans experiences of gender in relation to our pasts and to others around us, as we negotiate medical transitions. I argue that the stories trans adults tell about medical transitions are messy and require us as trans people, scholars, clinicians, and activists to consider how we think of time, age, relationships, and gender. My work asks: (1) What are the ways that adults who have or are transitioning talk about gender? and; (2) How do these stories of gender diverge, converge, or otherwise relate to dominant theories and stories of gender?

Dominant stories of gender/Transnormativity

Trans people's stories are constantly being reworked and rearticulated against cis standards. Dominant narratives of medical transition rely on the trope of 'being born in the wrong body' (Engdahl, 2014). This trope assumes a bio-temporal timeline that follows the crystallization of interpretable secondary sex characteristics within and on the body during youth, which is defined by the United Nations as persons between the ages of 15 and 24 (n.d.). This biologically essentializing preoccupation with *when* bodies are *supposed* to be recognizably gendered means that the emergence of the desire to medically transition later in life is considered suspect (Kennedy, 2020). This assumption produces transnormative narratives of medical transition. Dominant narratives outlining what it means to be trans are grounded in a set of tropes, stereotypes, and ideals informed by race, class, and dis/ability that are then generalized to *all* trans people (Latham, 2019).

In many situations, and particularly in accessing medical transition, if this transnormative narrative is not adhered to, our legitimacy as trans people gets called into question. It provides an outlined and rigid "hierarchy of legitimacy that is dependent upon medical standards" and "eclipses alternative explanations of gender non-conformity" (Johnson, 2016, p. 465). Indeed, Johnson (2016) states that "transnormativity [is] a regulatory normative ideology that structures interactions in every arena of social life" (p. 466). Transnormativity is the social discourse that comes from a medicalised understanding of transgender subjectivity that in turn reinforces hyper-pathologized notions of gender and embodiment. Gender becomes solidified within a "realness or trans enough hierarchy that is heavily reliant on accountability to a heteronormative model" of gender, sex, sexuality, and bodily desire (Johnson, 2016, p. 467-468). In short, transnormative narratives about medical transition not only scaffold what it means to be trans, but also whose experiences are not trans enough[1].

Transnormative discourse concerning embodied sex and gender expression restricts the potentiality of valid trans experiences to a narrow scope of desiring to become as close to being cis as possible. As Johnson (2016) states:

> Situating trans experience and identity within a medical model creates a normative process of becoming transgender that requires trans people to produce a biography wherein they have exhibited signs or symptoms of gender non-conformity throughout life that in turn have caused them emotional distress. (p. 469)

[1] For a more in depth reading regarding the history shaping transformative discourses of medical transition that continue to influence many standards of care see Benjamin (1966) and Riggs et al. (2019)

This relies on a narrative of discovery, of 'finding out' one is trans, predicated on the assumption that being cis is a neutral starting point which is deviated from (Davy, 2015). In this way, "trans people not only learn how to narrate their experiences but they learn the proper emotional response to those narratives and may even internalize them as part of their understanding of self" (Johnson, 2016, p. 471). According to Garrison (2018), this dynamic creates a distressing sensation of feeling "not trans enough" to be part of trans communities, access trans healthcare services, and name our genders:

> …when we are unable to 'do' gender in ways that others can recognize, others may challenge our performances. As a consequence, we may come to question our own authenticity and wonder whether we really are the people we've understood ourselves to be. (p. 618)

It is important to note that trans people, ourselves, contribute to the making of transnormative meaning concerning sex and gender. Meaning is co-produced through the dynamic relationship between trans person and medical professionals. Transnormativity can serve as a validating and reparative way of orienting to the concepts of trans and transition (Bradford & Syed, 2019).

Transnormativity factors into experiences of discrimination faced by trans people, as recent research literature shows. Trans people experience discrimination for being trans, but also for not being correctly or normatively trans. Transnormative ways of talking about gender inform what kinds of stories about our embodied experiences are possible. Bauer et al. (2015) implore researchers to consider that potential access to healthcare is only that: *potential* access determined by which embodied trans experiences are permissible. They suggest that "[a]ccess

must them be realizable (free from further barriers) before it can be realized (actually accessed)" (Bauer et al., 2015, p. 2). As part of their research, they unearthed how trans individuals' abilities to communicate openly, truthfully, and fully with healthcare providers was a key factor in our abilities to find security, stability, and comfort within ourselves (Bauer et al., 2015). While the researchers were focused on trans individuals' interactions with primary health care providers, the ability to feel secure in oneself is reliant on how thoroughly and authentically we can explore ourselves and our unease *in a professional setting* (Bauer et al., 2015). Ziegler et al. (2019) suggest that healthcare providers were more comfortable treating trans patients when trans healthcare was reframed as basic primary care needs for a vulnerable population, rather than being considered as a specialized field. This focus on primary care provider's willingness to acknowledge their discomfort with a lack of knowledge and awareness of trans bodies and health needs came from the Trans PULSE Project's[2] unearthing of the significant rates of discrimination faced by, or feared to potentially be experienced by, trans individuals in Ontario (Ziegler et al., 2019).

Based on data related to the Trans PULSE project and a focus group conducted in 2006 with 86 trans people and four family members, Bauer et al. (2015) found that discrimination was the key force driving increased rates of depression and suicide amongst trans people. Similarly, through an analysis of 380 reported suicide attempts by trans people aged 16+, Bauer et al.

[2] The Trans PULSE Project launched an 87-page survey that was passed around transgender communities in Ontario by word of mouth. By May 2010, the survey had received a total of 433 responses. From its inception, the Trans PULSE Project was "a community-based research project that investigated the impact of social exclusion and discrimination on the health of trans people in Ontario, Canada" (Trans PULSE, 2012, About Us). This project was particularly interested in unpacking how transphobia and cisnormativity "shape the provision of services for trans people…and how these in turn may affect health" (Trans PULSE, 2012). Forty-six documents ranging from academic papers, e-bulletins, videos, presentations, and reports were produced from this data. For more information, see Trans PULSE, 2012.

(2015) found that social inclusion was the best way to mitigate risk. Likewise, in MacKinnon's 2020 study, it was argued that social discrimination and exclusion were the biggest barriers to accessing care.

While the studies carried out highlight an important point about how discrimination impedes trans people's abilities to feel good and secure about ourselves, the focus remains almost exclusively on how trans people make sense of how others treat and respond to us. Very little work considers how trans people feel about our own impacts on others. This thesis attends to how trans people make sense of ourselves, our genders, and medically transitioning as we navigate relationships with others in ways that are always in negotiation with how others feel about us and our roles as affecting bodies.

Study Design and Overview

My research considers how the dominant stories of gender inform how trans adults in Canada and the USA negotiate and make sense of their own genders and transition. Tamas' (2011) autoethnographic approach allows me to contextualize people's stories in conversation with my own, linking our personal narratives of medically transitioning to the experiences of others. As well, this allows me to consider how my own transition story as well as my double-position as both community member and healthcare professional play a role in what participants felt comfortable sharing with me, when, and for what purposes, and offers readers potential insights into my interpretation of the participant's stories. My work also follows Muñoz (2020), in shifting the conversation about our social locations away from fixed identities and towards affective negotiations.

Calling for scholarly research regarding medical transition to return to considering what gender means when starting from the perspective of trans lives and voices, I gathered personal narratives from interviews with nine trans people over the age of 25. While most participants shared similarities in race and gender, they all made sense of gender differently. I used a preliminary survey, described in detail later in this manuscript, to identify potential participants based on variations in age, education level, race, gender, and geographic location. In interviews, I invited them to explore how they make sense of their own genders, with a focus on what gender and transition mean for them. I then situated their narratives socially, emphasizing commonalities and differences in how participants spoke about gender and what nonverbal emotional responses I perceived in them that were visible or audible while participants reflected and told their stories.

Chapter Summaries

This thesis is structured to develop my critique of a 'one size fits all' approach to gender, unfolding as I go. I began by prefacing how this project came to be, situating myself regarding my gender and age, and my relationship to medical transition. Throughout, I include autoethnographic 'interludes' to centre and share the felt and emotional experiences of medically transitioning, the memories that tended to haunt me throughout doing this work, and offer some context for the interpretation that emerges in the thesis. Chapter One outlines my theoretical framework and how I take up the core concepts of gender, transition, and story. In Chapter Two, I elaborate on this project's engagement with life history and autoethnographic approaches and discuss the study's design. I introduce participants and their relationships to gender and medical transition through brief vignettes.

Chapters Three and Four lay out my interpretive analysis of participants' varying ways of making sense of their medical transitions and genders within their unique social contexts. In Chapter Three, I highlight the commonalities and differences in how participants across varying gender categories and age cohorts define and relate to gender and transition. In Chapter Four, I examine how participants' personal transition narratives are imbued with interpersonal losses, grief, and melancholia. I show how these social experiences shape how participants relate to the concept of trans. My final chapter includes further interpretation and reflection. In Chapter Five, I return to theory to summarize my key contributions, their implications, and limitations.

Theoretical Influences and Framing

In *The Sense of Brown,* José Muñoz (2020) encourages us to move beyond notions of the fixed (something that people are) and, instead, attend to the performative (what people do) (p. 12). I argue that gender needs to be understood as a continuous process of becoming: an unending convergence of something we are, what we feel, *and* what we do. I am interested in thinking through the messiness of gender as a relationship between an individual affective terrain and a socially, culturally, and historically formed set of expectations and experiences. In other words, what happens when we consider gender as an engagement of affect and aesthetics that moves beyond being 'something that people are' and think through how 'what people do' affects, and is affected by, others? In doing so, we attend to how we talk about transitioning and gender and our relationships to dominant theories and stories of gender and transition. Further, by bringing gender as it shapes and is shaped by our interpersonal relationships into the conversation, we start to see how our relationships inform and influence how we understand the gendered world around us and where we fit in it.

Shifting Structures, Changing Feelings

As already noted, I have been inspired by José Muñoz (2020), who considers how understandings of race shift when thought of as an affective category rather than one of identity. In his work, he shifts away from external representations of Latinx lives and towards what it might *feel* like. He attends to brownness not as a fixed point of origin or being, but rather a shared and collective experience within ethnicity, as a structure of feeling. He suggests that "Whiteness[3] is a cultural logic that can be understood as an affective code that positions itself as the law" (p. 10). In this work, I take up this point to consider how gender in North America, infused with Whiteness, is a cultural logic and affective code positioned as law, as a structure of feeling. In his work *Preface to Film* (1954), Raymond Williams introduces structures of feeling as a way to problematize the notion of hegemony, without denying its existence. Williams' work seeks to show the impossibility of total domination.

Simply put, Williams argues that societal structures of feeling delimit the socially acceptable and unacceptable ways of being and knowing at a specific point in time, and in a specific place. It is in the internal engagement with official discourses, regulations, policies, broader societal responses, and community understandings of these domains that different possibilities for existence emerge (Williams, 1954). For Williams (1954), it is feeling, not thought, that helps us to know what cannot yet be fully articulated. A structure of feeling is merely a trajectory. According to Connell in *Gender: Short Introductions* (2009), a structure can

[3] I intentionally chose to use the uppercase W for 'Whiteness' here based on a statement put out by the National Association of Black Journalists in 2020 to attend to how colour is used to describe race. Nell Irvin Painter writes in an opinion piece for the Washington Post, "The capital W stresses "White" as a powerful racial category whose privileges should be embedded in its definition…. The capital letter can underscore the existence of an unjust racial power imbalance." For more, see Painter (2010; 2020).

only ever be a trajectory because of its capacity to change as it engages with the world. It grows, shifts, and re-assesses its truths through its continual bumping up against incompatibilities between what is felt and known, even if not fully articulatable, and the social conventions that conditioned its possibilities in the first place.

Gender as a Structure of Feeling

Connell (2009) outlines gender as a multi-dimensional structure: it operates through power, production and consumption, emotional relations, and symbolism (Connell, 2009). These dimensions are analytically separate, but intimately and inseparably interwoven. Further, these dimensions in which gender operates are interwoven with other intersecting social structures as well, such as race, dis/ability, class, among others. Connell (2009) argues that "we need to treat gender as a structure in its own right. We must avoid collapsing it into other categories and treating it as the effect of some other reality" (p. 87). At the same time as gender cannot be isolated as its own structure, it also cannot be an effect of other social structures. Gender can only ever be understood within context and through its engagements with the social world (Connell, 2009).

To think of gender in this way problematizes the concept of identity. As Connell (2009) explores, gender identity requires a conscious recognition of 'who I am', but this only addresses one part of a person. Connell (2009) discusses the concept of gender identity further by tracing its history as a form of self-knowing that emerges by aligning with a social practice, as a fixed-point of being. When gender is a state of 'who I am', any hint of change to it brings about the entire de-structuring of the self to be rebuilt into something new, unknown, and different (Connell, 2009).

From this perspective, transition is not just a change to gender identity, but a shift in who we understand ourselves to be and, in turn, how we relate to others. It is distressing and transitioning can become a crisis of being. Weaver argues in *Monster Trans: Diffracting affect, reading rage*, "monsters threaten to destroy not just individual members of society, but the very cultural apparatus through which individuality is constituted and allowed" (2013, p. 290). We are presumed to become monsters because of our medical transitions. Further, our being trans—being some*thing* else—creates havoc for cisnormative discourses of gender essentialism. In *(De)Subjugated Knowledges: An introduction to transgender studies*, Susan Stryker (2006) makes clear that "'difference' and 'hierarchy' are never mere abstractions… [they] reveal the operations of systems and institutions that simultaneously produce various possibilities of viable personhood and eliminate others" (p. 3). All of us sometimes make assumptions that others experience the world in the same ways as we do, a way of thinking predicated on the idea of a 'universal human nature' that helps us feel less abnormal and less alone. It makes sense, then, that when these assumptions are destabilized, people can translate this reality into an attack against who we fundamentally *are*.

Drawing insight from Muñoz and Connell, I suggest that to consider gender not as an identity but as a multi-dimensional structure of feeling allows for an understanding of gendered personhood—gendered subjectivity—as something that changes through engagement with the world, both affected by and affecting others. To consider gender in this way opens the possibility of attending to what gender *feels* like as an internal sense that is distinct from, but interwoven with, Connell's dimensions of gender structure: emotional relations, power, symbolism, and production and consumption.

I wonder what might happen if we think through gender as something felt—both affecting and affected by others—and as something that might not be possible to articulate in a fully fleshed out way? If gender is a multi-dimensional, ever-shifting structure of feeling, is it possible for the concept of gender to carry as many different meanings as there are different experiences? I am interested in plotting how gender performance (and its rejection) has become understood as the rejection of *gender* rather than of a certain mode of feeling and doing gender in a world organized by cultural mandates not only to be but also to feel cis.

Feeling Gender

I argue that cisness, as it is infused with Whiteness, could be considered a cultural logic—a structure of feeling—that can be understood as an affective code that positions itself as human nature. When we considered gender as raced and race as gendered, we can talk about cisness using the same framework outlined by Muñoz (2020). Cisness can be understood as a truth game that is rigged because it is predicated on the nonexistence of other ways of doing and feeling gender. Like how Muñoz considers Whiteness, I suggest that cisness is "meant to block access to freedom for those who cannot inhabit or at least mimic certain affective rhythms that have been preordained as acceptable" (2020, p. 10). Media representations of being trans attempt to carefully curate and contain trans experiences as spectacles of feeling distress and feeling unnatural in one's own body.

Inspired by Muñoz's assertion that Whiteness "claims affective normativity and neutrality, but for that fantasy to remain in place one must only view it from the vantage point of cultural and political hegemony" (2020, p. 11), I argue that the same can be said about cisness. Once we look at gender outside of the immovable absoluteness of cis hegemony, cisness as the

default experience begins to crumble. If we also consider how gender occupies an affective category rather than one of identity, the structures of feeling associated with gender, as inseparably imbricated with the power relations embedded in race and class, are brought into view. This allows us to attend to how our senses of self, including our gendered sense, are always in negotiation with what we believe is possible. The recognition of new possibilities may cause us to reconsider ourselves in light of new knowledge and react accordingly. Simply, what we come to know about the world and how we fit in it emerges from our experiences in it. We are constantly negotiating the social structures of the right/wrong ways of feeling gender, and what is considered normal or deviant.

Possibilities for Feeling Gender

Often, I see trans folks refer to their past selves as 'dead' and I wonder how much space they have given to grief—to feeling that loss. It is only in the absoluteness of death that they envision a future self—a new self (Awkward-Rich, 2017); a self compatible with a socially just world in which the violences of (cis) gendered expectations are no longer perpetuated. In desperation to escape feeling bad, trans people sometimes end up "objectifying" (Crimp, p. 16) our past gendered selves as external threats. (Cis) gendered expectations become synonymous with gender, itself. Gender gets spoken about as inherently violent and suspicious.

This suggests that gender can never truly be embodied: it can only be performed and re-asserted so that it may be interpreted by others and inscribed. In Garrison's view, gender is a social construction: it is "a negotiated social achievement" (2018, p. 615) external to the self and impossible to opt out of. This understanding suggests it is possible for gender to be unachieved

through our failure to perform acceptably, resulting in a misrecognition. But, is gender only what is recognized by others? Can it not also be something *felt*?

Our expectations of a gendered life can foreclose the infinite possibilities of gender to a spectrum between binaries—cis trans, masculine feminine, binary nonbinary, etc.—with new binaries popping up to promote inclusivity. Echoing both Connell's work on gender and Muñoz's theorizing about race, I suggest that to think about gender "is to accept that it arrives at us, and we attune to it only partially" and that all we can hope for is to be aware of what gender "does in the world, what it performs, and the sense of the world that such performances engender" (Muñoz, 2020, p. 3).

My research is not about the simple and futurist solution of abolishing gender. As becomes clear from the interviews at the heart of this project, people have multiple, messy, and contradicting relationships to gender. While to abolish gender would be a utopia for some, there is no 'one size fits all' narrative of gender and transition for trans and nonbinary people. Rather, in the interviews in this study, a world emerged where there are infinite possibilities of gender that cannot be neatly separated into 'cis' and 'trans', because they overlap. Infinite possibilities of gender fracture existing categories, simultaneously relating to and resisting their hierarchies through constant mediations[4].

[4] At a time of Indigenous resurgence, it is important to note that the sex/gender binary system functions as part of a settler-colonial system of governance. While my work challenges a rigid binary in favour of a more fluid and flexible understanding of gender, see Pruden (2020) for a more detailed overview of Indigenous approaches to gender.

Telling Our Stories

"I want to share my story to help people" one participant told me. This sentiment was echoed by all nine trans folks I interviewed for this project. "It's my way of giving back", "I want people to know that it's not all doom and gloom, that it's possible to be happy", and "If my story can help someone else not feel as bad as I did at the beginning, wouldn't that be something?". Overwhelmingly, it seems, stories are our way of affirming our existence in a world that never meant to acknowledge us. For these participants, they were also a gift offered to other trans folks, a manifestation of trans care. In this thesis, stories are how trans understandings and feelings about gender are formulated for ourselves and offered to others.

In *The Better Story*, Dina Georgis (2013) states that story "stands for the way we narrate the past, transmit knowledge, and imagine our futures" (p. 1). It is through stories that we convey ourselves and construct meaning in the world. This is an emotional process that "gives us access to the deeply human qualities of how political histories get written from the existential experience of trauma, loss, difficulty, and relationality" (Georgis, 2013, p. 1). The stories trans adults construct and tell about gender shape and are shaped by broader socio-political discourses about who is permitted to be trans and what being trans can possibly look like (Stryker, 2006). Sizing up how we relate to generalized narratives of trans experience is, in part, how we create our own stories.

Taylor et al. (2018) argue that personal narratives highlight how individuals choreograph their life journeys, especially those, such as trans people, who embody pathologized identities. The biologically essentializing transnormative narrative underpinning medical transitions often situates, and subsequently limits, becoming trans within the context of puberty. It is during this

supposedly tumultuous life stage that trans people are expected/allowed to discover whether we align with our bodies or not (Engdahl, 2014). This narrative suggests that trans people are just as 'normal' as cis people, despite our biological differences (Taylor et al., 2018). At the same time, this narrative pathologizes those have other trans experiences. A uniform experience is expected, even called up, by health care providers, and acts as a canvas for those trans people navigating the terrain of healthcare, affecting how trans people perceive our journeys through care and the stories we tell throughout.

Concluding remarks

In this chapter, I have sketched my theoretical framework, outlining a conception of gender as 'felt' and always imbricated with other relations, including race and class. I theorize gender as both a social structure a la Connell (2009), as something people do, and as a structure of feeling. I suggest that gender is also affective experiences of the self, and that this 'felt' sense of gender can be in tension with gender structures in society, offering new, infinite, and fluid gender possibilities. I present this concept in the context of a critique of transnormativity, arguing that a binary of trans and cis, and a prescribed 'normal' way to transition, constrain and restrict possibilities for trans lives.

Then, I point to the work that stories do to help us find meaning and our way in the world. I open space for stories of transitions that may depart from or contradict transnormative discourse. I lay out this terrain within the context of my reading and my experience as someone who has pursued medical transition. In the next chapter. I build on this theoretical framework to lay out my research methodology and methods.

Chapter 2: Methodology and Methods

This study uses a transfeminist methodological approach to examine the multiple ways trans adults articulate their understandings of gender and transition. In line with Erickson-Schroth's definition of transfeminism in *Trans bodies, trans selves: a resource for the transgender community*, this study takes "an approach to feminism that is informed by trans politics" (2014, p. 620). More specifically, this study follows Emi Koyama's lead in *The Transfeminist Manifesto* (2001) and focuses on the infinite ways people live their lives, define ourselves and articulate who we are, including the fluidity with which this occurs. In being mindful that a transfeminist perspective supports the declassification of gender identity, dysphoria, and incongruence as disorders (Hill, 2001), it is nevertheless central to this thesis to prioritize the stories participants told, in their own words and shaped by their own trans politics, and to consider the conflicting personal reactions to the ways in which our lives get politicized and what that *feels* like. This research is transfeminist in the most basic of definitions as it attends to gender and begins from trans voices and lives.

In this study, I use an interpretive approach to examine the narratives offered by participants as they articulate their understandings of gender and transition across their lives. I call up life history as research method and engage with the personal narratives provided by the nine individuals I spoke with, as well as my own narrative, through auto/ethnographic work. Reflecting on my own and others' experiences navigating medical transition and the central role of personal narrative in these processes (Garrison, 2018), I have worked to sketch how trans adults produce and position themselves in relation to others through personal narratives, how we feel about it, and how we make sense of these feelings.

Throughout my research process, I have drawn on my experience as a therapeutic counsellor to engage in continuous reflexive practice through autoethnographic writing practices. In doing so, I have found myself highlighting how we make sense of ourselves (and the world around us) as always affecting and affected by others as we inhabit, resist, or otherwise bump up against bigger social structures of gender, transition, and care. This research starts and ends in conversation with others, taking care to recognize how our understandings of ourselves change over time in ways that might contradict. In this way, our stories become openings from which we can map out how our orientations to ourselves are always in negotiation and how knowing ourselves is wrapped up in how others can see us, regardless if this knowing comes from feelings of being recognized or invisible.

This work is also a call for social change while attending to the diverse, unique, and complicated ways trans individuals relate to our embodiments. In *From resistance to resurgence*, Strega & Brown (2015) highlight the importance of researchers being experienced as "relationally accountable" (p. 3). They suggest that a continuous process of critical reflexivity "especially about research positionality, is a necessary component of socially just research" (p. 3). This is because of what they call an "epistemology of ignorance" where researchers tend to become "authoritative agents of knowledge" based on a "belief in our right and entitlement to 'know the other'" (p. 3). Often, research is something that is done about marginalized peoples by those who are either not marginalized, or marginalized in differing ways (Strega & Brown, 2015). This further cements the assumption that those who are dominantly located in relation to those whose experiences are the topics of research are neutral and objective. This is a legacy of research that my study attempts to interrupt by situating these conversations in relation to our respective experiences and emphasizing the role of my own interpretations of these stories. The

goal for this research was never saturation or to have a generalizable underpinning of trans experience; rather, my aim is to unearth how trans peoples' understandings of gender and transition vary.

My interpretive study attends to how participants make sense of their genders and medical transitions given the contexts in which they came to know themselves. Gubrium (1995) suggests that interpretive research is concerned not only with how people articulate and narrate their experiences, but how these stories relate to broader cultures and discourses that structure and delimit their possibilities. I attempt this approach, but through methods that put different stories alongside each other, including my own story.

The interpretive work that I have done in this project is both obvious and invisible. Most explicitly, I write autobiographically using 'I' (Finlay, 2002). Reflexivity was an intentional part of the study design, how data was gathered, and how these conversations have been thought through. Some of this reflexivity was uncomfortable, challenging my own sense of self and what I think I know. As Strega & Brown (2015) emphasize, "reflectivity [is] an essential methodological strategy" because it allows for us to attend to how our own values, morals, and worldviews play a role in our research (p. 8). In this way, the interpretive work of reflexivity is what opens the recognition that I can never be separate from what I'm trying to understand. I can only ever be negotiating my relationship to my understandings. By engaging with the stories participants tell of their medical transitions, as well as situating and contextualizing my own, this work attends to the affective and relational influences on how trans adults make sense of gender and transition.

Following Taguchi's work in *A diffractive and Deleuzian approach to analysing interview data* (2012), I was committed to seeing myself as imperfect and "the interview as an already failed practice" where "the telling of one story has always been told in place of another possible story" (p. 270). While Taguchi (2012) critiques interpretivism as a "centring compulsion of traditional qualitative research that assumes the interviewee can voice coherent narratives in the very telling of their experiences" (p. 270), the interpretive work I engage with through reflexivity and auto-ethnographic writing disrupts my implicit position as a neutral and objective producer of knowledge. While it is important to note that the interviews had a formal framework in terms of ethics requirements, recruitment procedures, and general questions, this work was carried out in a form more akin to conversations. These conversations were "processes of entanglements and interdependencies in processes of ongoing co-constitutive co-existence" (Taguchi, 2012, p. 271). Intentionally and explicitly highlighting the interpretive part of this research is a way of attending to how, just as the stories told are always in place of another possible story, analysis, too, will always have the possibility to be something else.

In my analysis, I chose to focus on what I perceived to be emotional and affective charges coming from the retelling of medical transition narratives. Drawing on my clinical experience as a therapeutic counsellor, this allowed for me to tune in to more than what was being said; to consider the limitations of language in articulating possibilities of being that might be beyond how I understand my own medical transition. As I will briefly explore, I mobilized two methods—life histories or narratives and autoethnography—to take a relational approach to this work. I situate my understandings of life history and auto-ethnography as reparative forms of research with trans people. Next, I describe the phases of my research process. Finally, I

introduce the nine people I spoke with and their relational positioning within Canada and the United States.

Life History

To emphasize how varied and contextually specific trans experiences and medical transitions are, this study focused on how trans adults narrate their experiences of gender and transition across their lives. By attending to the inseparability of how we see ourselves and how we *can* be seen by others, life history research explores how we make sense of ourselves, "[our] lives, perceptions and experiences" in relation to how our worlds and possibilities are structured through larger cultural and social contexts (Cole & Knowles, 2001). Intentionally calling up and engaging with how people articulate their understandings of themselves, life history research is unquestionably "autobiographical and relational" (Cole & Knowles, 2001, p. 10).

My study consisted of nine interviews with nine trans people who began their medical transitions as adults within Canada or the United States. My approach allowed for the formality often associated with interviews to break down and for our time together to take on a form more closely related to a conversation between people with shared experiences. With each interview, the breakdown occurred differently and at a different point. Sometimes it was immediately after the reassurance that I, too, am trans. At other times it was when we paused the interview. Often, it was following a reciprocal self-disclosure after an intensely vulnerable moment. Drawing on my clinical social work practice skills to connect and reflect, I prompted the telling of medical transition narratives, holding space for each participant to direct the course of their own interview and encouraging each person to speak about whatever was coming up for them, as a result of their retellings.

The aim was to attend to and contextualize the narrative variations among us, and the variation among those variations. Linda Kauffman (1993) states that life histories can be "fatally alluring… the individual life story as coherent, unified, morally inspiring" and we "see similarity where in fact there are only… irresolvable, irreconcilable differences" (p. 263). I wanted to do some engaged rethinking of individual stories, without assuming they hold generalizable truths about a specific experience, because experiences can never be separated from the contexts in which they happened.

Autoethnography

In *Autoethnography, Ethics, and Making Your Baby Cry*, Sophie Tamas (2011) implores us to consider how "[t]he way we perceive and recount traumatic histories, in our efforts to educate, change, or heal may, in fact, perpetuate and compound our personal and social losses" (p. 258-259). Using the "much-studied field" of spousal abuse, Tamas (2011, p. 258) highlights how witnessing life histories is often how we can make sense of what happened. Tamas (2011) discusses how experiencing trauma in research is both simultaneously necessary to understand how people are affected by their experiences of spousal abuse, and impossible to believe that it could or has ever happened to the researcher. These underlying assumptions within conventional qualitative research further entrench the misconception that by being personally removed from the work one does, one will have a clearer, more neutral, more objective understanding. However, as Tamas (2011) argues, this is not only a means of maintaining power and authority as a researcher over participants, but also contributes to a culture in which empathy becomes a liability to accuracy. This is because we are considered to relate too deeply to the subject matter and, therefore, unable to hold space for perspectives other than our own interpretations of our own life events (Tamas, 2011).

Like spousal abuse, I consider medical transition a 'much-studied' field. Often, this research tends to fall into the following categories: how healthcare professionals understand trans identities and perpetuate discrimination via misrecognition (Bauer et al., 2015; Eyssel et al., 2017; McCann & Brown, 2017; Ziegler et al., 2019), cis people's attitudes toward trans people (McCann & Brown, 2017; Robson Day & Nicholls, 2019), analyses of trans narratives in fiction and popular culture (Boyd & Bereiter, 2017; Putzi, 2017), and or single-narrative case studies tracing trans people's processes of 'coming out', or rather, coming to know ourselves *as* trans (Scharaga, Chang, & Kulas, 2020). Very little research has been done that considers trans people as both patient and provider, both participant and researcher, both service user and service provider. Tamas (2011) argues that "[w]hen, as scholars, we write about others, we are not contaminants that can be quantified and contained in the preface or margins of our accounts… our power and voice are everywhere" (p. 262). She goes on to say, "if objectivity of even transparent subjectivity were possible, I could argue that my stories are justified because they are true" (Tamas, 2011, p. 262). In not writing about ourselves, we are looking for justification of our stories as not only true, but *the* truth. Following Tamas, my study mobilizes autoethnography as a reparative approach to research, which has historically been "done on" trans people (Strega & Brown, 2015, p. 5). Autoethnography puts the spotlight on "what we consider to be 'natural' ways of understanding" (Brookfield, 2009, p. 299) and, instead, reframes every thought as an interpretation informed by our own unique internalized ideologies. My work, like Tamas, rejects the possibility of objectivity.

In offering my own story as an integral component of this research with other trans people, my aim is to trace how and why I am interpreting and retelling these stories the way I

am. By placing my own story in conversation with others, I attend to research as a process of reading with others.

Phases

My study involved four key phases: (1) locating trans adults who had experience medically transitioning in Canada or the United States; (2) narrating their various experiences of medically transitioning; (3) analyzing and situating transition narratives within the relational and affective personal understandings of gender and transition; and (4) critically reflecting, using autoethnographic writing to consider how my own experiences as a trans person who has medically transitioned, as a healthcare provider for trans people, and as a graduate researcher, have influenced my conversations with participants throughout the analytical and writing phases. These phases allowed me to explore how trans adults make sense of gender and medically transitioning as their personal stories bump up against dominant understandings of trans lives and what that feels like, whether the stories converge, diverge, or otherwise relate to one another, and how the stories get articulated. In doing so, I was also able to think through how trans folks make sense of transition and gender within broader societal discourses of gender and trans politics.

Recruitment and data collection for the project took place in three stages. I mounted a brief survey so potential participants could express interest, I conducted online interviews, and I offered an optional follow-up interview once participants had a chance to review their transcripts.

Phase One: Locating

The first phase of my research aimed to recruit people for what was titled "The Stories We Tell: More Than One Transition Narrative", a project investigating the transition narratives told by trans people with experience medically transition at the age of 25 or older in North America. I recruited participants with diverse experiences of gender (e.g., men, women, nonbinary, agender), of diverse ages (the youngest being 28 and the oldest 69), and at diverse points in their medical transitions (one individual had just had their first appointment with a physician to begin their transition, while others identified their transitions as "complete"). Rather than focusing on a predetermined balance in the experiences of specific gendered goals of medically transitioning (masculinization, feminization, or otherwise), my goal was to connect with adults across a diverse age range to explore how people who medically transition later in life narrate their experiences.

In light of the continued context of the COVID-19 pandemic, I opted to turn to online communities as recruitment sites. I focused my recruitment efforts on Reddit because it is a massive hub of user-created communities whose members are concentrated mostly in North America. I found 37 relevant online trans communities of varying genders. After reviewing the community-created rules for each and their openness to research recruitment, I ended up reaching out to nine separate trans community forums by first sending a message to their respective moderator teams for permission to insert my study into these spaces. I wrote that my aim was to think about gender "across institutional, community, personal, and individual contexts in order to highlight a diversity of trans experience that goes beyond mainstream medicalized understandings of gender and transitioning to make them more available to today's trans community, activists, and the public." Included in these messages was a link to both a

document with extended information about the study, as well as a survey to express interest in being interviewed. I got permission from seven of the nine communities to post recruitment materials within the week. However, I never ended up posting because the survey to gauge interest received 26 responses within 72 hours of going live. The survey allowed for potential participants to self-disclose as much or as little about their stories in advance. This gave me an opportunity to gauge each person's comfort level discussing their transitions and to intentionally select participants who reflected as diverse of life experiences as possible.

Expressing Interest. The survey was included as a means of ensuring a diversity of experiences were represented in the participants interviewed. It consistent of 13 questions, nine of which were mandatory to complete and four that were optional, that allowed for interested individuals to identify how they describe themselves in terms of age, pronouns, gender, race, geographic location, education level, and any additional information they felt compelled to share. Of the 26 interested individuals, 12 were selected for interviews. Participants were selected based on their responses to the preliminary survey that prioritized a diverse sampling of age, race, gender, education level, and geographic location. Nine of the 12 selected individuals opted to continue their participation in the study and to share their stories with me in an interview.

Phase Two: Interviews

I conducted in-depth interviews with nine people. I video and audio recorded 11 hours and 25 minutes of interviews, an average of 1 hour and 15 minutes each, hearing about these trans adults' experiences medically transitioning. The shortest interview was 49 minutes (with Crystal), and the longest interview was 1 hour 47 minutes (with Ginger). Beyond each recorded interview, we spent time together after recording stopped, mutually sharing our experiences

moving through the world as trans people who have medically transitioned. I lost count of the total time spent in this way. I wrote short entries into a journal before and after each interview as a form of reflexive practice, to attend to how my own narrative of medical transition plays a role in my interpretations of other's stories. These journal entries are what have informed my autoethnographic sections of this thesis.

Each of these interviews began with me inviting the participant to tell me their transition story. I asked, how did they decide that medically transitioning was necessary for them? What was their process like, who did they see with regards to healthcare professionals, what questions were asked of them? Answering these kinds of questions is the basis for the stories trans people are used to telling. In popular discourse within trans communities and in mainstream media, transitioning is often framed as an individual journey of self-discovery, where rejection from others is an inevitable chip on our shoulders. That, through persistence and resilience, we stay true to ourselves, and we persevere. Medically transitioning seems to become a finish line. In these conversations, however, as they progressed, we started to explore how participants felt and how they made sense of what they went through. Shifting from a retelling of a medical journey, participants shared with me how they came to find themselves in life and understand the world around them. Our conversations become co-produced life histories with a focus on gender and transition.

Following-up. When I sent a transcript of our conversation by email to each of the nine participants, I opted to send them a copy of what was said verbatim. Part of what informed this choice was my commitment to attempting to represent the stories that were shared with me in the words of the people who shared them as accurately as possible. As well, I was curious what

emotional responses might come up in being confronted with what was shared and how. In my email, I asked everyone to let me know if they have any concerns with the content that was shared and reminded them that they are allowed to withdraw their participation and their stories, in part or in full, from the project. I received immediate email responses from three participants who expressed concern at the grammatical errors in the written transcripts. In my reply, I attempted to validate these concerns as much as possible and reassure them that the completed transcripts would not be included in the final submission of my thesis and would be destroyed. Further, I reassured them each that selected fragments of conversation incorporated into the written thesis would have the grammar and spelling corrected. This was because I prioritized the comfort of participants and my aim was to encourage each person to remember that they can withdraw any part of their story from this project at any point prior to its final submission. Given the constraints of interview-based research as always interpretive, I wanted to foster a research relationship that maintained participants' agency over their own stories as much as possible. I have not heard from anyone since. None of the nine people I interviewed opted to participate in a second meeting which was intended to be a time where we could review the transcripts and address any concerns in real-time with immediate resolution.

Phase Three: Situating transition narratives

I transcribed and analyzed the video recorded interviews. I engaged with each recording and interview transcript both independently of each other and comparatively. I compared and contrasted my interpretations of each story of medical transition. I first listened to the words that were said, spending time with the ways people articulated how they've come to understand themselves, gender, and transition. I listened for the slight changes in tone, volume, and pitch of the voices. I attended to how they paused, took breaths, and intentionally curated what they

wanted to share with me. As I started tuning in to the affective cues and reactions to retelling these stories, I focused my attention on the ways that emotions were coming to the surface, what emotions were allowed to make an appearance, and any noticeable attempts to shut down or hide emotional responses. My goal was to attend to not only what happened and how participants made sense of their medical transitions, but also how they remember it felt to transition and what it feels like to remember.

As part of this process, I shared video recording of the first two interviews I conducted with Dr. Braedley to think through how my unique positionality as both a social worker asking trans people about their experiences and as a trans person myself played a role in what was shared in the co-production of these life stories. This opened up questions about what assumptions and implicit understandings were taking place as people with shared experiences, how we were each negotiating with each other, and in what ways narrations shifted away from the logistics of medically transitioning and towards how it felt, how it feels, and how it has had an impact across our lives regarding the dominant trans narratives and discourses present throughout our respective timelines of transition. Dr. Braedley worked with me to develop an interpretive guide to help me reflexively re/read the stories through and with one another, including my own story. This guide helped me to understand these interviews as life stories, curated social texts, and relational encounters that are in a constant negotiation with the complicated messy webs of relationships we each bring together to shape the ever-evolving broader social understandings of gender.

In taking this approach, I came to ask of my research: How does gender show up? How does gender function as a power relation (as norms, obligation to and expectation of family, society, as embodied feelings)? How is gender wrapped up in feeling?

The participants

The table below provides socio-demographic details and pseudonyms for participants. Participants were invited to supply a chosen pseudonym, and if they did not, one was provided. Following this table, I provide brief a brief vignette introducing each person, their relationships, and how they relate to gender prompted only by the question "How would you identify yourself in terms of gender?"

Table 1

Overview of participants

Name	Age Range	Time Medically Transitioning	Pronouns	Race	Partnership Status	Family Ties
Grey	25-35	< 1 year	They/them	White	Single	None
Jeremy	25-35	1-3 years	He/him	Mixed race (black)	Long term relationship, living together	Parents
Avery	25-35	3-5 years	She/her	White	Single	Some family
Shawn	35-45	3-5 years	He/him	White	Long term relationship	Some family, partner has children
Crystal	35-45	7-9 years	She/her	Chinese	Single	Parents
Valerie	45-55	3-5 years	She/her	White	Married	Children
Eileen	55-65	1-3 years	She/her	White	Married	Children
Ginger	55-65	5-7 years	She/her	White	Divorced	Children
Judith	65-75	5-7 years	She/her	White	Married	None

Grey is in their late 20s and is an agricultural worker in Southern central Canada. They began to refer to themself as trans around five years ago, but only just started their medical transition a few days before our conversation. Their decision to defer their medical transition was influenced by "needing to get to a place where I could do it financially. I moved for my transition." Coming to terms with themself has resulted in an on-going struggle to be seen, respected, and recognized by their family. Grey shared, "I had to cut her off, my mom. It got to the point where I just couldn't take her wanting me to be someone I'm not." When talking about their gender, Grey said "it's like a layer of being a person that just isn't there for me. There is no layer."

Jeremy works in the sexual health field. He is in his late 20s and lives with his long-term girlfriend in the Northeastern USA. Jeremy began his medical transition around three years ago but shared that he had gotten the okay from his doctor about six months before that. Jeremy told me how he "grew up with some religious values that meant I didn't really believe that medicine was a thing." On top of that, he said, "I wanted to wait until I told my parents. They're important to me and I wanted them to know that I was going to do this big thing and that there would be some changes." When telling me about his gender he told me, "I identify as a guy, I guess. But I think it's a little more complicated than that. I'm not nonbinary, that doesn't feel right. But I feel a bit weird just calling myself a guy because it feels like I'm tricking people. But I also feel weird tacking trans on that because I'm just a guy."

Avery is in her early 30s and works in retail in Southern central Canada. She began her medical transition approximately three and a half years ago. When asked how she identifies her gender, she bluntly stated, "I'm not nonbinary, if that's what you mean. I'm a woman." Avery

told me about living in Holland and trying to ignore how she felt about gender. When asked what made her decide to pursue medically transitioning, she said, “I just got to my breaking point. It saved my life. If I didn’t… I don’t think I’d still be here.” Because of medically transitioning, Avery spoke about how she lost a lot of her friends and family. She said, “I lost everybody. They were like ‘thank you for telling me, now stay away from me’ and, I guess, it really shows you who is in your corner and who your real friends are.”

Shawn is in his late 30s and works in the technology field in the Southern USA. He began his medical transition around four years ago. Shawn has a long-term partner who he was with prior to coming to know himself as trans. Shawn told me how he often feels like his process of understanding his gender doesn’t fit with others. He told me, “It’s not so much that I hated being a woman, I just feel way better as a man.” When asked about his experiences medically transitioning, Shawn told me that he often reflects on how he felt urged to set aside his previous experiences. He said, “I identified heavily with the lesbian community. I knew I was a lesbian from as far back as I can remember. And a big part of me misses the queer women’s community because that was all I knew and now that’s not a space for me.”

Crystal is in her late 30s and works in customer service in Western Canada. She began her medical transition around seven years ago while navigating the immigration process at the same time. Crystal spoke about how it was frustrating and convoluted to access healthcare, but that her outlook was to “just have thick skin. It’s just something I got to do so everything can be where it needs to be.” Crystal cares about her parents deeply and the fact that her medical transition has made them the targets of discrimination and violence back home causes her a lot of distress. She told me, “I have to have two lives, kind of. Like, on Facebook, I have one where

only certain people can see me so that I can shield my parents from what's happening because of me."

Valerie is in her late 40s and works as an engineer. She lives in central Canada with her wife and children. She began her medical transition around four years ago, though she can remember wanting to do so decades before she moved to Canada. Valerie told me about how her family life impacted her medical transition. She said, "I was so worried about my kids. Am I going to ruin them? Are they going to get bullied?" She turned to her wife who was just outside of the screen and said, "And my wife… Going from having a husband to having a wife and losing your parents because of it? That's tough, that's for sure." Valerie's family have been her number one supporters. For Valerie, it's important to share with other trans people that "it's not all doom and gloom. It's a possibility, for sure. But only focusing on that is what personally paralyzed me for years. It's not all doom and gloom and I think that's an important narrative to be heard."

Eileen is in her late 50s and works as an industrial electrician in central Canada where she lives with her wife and works with her son. Eileen shared with me that because of her decision to medically transition approximately two years ago, her and her wife are navigating the process of separating. She told me, "I love my wife. But this doesn't work for her and I can't stomach the pain I'm causing her. I can see it on her face, y'know?" Eileen's medical transition has been complicated by adverse reactions to medications that have had significant impacts on her mental health. She spoke about the challenges she's been working through, but how good it feels to finally know who she is and to get to live it out.

Ginger is in her early 60s and lives in Western Canada. She's currently in the process of figuring out what she wants to do in this "next chapter" of her life and is excited to "finally get to spend some time just for me." Ginger began her medical transition around six and a half years ago, but said when she reflects, "I can remember knowing something was off from when I was around four. But I buried it." She spoke about how transitioning meant that her relationship with her ex-wife had to end because she needed to figure out who she was. In the process, her daughter decided to distance herself, as well. She told me that her youngest child, her son, was there for her, but that she understands why her daughter needed space and they've recently begun to reconnect. She said, "For my wife, it was hard. She had all these people asking her 'well, couldn't you tell?' and that's a lot to carry." She paused for a moment before reflecting, "And so for my daughter, too, it was like, well was dad lying this whole time? Did dad ever actually love me? And that's hard. It's not just my story. It's never been just my story." Ginger struggled for years with alcoholism and credits her medical transition as the catalyst for making it through, quitting drinking, and reconnecting with her life.

Judith is in her late 60s, is retired, and lives in Western Canada. Judith began her medical transition around six years ago after a near death experience that left her in the hospital for months. She recalled that she felt "a flood of memories all came back. It was like a lightbulb finally turned on. That was it. I'm a woman." Judith is married but told me her relationship is "more like we're really good friends than anything. We'll probably eventually go our separate ways, but for now it's what we both need." When asked about gender, Judith referred to herself as "a woman of trans experience. I'm just a woman. Don't think I'm anything else." Judith is set to, in her words, "complete" her transition approximately two weeks after our conversation

together. She told me, “If there’s anything you need to know about me, it’s that I don’t do anything halfway.”

A Research Dilemma

Throughout this thesis, I have made an ethical decision to not directly include Eileen’s story. A particularly challenging part of being a trans person doing research with trans people is that sometimes our stories relate too closely. There were moments where my shared experiences with participants was propelling. But Eileen’s story reminded me of some of the most difficult and painful parts of my own, and I could not get myself to return to her transcript. However, it was because of my conversation with Eileen that this project took on its current form with a focus on relationships and what makes imaginable possibilities realizable. Eileen’s story is not included in the analysis, but it shaped the thesis direction and my analysis of the other interviews, while revealing personal work I have yet to do. I thank her for this contribution.

[Interlude] Stories in Transition

"I just didn't know what was going to happen" Avery said when I asked her about how it felt to begin medically transitioning. Speaking slowly, seemingly carefully, her voice was quiet and intentional. She looked away from the screen and wrapped her arms around her body. "I didn't realize just how long I had wanted it for," She reflected. "I was excited and terrified. I didn't know what I was in for, or what I would go through." She paused. Her eyes met mine through the distance of our virtual setting. "I had no support. Nobody knew."

I thought about how lonely that must have been. Transitioning as a young person comes with its own unique set of challenges: parental barriers, age of consent, censored and controlled access to information. Avery began her medical transition a few years after I did. I can still remember how urgent it felt for me once transitioning became an imaginable and realizable possibility. I remember wanting to tell everyone I knew. I was a teenager and surrounded by people I had known for years. It was inevitable that someone had to know because legally, I was too young to be allowed to change my gender marker, my name, or to start any new medications. It was scary, but I wasn't alone. Avery, like the other eight individuals who shared their stories with me, started her medical transition as an adult. She was not in school every day and she did not live with her family. She was out in the world on her own at a point in her life where any self-disclosure could be, and often had to be, uprooting.

Transitioning is life-altering. Ginger said that medically transitioning felt like her "life was starting" and that everything before that "felt like a black ball where there's no senses, there's no feeling, there's no taste, there's no color, there's no time, there's no nothing." Valerie said, for her, it "was not a new thought. It was a realization of the actuality." She spent the first

40-some-odd years of her life pushing her reality aside. Valerie reflected, "even though I was living like probably 60 percent of my time as a woman. I still refused to accept that I might actually be one." She paused for a moment, and the pause almost seemed like it was unintentional. She stared off to the side where her wife and daughter were puttering around in their home together. I could see her shoulders relax as her faced softened into a smile. "It was vital," she said to me.

As adults, people come to medically transitioning having experienced more of the world. The first person I spoke with, Grey, was only slightly older than I am, at 27, and had just started their medical transition the day before. I thought about how long it had been since I experienced medical transition. I thought about how much the world has changed, how much trans healthcare has changed, in the last 10 years. I thought about how wild a coincidence it was that the first interview for this project was with someone who was going to have an experience so similar, but still so incredibly different from my own.

Grey said, "I have a lot of medical trauma for other reasons besides being transgender." Grey had past experiences navigating the medical world as someone who is invisibly, chronically ill. They talked about how they were frequently accused of making it up, told there was no medically legitimate reason to be in pain, and felt as though there was something wrong with them for feeling pain anyway. They discussed how this was true of their exploration of gender, too. "I was actually really heavily looking for a label for myself because a lot of the narrative I had heard were people who experienced gender and that isn't something I've ever experienced." Grey told me about how a lot of their anxieties and reservations about medically transitioning came from what they had heard from other trans people. I caught myself wondering

why Grey felt the need to transition medically if gender wasn't something they had ever experienced. Grey told me about how medically transitioning was an escape from being read as feminine. They spoke about how it feels better to be read as a masculine person, even if that's still not how they see themself. Even though they don't see themself as a man, being perceived that way doesn't come with the same history of erasure, misrecognition, and violence.

The stories we share with each other inform how we approach similar situations. I thought about how many of my own friends had started questioning and exploring their genders and turned to me for advice. I thought about how many of my experiences were distressing, and how that shaped a high level of caution I insisted they needed. In my conversation with Grey, it became clear that sharing difficult experiences with the medical system is one way that trans people help each other survive. It also reminded me how much our own difficult experiences influence not only how medically transitioning is approached, but how safe we feel opening ourselves up to questioning gender at all. Transitioning doesn't happen in isolation and there's no one right way of doing it.

Concluding remarks

In what follows, I consider how the dominant stories of gender inform these trans adults in Canada and the USA stories, as they negotiate and make sense of their own genders and transition. Troubling the concept of gender identity (gender as an identity), I explore gender as something that is felt—both affecting and affected by others—and as something that might not be possible to articulate in a fully fleshed out way. If, as Connell (2009) argues, gender is a multi-dimensional, ever-shifting structure, including a structure of feeling, is it possible for the concept of gender to carry as many different meanings as there are different experiences? What

happens when trans people's narratives are about more than gendered experiences of power, production and consumption, and symbolism? How can we articulate our *felt* relationships to our bodies and genders to be legible within a cis and heteronormative society? Having introduced my theoretical and methodological approach, the next two chapters present findings from the nine interviews. The next chapter begins by exploring how participants make sense of their genders, their transitions, how they relate to both cis and trans, and how they negotiate their own feelings about it all.

Chapter 3: Stories/Making Sense of Gender

In this chapter, I attend to the uniquely situated and contextualized ways that gender is understood as it relates to each person's medical transition. I also show how these conversations trouble research tendencies to assume trans people understand the concept of gender in a shared way. I explore patterns regarding how gender gets articulated through the language of feeling—as something felt or not felt. To close, I consider how binaries appear—cis/trans, masculine/feminine, binary/nonbinary, felt/not felt, right/wrong—and how participants sense-making is conditioned by their social locations and life histories.

I begin by asking: What stories are being told about gender and transition? I review relevant research literature that explores medical transition and trans lives, to establish what is known, but perhaps more important, what is being said and circulated about trans lives. Whose stories are being told? What are the conditions of their retellings? Next, I show how gender is defined and experienced very differently by participants. I show how, even through the variance in definitions and experiences, what was common across participant's stories was that gender was spoken about using the language of feeling. Gender was not explained through social structures, belonging, or rejection. Rather, gender was articulated as a sense of being and embodiment, and medical transition as a means of getting there. In these interviews, I highlight how some participants draw on a binary between cis and trans, while others do not.

To understand how trans people who begin their medical transitions as adults negotiate and articulate gender, we need to understand how they make sense of what gender *is*, as well as *why* medical transition was necessary for them. Explorations of how decisions to pursue medical transitions were informed, and the relationship between these understandings and our unique

lived contexts, have the potential to shift the assumed definitions, distinctions, and relationships between conceptions of cis and trans.

In 2019, Bradford and Syed, two professors of Psychology at the University of Minnesota, held four focus groups, comprising of 15 participants in total. In their findings, Bradford and Syed (2019) troubled the understanding of being trans as a shared experience in opposition to being cis. They identified cisnormativity as a "master narrative", meaning a "culturally shared story that informs thoughts, beliefs, values, and behaviours" that "guide the 'construction' of individual life stories" (Bradford & Syed, 2019, p. 318). In their study, they investigated why trans people retell master narratives about how and when they came to know themselves as trans. They concluded that it often stems from a deep desire to be perceived as legitimate (Bradford & Syed, 2019).

The conversations I had troubled these claims. There was a lot of variation in what the trans adults I spoke with were saying about their medical transitions and their genders and how they understand themselves, and we need to believe them. We also need to consider that trans people tell multiple stories and they vary depending on who they are being told to, when, and for what purposes. As Judith Butler notes, to trouble "is not to negate or to dismiss, but to call into question and, perhaps most important, to open up… to a reusage or redeployment" (1995, p. 165). For some of the participants in my study, the desire to be perceived as cis was as simple as *feeling* cis. It was not so much about being perceived as cis as it was about knowing there is the possibility to exist. They could not exist as gendered in a way they had been taught throughout their lives. That was impossible. They were not searching for the justification of their existences, but rather an awareness that existence is realizable.

My conversations with these nine participants map out failures to be recognized, being misrecognized, experiences of erasure, and the implications of needing to inhabit a particular gender category to be recognized. We are all navigating our social ideas of gender differently, whether as a pursuit of something that feels right, moving away from something that feels wrong, or even figuring out how it feels to be gendered at all.

Setting the Stage: What stories are being told?

There are dominant and infrequently questioned ways of talking about gender as it pertains to trans lives. In the first volume of *Transgender Studies Quarterly*, published in 2014, Engdahl describes the dominant story of being 'born in the wrong body' as being promulgated by the medical community through the regulation of trans access to hormones and surgery, and concretized in the fifth edition of *Diagnostic and Statistical Manual of Mental Health Disorders* (DSM-5). This authoritative text, produced by the American Psychiatric Association, restricts medical transition to those who experience a disconnect between their gender identity and assigned sex. Although not listing significant distress as a criterion, it lays out that gender incongruence is marked by an underlining wrongness of the body relating to a felt sense of gender. This 'wrong body' narrative is rooted in what Dean Spade (2006) describes as an essentializing association with puberty, and discomfort within the body, as markers of an authentic trans experience.

This 'wrong body' narrative is the dominant trans discourse that conveys an acceptable experience that can be authenticated by cultural and medical authorities. Engdahl (2014) notes that the idea of the wrong body really means that the body is "wrongly gendered in relation to a self-identified gender identity" (p. 267). However, this understanding of trans bodies as innately

wrong relies on what Stryker (2006) suggests is the perception of gender non-normativity. She argues that "sex [is] the referential anchor made known by signs of gender that reflect it" (Stryker, 2006, p. 9). When trans bodies are perceived as anything other than their assignments at birth, our presentations are considered intentionally or willfully deceitful.

Trans bodies, as Stryker (2006) claims, are thus seen as "bad" by definition (p. 9). We resist traditional expressions of our assigned genders which ultimately results in the wrongness being attributed to our bodies existing outside of a biologically essentialist discourse and its comatic requirements for social recognition. The notion of the wrong body results in "interpreting transgender expression as pretence and genital status as reality" ultimately resulting in denying trans people's autonomy and authority to self-identify through expression (Engdahl, 2014, p. 268). Trans is often assumed to be juxtaposed to cis. They become mutually exclusive. This dominant way of talking about gender informs what kinds of stories are *possible* to be told about embodied experiences and acceptable rationales for pursuing medical transition. We are bounded by language, but feelings exceed these borders because they are operating at the levels of the unsayable.

I have not been able to find recent research regarding medical transition that has begun by situating and contextualizing gender uniquely for each participant. Often, studies begin from the assumption that what gender *means* is understood in the same way by everyone. Research about medical transition has tended to focus on barriers to access, negative interpersonal experiences, and a lack of knowledge of the existence of trans people in healthcare settings (Blodgett et al., 2017). This chapter contributes to scholarship about gender, transition, and how

trans people come to know themselves as trans. This chapter considers gender from the position of trans people's lives and personal stories about their medical transitions.

Although medical systems in both Canada and the US are shifting toward a model of trans healthcare that operates on the premise of informed consent, trans individuals maintain a tumultuous relationship to medical discourses. We must convince mental health practitioners that we are well enough, secure enough, and stable enough to access the tools needed to medically transition (Blodgett et al., 2017). The ways that trans people feel safe using health services are shaped by our continuing positionality as sites of discriminatory *possibility* and the fear of a revocation of primary care. As Eyssel et al. (2017) emphasize, "this system [is] characterised by gate-keeping [and] is likely to foster hierarchical patient-[Trans Health Care] professional relationships with little room for trust and individuality" (p. 85). This is even more true for those who do not fit within the predetermined authentic trans narrative, such as those who question gender and transition as adults (Blodgett et al., 2017; Eyssel et al., 2017; Miller and Grollman, 2015). While important and necessary inquiries, these studies primarily focus on how people who are not trans make sense of trans embodiments and how trans people felt in response.

In 2020, MacKinnon carried out interviews with 22 individuals to investigate the role of pre-transition assessments in health care inequalities for trans people. They spoke with 11 clinicians, nine trans people, and two administrative personnel. MacKinnon spoke about how, even with changes to the DSM criteria that informs the World Professional Association for Transgender Health Standards of Care, trans identities continue to be tied to an identifiable mental illness. Reflecting on the "organized international trans depathologization movement" (MacKinnon et al., 2020, p. 58), MacKinnon et al. attend to the politicization of trans lives in a

way that unifies trans experiences and neglects to ask how trans people orient themselves, not only to cisness, but to the idea of being trans in and of itself. There is so much research that explores the material realities of transition: the social costs, employment difficulties, housing, bureaucracy and its roadblocks. However, very little of this research attends to whether there is variance in how trans people make sense of their realities, and what it feels like to retell these stories. In fact, I was not able to track down any scholarly work that addresses medical transition that did not begin with the assumption that cis and trans are oppositional.

Gender, defined

With the goal of highlighting the varying ways that trans people understand gender and our reasons for medically transitioning, I show how trans people of differing life contexts (age, time since starting medical transition, familial ties, and gender to name a few) articulated their genders differently. These variances are important to attend to because they bring into view the ways that gender and its possibilities get structured uniquely for each person. That said, even in making sense of what gender is for them and how they understand their transitions, my analysis highlights how gender was articulated as a feeling: something that feels right, something that feels less wrong, or maybe something that is not even felt at all as Grey shared.

When we find a story in which we can see ourselves, we tend to understand these as the *only* stories. When one exists for so long in a state of not knowing who they are, it makes sense to get defensive when the self is at risk of being denied. The assumption that others experience the world in the same ways as we do is predicated on the idea of a 'universal human nature' that helps us feel less abnormal and less alone. It makes sense, then, that destabilizing these assumptions translates into an attack against who we fundamentally *are*: our identities (Connell,

2009). Identities offer a seductive destination: Intelligibility. Being intelligible is linked to being seen as human.

As outlined in Chapter One, research regarding trans people often begins from an assumed distinction between cis and trans identities to categorically analyze and theorize gender. However, in my conversations with both Ginger and Judith, two women in their 60s from Western Canada who both began their medical transitions around six years ago, this insistence of differentiation was painful. Both Ginger and Judith told me that when they look back on their lives, they can remember feeling their womanhood from a young age but did not have the words to describe it. Being perceived as trans was, for the two of them, a failure to be recognized *as* a woman. When she described her gender to me, Ginger leaned back against her couch. She closed her eyes and her voice softened and slowed. She told me, "I'm a woman. Through and through." Similarly, Judith spoke slowly and with intention. She said, "I'm a woman who is currently completing my transgender process." Ginger said, "I don't like the prefix trans. I don't want the prefix trans. I really hate it. I despise it because I'm not different than anybody else. I'm just a woman." Their quick, firm, self-assured responses came off, to me, as self-protection. Having experienced the pain of being misrecognized, Ginger and Judith had oriented themselves away from trans as an identity oppositional to cis. For them, being trans was a medical designation and not mutually exclusive to being cis. Being a woman simply *felt right*.

Crystal, a woman in her late 30s living in Western Canada who began her medical transition just over seven years ago, told me she, too, recalls having "always known, but maybe not consciously". She said, "All I know is that this is a feeling that I had from when I was little." She told me how she would fantasize about removing "certain parts of [her] body" while

gesturing to her groin. She told me “I wasn’t even really sure why” and sometimes there were moments where she would attempt to do it. When Crystal discovered that medically transitioning was a possibility, she said “I thought about it all and it just kind of made sense.” Like Ginger and Judith, Crystal articulated her gender as something she felt. But her relationship to gender as a structure differed from Ginger and Judith because she grew up in a cultural context and with a language that did not emphasize gender in the way that English and French do. Gendered terminology like pronouns and the labels of cis and trans were not so clearly separated. She told me, “Where I come from, the language itself, we don't have those kinds of pronouns. So, if I say you, it's only you. There's no male, there's no female, it's you.” Even though there were differences in how Ginger and Judith articulated their relationship to the concept of being trans in a way that differed from Crystal, what the three of them had in common was that they knew they were women because they just *felt* like women. However, for Crystal, what felt right was tangled up in reflecting on what also felt wrong, even before she could make sense of why.

When I asked Valerie, a woman in her late 40s living in central Canada who began her medical transition just under five years ago, what gender meant for her, she told me, “Gender is such a loaded term and such a vague term as well. Mostly, at the end of the day, it is a feeling. This feels right.” Valerie told me:

> Quite often, I hear people reacting or positioning themselves against stereotypes or roles and saying like, oh, I'm not a woman because xyz and I'm like, OK, what does that has to do with *being* a woman? I don't think I fit many of the stereotypes for women and that doesn't make me any less of a woman. It took me a long time to understand and accept it.

I asked her why she thinks it took her a long time to understand her womanhood. She told me that she could feel it, but that she kept hearing that "gender is a social construction, it's artificial, it means nothing." This was frustrating for her because she understands gender as an integral part of herself. Valerie understood gender as anything but artificial. For Valerie, like Ginger, Judith, and Crystal, situating her womanhood as naturally occurring rather than as a social relation is how she makes sense of her own existence. Valerie continues:

> Woman means a ton of things for me and so does man. When I hear that gender is purely a social construct and artificial, I'm like, OK, so please explain to me why when I was born in the dominant gender and raised in the dominant gender and I had the body to go with that and I had everything to do, I mean, why in Hell, would I develop this strong identity and, you know, basically being at war with myself for my whole life up to the age of 47? There is something deeply innate with my gender.

For her to consider gender as a shifting and evolving shared story is foreclosed by her understanding of gender as nature. The potential of considering gender differently, as artificial or constructed, was distressing because it necessarily calls into questions her sense of who she is and the possibility that who she understands herself to be might not exist. For Valerie, gender is an essence of being. To toe the line between existence and not is distressing. Ginger, Judith, Crystal, and Valerie understood their medical transitions as pursuits of what felt right.

Avery, a woman in her early 30s living in Ontario who began her medical transition just under five years ago, made sense of gender similarly to Valerie. She told me, "All I can say is that, for me, gender is the feeling that you have inside that that matches what people anywhere else sees." I asked her if she could tell me more about what that feeling inside is, and she said,

“It's just the way—the things I wanted to do, the way I was wired, the way I wanted to approach things, the way I wanted to—how I felt.” She paused and took a deep breath before continuing. “It's not something that's easy to put in black and white and say ‘OK, this specific thing.’ It's just the disconnect from who you feel inside and how your body evolves in the wrong direction is just wrong.” But this is an important distinction from the conventional wrong body narrative: the direction her body evolved felt wrong, but her body, itself, was not wrong. Avery made sense of medically transitioning as coming back home to her body. Like Ginger, Judith, Crystal, and Valerie, Avery understood her medical transition as a pursuit of what felt right, of what she articulated as feeling like a woman. However, what differed slightly was that coupled with her pursuit of what felt right, Avery, like Crystal made sense of her transition as also moving away from what felt wrong. This was not something that was spoken about in my conversations with Ginger, Judith, and Valerie.

Shawn, a man in his early 40s from Southern USA who began his medical transition around four years ago, said that “it wasn’t so much that I hated being a woman, but I prefer being a man” and noted that this wasn’t an easy conclusion to come to. “In my brain, I was starting to ask myself: What if this isn’t what I want?” he said when I asked about how he got to the point of pursing medically transitioning as a part of his life. Even when we feel confident about our need to medically transition, these stories get complicated. Medically transitioning can be a way of feeling better and feeling good, but that does not erase any trace of self-doubt. Shawn said, “I don't know what it's like to be a cis man, a straight hetero man, except for the last three years, four years. And I dislike the seeming expectation that I shouldn't embrace that.” Shawn told me about how the idea that gender was a sliding scale helped him make sense of it. He likened it to lights. He said “it’s more like a dimming switch than strictly on and off.” While Shawn

positioned masculinity and femininity at opposite ends of a spectrum, they overlap to varying degrees with no clearly defined boundaries. For Ginger, Judith, and Valerie their medical transitions and senses of gender felt right. For Crystal and Avery, their stories were in pursuit of what felt right by reflecting on what felt wrong. However, Shawn's story was making sense of himself through what felt *more* right than the other possibilities.

To believe that trans narratives are generalizable experiences that operate with a shared understanding of what gender means is, as Shawn mentioned in our conversation together, "the reduction of trans identity to a binary." For Shawn, he perceives that he is socially and culturally expected to have always been male, that he is male, and that he must be "just like every *other* cis man" (emphasis added). In this view, cis and trans become binary opposites: confining, restricting, and oppressive. The tensions between cis and trans experiences of gender exist not within any form of 'truth' about gender itself, but almost exclusively in interpretations of why other people feel gender differently than us. Our social tendency to homogenize experiences within specific labels and identities allows for the assumption of a universal intention that undergirds the things that we do.

Like Valerie, Shawn understood gender as something more complex than the stereotypes associated with it. There is an internal feeling that is difficult to articulate as anything more than knowing what feels "right" about oneself. He said:

> It took me a lot of work to wrap my head around that I can be male without being the local stereotype of male. And so, at first, it was very much about becoming male and what is it to be a man? I was introduced to the term performative masculinity and I felt like I was in college again. But yeah, performative masculinity. What does it mean to

> perform as a male? What do you have to do to be seen as male to qualify in other people's terms as male? How much of that do I need to adopt, do I want to adopt? How much of that is innate to me? How much of that would just be pretending? So, yeah, first it was much more about being male and the performative masculinity and how much of that I wanted to adopt or needed to adopt. And then I guess as I matured in my transition, if that's the way to put it, I became much more aware that me being male doesn't exclude my feminine past. I don't know if I'd say my femininity, I don't know if I still have femininity, I'd have to think about that. But I definitely have the female past, the life experience as a female, the knowledge as a female. And I guess it's shifted away from moving from one end to the other, to recognizing that there's some balance in between, that becoming male doesn't mean that I have to reject the female, if that makes sense.

While some participants like Ginger, Judith, and Avery make sense of gender through a narrative of 'having always known', Shawn did not see his embodiment of masculinity and sense of self as a man as being mutually exclusive with his past as a woman. For Ginger, Judith, Crystal, Valerie, and Avery, being women just felt right and medically transitioning was a logical, rational step in their lives. Crystal told me, "It was like paperwork, I just do what I got to do and then get to the next step so everything can be where it's meant to be." But for Shawn, medically transitioning was a step into the unknown. He was worried about whether it was what was right for him. And, as he recalls how he came to the decision to medically transition, it wasn't that it felt right to be a man and wrong to be a woman, it just felt *more* right for him to understand himself as a man than to continue living his life as a woman.

Jeremy, a man in his late 20s from Northeastern USA who began his medical transition just over three years ago, shared similar sentiments as Shawn when it came to negotiating his understanding of what gender is. He told me he would often wonder:

> What does it mean to feel like being a man or how do you decide that that is, in fact, what you are? Do you just know? Am I supposed to just know? And I think so. For a long time, I was like, well, maybe I'm not that either, or maybe I'm somewhere else. But being in that kind of either or neither space socially and in terms of everything else, didn't feel right. That's why I ended up being like, OK, so that's not right either. For some people, I know that that's actually what they're going for, but I realized that I wasn't really comfortable with it. And so, then I was like, well, maybe I am just a guy.

While Ginger, Judith, Crystal, Valerie, and Avery could point to an innate feeling of *being* a woman, Jeremy, like Shawn, came to understand his gender by trying to tease out what were feelings of gender and what were feelings about being gendered. For Shawn and Jeremy, the two overlap and work together to inform what their gender might be, leaving the possibility for its continued evolution.

Grey, an agender person in their late 20s who lives in Central Canada, had a different take. They told me about how they "feel as though gender is something that could be layered on top of a person." They went on to say, "I just feel as though I'm missing that layer entirely." Grey defined gender as something external that is given to us through our interpersonal experiences, as something recognized by others. While directly contradicting how Ginger, Judith, and Crystal made sense of what gender is, Grey's understanding of gender is that it's something that is ascribed that one performs. Then, from Grey's point of view, one has feelings

and reactions—including perceived reactions—to how people recognize their performance and adjust accordingly when it doesn't feel right.

For Ginger, Judith, Crystal, Valerie, and Avery, medically transitioning was the pursuit of what felt right. Shawn and Jeremy's medical transitions to what felt *more* right. Crystal, Avery, and Jeremy's pursuits of rightness were interwoven with a desire to move away from feelings of wrongness. Grey's medical transition was an adjustment away from what felt wrong, shedding the possibility of being recognized as a woman. For Grey, that misrecognition was wrapped up in a longer, emotionally exhausting history of not knowing who they are and trying to negotiate the struggle of not feeling gender at all in a world that won't stop gendering them.

Medically transitioning offered a way for participants to orient themselves to gender differently. Their stories also reveal the role that their specific life circumstances plays in how they were each able to develop their own understandings gender. All the people I spoke to talked about gender through the language of feeling. How participants made sense of what gender meant for them was structured by negotiations of feeling right, more right, or wrong. While Ginger, Judith, Crystal, Valerie, and Avery all understood their genders and relationships to medically transitioning in relatively similar ways, all of them recognized themselves as binary women. Shawn and Jeremy both recognized themselves as binary men and had some similarities in the ways they negotiated their understandings of what felt like gender and what felt like being gendered. Grey, who recognized themself as agender, spoke about gender differently, as more of a lack of innate feeling and a reaction to the roles and stereotypes ascribed to them. These conversations bring up questions about the role of age: Were there any similarities between how people in similar age ranges made sense of gender? Likewise, were there any correlations

between the stories people told about their transitions and how long they had been medically transitioning for? And, is there a relationship between the two that complicates time and generational understandings further?

Trans Time

Ginger, Judith, and Valerie shared their stories with me from the starting place of having always, in some way, known they were women but spent their lives burying their feelings and setting their genders aside. As the three oldest in terms of chronological age, Ginger, Judith, and Valerie were all over the age of 45 and had all, at one time or another, been married for a significant part of their lives. They three of them spoke of their genders as just something they knew felt right. The stories they shared with me were about self-permission; how they made sense of their medical transitions was about allowing themselves to finally feel what they had always known was there but made a conscious decision to suppress. They gave themselves permission to recognize themselves as women and it *felt* right. They didn't speak of their past experiences of being gendered in other ways as wrong, but rather as catalysts for permitting themselves to be women.

Crystal and Avery's stories echoed them, but were also different. Crystal and Avery included accounts of interwoven feelings of wrongness not present in the stories offered by Ginger, Judith, and Valerie. Both in their early to mid 30s, Crystal and Avery spoke about their experiences of navigating distress without being able to figure out why they felt distress. However, Crystal (like Ginger, Judith, and Valerie) described her gender as an innate feeling, once she was able to articulate what felt wrong. While for Crystal the wrongness was situated within her body and the story she shared with me aligned with the dominant wrong body

narrative, Avery's shared with me that the wrongness and disconnect was present more in being misrecognized by others. Chronologically, Crystal and Avery were similar in age. However, Crystal had started her medical transition just over seven years ago whereas Avery had begun hers just over three years ago.

The slight difference between how Crystal and Avery make sense of and relay their transition narratives might have something to do with the number of years each has had into their medical transitions. Crystal's time medically transitioning was closer to the number of years that Ginger (six), Judith (six), and Valerie (almost five) had spent medically transitioning than she was to Avery. Similarly, Valerie was closer to Shawn (almost five) in numbers of years spent medically transitioning but was chronologically situated closer and closer in gender to Ginger, and Judith and her understanding of her gender as an essence of being was more aligned with the older age group.

While Shawn and Jeremy shared a relatively similar sense of themselves as binary men and shared similarities when articulating the tension between what feels like gender and what feels like being gendered, Jeremy (just under three years) was closest to Avery (just over three years) in number of years spent medically transitioning. They began their transitions at similar ages and the stories they shared with me about how they make sense of gender were both tangled up in how they might be recognized by others. Grey, starting their medical transition at an age similar to Jeremy and Avery when they started but only just starting at the time of being interviewed compared to Jeremy and Avery's multiple years of medical transition to reflect on, also spoke about transitioning as a way of being recognized more as how they see themself rather

than as permission to be themself, like the older participants who had also spent more time medically transitioning.

While I cannot point to precise patterns or relationships between this trans time, chronological age, and sense of gendered self, and my participant pool was also too small for such inquiries, how narratives develop or shift over trans time emerged as a topic worth more attention. Time gets messy when age needs to be considered in multiple ways. More research needs to be done that addresses time in the context of trans lives and medical transitions.

Concluding Remarks

This chapter discussed how trans people make sense of gender through our own specific experiences of gender. This chapter is a call to pursue research regarding trans lives beginning from an understanding of what gender means for people and the possibilities of difference. All the people I spoke to talked about gender through the language of feeling. While Ginger, Judith, and Valerie aligned with the wrong body narrative in that they share stories that narrate having 'known' their genders from a young age, what they shared about their transitions were stories of self-acceptance. For Crystal and Avery, medically transitioning was a negotiation with feeling wrongness about their bodies. Shawn and Jeremy's stories were about the navigation of teasing out what gender felt like in specific ways. For Grey, medically transitioning offered an escape from being misrecognized and a hope for future recognition of being agender. How participants made sense of what gender meant for them was structured by negotiating feeling right, more right, or wrong.

The ways that research has tended to approach trans lives operates from an assumed understanding of gender and a distinction between cis and trans. While much necessary and

important work has come about from this, this chapter considers how these conversations might change if they begin from seeing gender from Connell's (2009) point of view: as multi-dimensional and contextually specific. Further, when stories about transition are situated within specific trans lives, we can attend to their differences and destabilize processes of legitimizing dominant stories as concrete truths. Doing this work requires us to attend to not only how trans people make sense of ourselves, but also how social connections are deeply implicated in how we know ourselves. To make sense of how trans people feel about gender, why, and how we turn to medical transitions, we need to contextualize our senses of self in relation to the world around us, as bodies that are both affecting and affected by others.

Moving forward, chapter four engages with the role of relationships and social connection in how participants negotiate gender and transition as imaginable. Having elaborated of how they make sense of and understand themselves in differing ways, I will now explore how trans as possibility is made accessible through communities of trans care. Emerging from the interviews at the heart of this project, the centrality of relationships in how we understand ourselves came into view. It was revealed that although participants reflected on their medical transitions as necessary and positive movements in their lives, there are many social implications highlighting how our lives and senses of self are entangled with others.

Chapter 4: Stories about Relationships

With a focus on how participants make sense of themselves, their genders, and their transitions, I argue in this chapter that although transition as a realizable possibility is communicated interpersonally, our past social traumas haunt us and inform if and how we move through the world in relation to others. This is observable in participants' stories and tells us about the centrality of relationships in determining how we make sense of gender and transition. Shaped by familial and community ties, participants told me about the social implications of pursuing medical transition as they recounted how and when they came to explore their gender. First, I present the varying ways that participants concluded that transition was possible. Along the way, I attend to how their stories about their relationships with others reveal the inevitability of trauma of existing as trans. I conclude with participants' reflections regarding possibilities of pleasure, joy, and belonging.

Emerging from these interviews was a clear message: we don't know ourselves fully until others can see us. These interviews revealed that who we understand ourselves to be is always in negotiation with how others see us. We test our intelligibility and look for belonging. As social beings, relationships are central to what it means to be human. Therefore, social connection is deeply embedded in how we come to know ourselves. This chapter situates each participant's stories about gender and transition in conversation with their social worlds. We can learn from their narratives about the social implications of medically transitioning. As I will argue, transition as an imaginable possibility is communicated interpersonally—through relationships and the loss of them—and made realizable through communities of trans care. I argue that this is partly because of invisibility, but also informed by rejection and loss. How participants navigated social relationships varied depending on interplay between their context and choices. They made

choices in how they were involved with broader trans communities, if at all, based on the implications of the medical transitions in their close personal lives.

Eight out of the nine individuals I spoke with told me they started seriously considering medically transitioning after meeting, in real life, another trans person who had medically transitioned. It was through their interpersonal connections that trans as an imaginable and realizable possibility was communicated to them. It was through these personal relationships that trans became a possibility and that gender could be restructured. Seven out of nine told me that they found affirming and accessible care by asking for advice from other trans people in their local areas. Community seems to be how we share information. As Hil Malatino (2020) tells us in *Trans Care*, trans people tend to make webs of care. We connect to each other through each other, and this is the netting that catches us when we fall. Our care webs become our safety nets. Community is where, even when everyone else around us tells us we cannot exist in any meaningful way, we can find others who reflect parts of ourselves back to us.

In the interviews, trans care and community were both a context for the research relationships and an ethic that guided my interactions. This became more clear as participant's stories of relationship and trauma nudged my own. In this chapter, I weave in some of my interactions with participants, and reflections on the interviews, making visible my implication in the stories, related to my own losses and my own mourning.

Loss and transition

"Their story is just as important, if not more, than my story," Ginger said as she told me stories about her family grappling with her transition. She told me stories about hunting and fishing with her younger brother, how he lived with her and her wife at one point, and how they

were next to inseparable their whole lives. I wondered why she was sharing these memories when it wasn't clear how they related to her transition. These were moments from years before trans was even an imaginable possibility for her and my research project was supposed to be about medical transitions. Finally, after more than an hour in conversation together, Ginger said with tears in her eyes, "You know you lose everybody, right?" When she told her younger brother she was going to transition, he cut her out of his life with no warning. Shortly after, he received a terminal diagnosis. She told me about finding out about it from others, not from him, and how much that hurt. She said, "He was going to die. I wasn't allowed to see him. Talk to him. When all the family would get together to see him on his last days, I wasn't there. I wasn't invited." She paused, apologized to me for crying and tried to slow her breathing. My own breath caught in my chest as our rhythms synched up. "That's when hatred of my identity came out," she said. "I wanted nothing to do with the trans part anymore. When my brother passed away, I was like, I can't do it. I want nothing to do with this community." Ginger's understanding of her womanhood was shaped through her relationships with others. Through the loss of her brother, she came to 'hate' the concept of trans without rejecting the fact that she knew she was a woman. Where being trans and transitioning has been a fundamental part of how I understand myself, For Ginger, being trans was directly involved with painful loss.

"I look back and think where I would be if my wife hadn't said it was OK," Ginger said, in reflecting on the moment she decided to medically transition, "There'd be a difference if she said, 'yeah you can do it, but I never want to see it' or 'I never want to hear you talk about that again'". She was tense when she told me, "I didn't expect to cry. I thought I was over it, but I don't know if you ever really get over it." And I wanted to cry with her.

We grieve a life that we could have had if only we weren't trans, if only the world—and the people in it—were less closed off to any experience of gender that might not be the conventional understanding of what it means to be cis. Our relationships to others get complicated by this melancholia and, in turn, so do our relationships to ourselves. To disidentify with being trans isn't necessarily internalized transphobia. For Ginger to identify as trans is traumatic terrain. She doesn't "feel trans" because she doesn't "feel any differently from being a woman." Having the time to mourn the losses of those she loves has allowed her to process how she's come to understand herself, as well. For Ginger, this has given way to her re-entry into trans community even with complicated feelings about the use of the word 'trans' in reference to her gender. While noting that she isn't ashamed of her trans experiences, it's the relationality to 'trans' as a word that is emotionally charged. "The two people who helped me the most become the person I am today were my ex, because without her saying yes I couldn't have. And my mom, who passed away. Both of them aren't in my life anymore."

Similarly, Crystal talked about how she tries to keep a "thick-skin" because she knows who she is, that life is short, and that she doesn't want to lose herself the way she lost her close friend who passed away. She tells me about how one of the benefits of being far away from her family is that they only communicate through Facebook. This way, she can filter what a lot of people have access to in her life. I asked her why she filters information about herself to her family and she told me, "It's more so for my parents. I don't want them to get hurt because of my being trans." She told me that she feels positively about so much of her transition. But when she thinks about or talks about her family and the connections she has lost, it's too painful. She can't go there. During our interview, she was trying not to cry but told me how it feels like it's boiling over. Thinking about how she might be hurting her family members or making their lives harder

is too much for her and she would rather avoid it. I tell her that it is okay to not want to relive it. I want to tell her I get it. I want to tell her about how I feel like a monster even ten years later. I want to tell her about how I feel ashamed for all of the ways I've had to ask the people I love to adjust their lives and their understandings of the world for me. But we don't go there. Going there wouldn't be any more cathartic than sitting with a simple "I understand more than words will be able to let you know." Like Ginger shared, our transitions, for some reason or another, tend to come with interpersonal losses.

Avery told me that she told people she cared about very slowly, intentionally, and "one-by-one." I asked her why and she paused. I could she her arm tense again and the tone of her voice sharpened, "Because of the fear of, well, what basically did happen—losing everyone." She said, "once I came out, they were gone. People were like, 'OK, thank you for telling me. But now stay away from our family.'" I asked her how that felt for her and she told me that "actions speak louder than words." She told me about how she tries to frame it as knowing who her "real friends are" because it's too painful to think about it any other way. She told me, "The people who are closest to you can hurt you the most emotionally." She said, "It's painful, but beneficial because experiences like this show you who really supports you when relationships get thrown curveballs." These losses are experiences that have influenced how Avery moves through her social world.

Jeremy told me that even still, he gets nervous with his family even though "they've been really great." He told me, "[i]t just feels like this thing I was kind of hiding and being private about for a really long time, which maybe is why I still feel a little weird talking about it out loud." Jeremy told me about how medically transitioning was something he came to realize as

what was right for him because of the separation from his previous partner. It was in the end of that relationship and coming back home to stay with his parents that he felt like he could begin his medical transition. He told me about how his mom would ask him about gender and what he wanted to do with transitioning. “I was like woah, woah, woah, hold on! Because I hadn’t even gotten to the point where I could talk about it with myself yet.” He told me about how starting to think about his gender seriously, and if he wanted to go through any type of transition, made him feel more distant from his parents. “It was like this part of my life that wasn’t really a part of my life with them before.”

Jeremy’s medical transition became realizable through his considerations of how it might impact his relationship with his family. He told me about how he got blood work done to start taking testosterone and then prolonged the next step for more than six months because he was nervous about telling them. He told me he had spent his time exploring his gender mostly in isolation. He pre-emptively unfriended people, blocked people, and removed some from his life. He knows that “they’re out there” but they aren’t voices he valued in his life. His parents, though, were intimately linked to his sense of who he is and who it’s possible for him to be. When he told his mom, he recalled:

> I was like, you know, people like me have always been around. It's just that now we have more options for how we can live in our bodies. I think once she processed that, she started thinking about it. She was like, well, I had this one family member. And she told me that she had an aunt who wore men's clothes at home and sat around smoking cigarettes and no one said anything to her about it. One time my mom asked my nana and my nana was just like, be quiet. You don't know what you're talking about. It's fine.

Almost as if he was reassuring himself in telling this story, his shoulders relaxed and he looked at the screen. He told me about how from there it just sort of made sense. Everything just sort of clicked into place. He was seen and his existence made sense in his mom's world.

For Shawn, telling his loved ones about his transition felt more procedural. He said, "I know that some of them are trying and some of them are just lost causes. I'm not going to fight it. For instance, I'm not going to give Grandma a hard time when she is 89 years old." He told me that it's not that he has any shame about being trans or his medical transition. He has just accepted that there are people in his family who will never see the world the way he does. He spoke about how terrified he was to come to the realization that he wanted to medically transition because he assumed it would end his relationship with his girlfriend. He told me about her two kids and how young they were at the time. How he thought about the stress and confusion transitioning might put on them. He talked about his girlfriend's ex and how much time and difficult self-work it took for her to see herself as queer and not wanting to throw her back into her anxieties about being with men. He didn't want her to relive the painful experiences she had had. When he reflected on the moment he told her, he said:

> I can't imagine where I'd be if she had shut me down. It would have been my first loss. I don't know how I would have reacted if I would have been like, I think I'm trans, and she said 'Oh my God, that's sick and disgusting'.

He told me about how that fear came from how much he valued her opinion and the not-knowing of how she would react. He was worried about being rejected, being "a freak of nature" or "off [his] rocker". It took him months to tell her. But telling her made it real.

Valerie told me about how she would talk to her therapist about how she didn't feel like her wife understood her or how important medically transitioning was for her. Valerie recalled that her therapist asked her "Well, have you told her that?" and she realized she hadn't. She had been "paralyzed by fear" assuming she would be rejected, that she would lose the people she loved. And she told me about how that stopped her from taking any concrete steps forward for a long time. She said, "Even with your parents, the level of commitment, communication, involvement, and I would say equity, you have with your spouse is entirely different. You're always thinking about what can go wrong." I asked her about her parents. She smiled and said, "I remember I was like, 'I hope they come along, but if they don't then it's not the end of my life.' I'm forty-seven, I can deal with that." But for her, the possibility of losing her wife and her kids was mortifying.

She spoke about wanting to "protect" her kids. She said, "I was worried that they would hate me, that they'd be bullied, that they'd see me as a monster." She paused and told me that she did not lose many people and that that surprised her. Beyond the computer screen view I had during the interview, I heard Valerie's wife, reminding her about her in-laws. Valerie went on to say "I mean, I have lost a few people. My in-laws, like my wife is mentioning. But also some close friends. On balance, though, very few of them." It was that fear of losing people, because she didn't fit in their world, or in a world in which she could have a wife and a family, that she felt stuck. She told me, "I had these inner voices telling me the world was going to end. So, I buried it to try and have a normal life."

Grey shared that they had similar anxieties about medically transitioning. They told me how it's felt convenient for them to be single as they have started their medical transition. "Part

of me was actually very afraid about how my partner would see my body changing. I had a deep fear that the more I become the person I want to be, the less appealing I'd be to them." For Grey, it was hard to consider reconciling how when someone they love might see them as someone else, it would be too painful because they would still want to be with them and want them in their life. Grey said:

> I know that their experiences of me wouldn't reflect me, but I was afraid of being judged for my own experiences. It's a very large fear of mine, whether or not they'd leave me because of it. Because it's one thing for me to talk about my body. It's another thing for me to share that body with someone else and know that what they see is not necessarily how I feel about it.

More than trauma

"We build mountains in our heads," Valerie told me as she relaxed deeper into her seat and folded her arms across her chest, not in the way that's rigid and closed off, but the kind of fold that allows her body to relax and align seamlessly with the shape of the chair she was sitting on. Her body sat softly. In another instant, her face tensed slightly, and she reflected, "You always want to not bother people and protect them from your inner turmoil." She glanced off to the side where her wife could be heard in the distance humming softly to herself. She paused and smiled softly to herself as she looked back towards the screen. She began to tell me about how she had only ever heard about how medical transitions end relationships. I asked her if she could remember how it felt to grapple with her realization that she needed to medically transition and the possible loss of her wife. Her face was beaming when she told me "I love my wife. I am probably the luckiest woman in the world. I have the kindest, most understanding wife." As she

interlaced her fingers and set her hands on the table, she told me about how she had always wanted a family. In discussing her feelings about transition, Valerie was clear about her concerns, "I don't know if I'd go so far as to say fear," she said, "but definitely a kind of 'what if I do this' and 'this is going to be a big step' and 'is it going to affect my job? My relationships? Is it going to affect my family?'"

The potential of losing the people one cares most about is terrifying. I asked Valerie how she navigated these nerves. She told me about how she continued speaking with her therapist even after she received a letter of support for her medical transition. She told me about how talking things through with someone who saw her as a whole person, as someone who had a life that was about more than transitioning, gave her the space to sit with her anxieties rather than trying to control them. She told me how her therapist said that "Most couples don't survive a transition. And not just with gender, but any big life change. But that's because most couples don't even try." For Valerie, the recognition that we "build huge mountains in our heads" about how we think other people will react and feel helped her see more clearly. She started to work on separating what she was worried about from what was actually happening. She told me about how she worked on her communication skills, on being more comfortable opening up to her wife, and on recognizing when she made assumptions about how she might be feeling or what she might be thinking. She said, "I was deeply scared. Again, I mean, you kind of operating under some assumptions. You're kind of assuming that there's no way she can accept that." Valerie and I spoke at length about how scary it is to not know how someone you love might react and whether they'll leave you in a lurch. And this was echoed by all the participants in this project.

Avery said, “The people who are closest to you can hurt you the most.” Grey told me about how one of their biggest worries with transitioning was alleviated by the fact that they were single because they didn’t have to wrestle with whether someone would leave them for being “true to [themself].”

Judith was worried about losing the networks she had built around the activities she enjoyed. She told me about how the loss of her closest friends prepared her for negative reactions from others. She told me about a Guild she served as President for for several years and how when she went to a meeting for the first time, presenting herself as herself, she was ready to be rejected. But that didn’t happen. She recalled, with tears welling up in her eyes:

> [The members are] 99 percent male, 99 percent over 60. All right, that's the demographics of the group. So not who one would think would be the most likely to be an accepting group. But at the meeting after I'd come out, three of the members came up to me kind of surreptitiously and said If anyone gives you any grief, you come and tell me.

As trans people, we experience rejection, isolation, and social trauma (Bauer et al., 2015). This takes a toll, but it is not the whole story. These interviews reveal trans people’s potential for pleasure, joy, and belonging as well.

“I think it's a useful narrative to say to people: It's not necessarily the end of the world if you actually transition,” Valerie said when I asked her about what she would want other trans folks to know if they were having similar anxieties about their families and relationships. “Things can still go awfully wrong. But, you know, it doesn't have to go wrong. It can actually go very positively. And I think that's a good message to hear.” Valerie and I talked about our

shared experiences of feeling like we get bombarded with all the possibilities of what can "go wrong" with our lives as we transition. She expressed her frustration that multiple mental health clinicians had focused on how she might lose her family, how she needed to prepare for the worst-case scenario. Yet, when she found a clinician who saw her transition as being more than just about her and her sense of gender, but also about how she could be a better parent, a better partner, and a better communicator, she developed the conviction that she could be vulnerable in all parts of her life. She told me about how freeing this was. She was almost giddy telling me about how relaxed she felt. She told me about how good life was once transitioning became less of a "time bomb" waiting to blow up the life she had built and more of an opportunity to become a person she loved.

This isn't to say that transitioning doesn't end relationships. I think all of our stories have some kind of deep loss. When we become someone incompatible with how others see us, sometimes that translates into being incompatible with their lives. We might lose someone close to us. But, from the stories shared with me in this project, it is also important to recognize how much our lives affect others. How might they be experiencing a loss of *us*? Our transitions aren't just about us. For Ginger, Judith, and Valerie, it was permission from the people they loved that gave them the security to explore who they might be. Whether or not a relationship survives transition matters less than whether we know it's possible for it to endure. Because when loss is the only possibility, how can we feel like anything other than a monster?

When loss is the only possibility, our transitions translate into a sense of becoming undesirable and unlovable. When the only possibility is to be rejected, it makes sense that we would be terrified of who we know ourselves to be and that being trans and medically

transitioning is a last resort and a final destination. But what if we could recognize the possibilities of rejection, discrimination, and trauma as just that: possibilities? What if being trans wasn't always and inevitably synonymous with loss?

In our conversations, each person had a story to tell of loss, but they also had a story to tell of joy, of finding themselves, and of belonging. Throughout all the stories of loss, of grief, and of pain, every single person I spoke with about their medical transitions told me that, from their point of view, their transitions were 'easy' because they had expected it to be so much worse.

Chapter 5: Community, Trans Care, and Returning to Theory

In this thesis, I have examined trans people's personal narratives about medical transitions, attending to how our stories complicate contemporary discussions of trans lives and ways of being in the world. I analyzed these personal narratives, situating and contextualizing how their lives were shaped—and continue to be reshaped—through and with others. In this chapter, I return to theory to share key insights and implications that my work has regarding scholarly and community conversations about medical transition.

I begin by returning to the stories that were shared with me. I attend to the emotions wrapped up in our unique lives that influence our transitions, making connections to theories of care, grief, and their implications. Next, I build on these connections to engage with how emotions complicate our identities and relationships to a broader sense of community. Here, I highlight the messiness involved in trying to relate to others in the wake of having lost people close to us. I then turn my attention to a methodological consideration of the role of critical reflexivity in opening up space for transformative possibilities for change with research regarding trans people. In doing so, I hold space to consider how my own medical transition has influenced how I have interpreted the stories shared with me. Finally, I end this thesis with some suggestions for future research and a brief overview of what my project adds to scholarship.

What the research reveals: Relating to gender, transition, grief, and trauma

When I worked with young trans folks as a community mental health worker, they were terrified of making one misstep, one wrong turn, or not being educated enough in a specific rhetoric of social justice to build community and networks of care. As Amber Hollibaugh (2000) states in *My Dangerous Desires*:

> When you deny any differences exist in the first place, you can only come up with a neutered definition where everybody's got to be basically the same because anything different puts the element of power and deviation in there and threatens the whole picture. (p. 73)

I catch myself sometimes, being uncomfortable in the work I do with younger trans people, by the ways they feel and do and talk about gender—especially trans masculinity. I find myself holding these individuals to an expectation that they ought to know better—that they ought to be more socially just, be more empathetic, and have better awareness of how their presence impacts others—because that was work I was expected to do to vocalize and legitimize my existence as trans. In *Trans Care*, Hil Malatino (2020) muses:

> Sometimes young trans guys annoy me in precisely the ways that Fall Out Boy[5] annoys me. But I want them to have their clueless and self-involved boyhoods. I want them to be able to take the long road through navigating toxic masculinity, to sloppily grapple with it the way that other boys get to do. I want them—I want all of us—to maintain the kind of wide eyed silliness and unabashed enthusiasm that we associate with childhood but that, in fact, only the most privileged and unharassed kids get to experience. (p. 18)

I catch myself being frustrated and envious that trans folks get have a youth and a boyhood and I did not. And I think that comes from what Judith Butler (1997) describes in *The Psychic Life of Power* as melancholia: uncompleted grief. Uncompleted because these young people remind me of my own lost youth as "a loss that cannot be grieved because it cannot be

[5] Fall Out Boy is the name of an American pop punk and alternative rock band consisting of 4 men formed in 2001.

recognized as a loss, because what is lost never had any entitlement to exist" (p. 24). I'm filled with grief over an imagined time lost: both a boyhood I didn't get to have and for the girlhood I experienced but with which I couldn't connect. I'm not sure if either had any entitlement to exist.

However, I try to set my grief aside and, instead, attend to the humanity and the person in front of me, within these gendered experiences. I'm trying to not write off people who are thinking through their trans masculinities just because they do and say and act in ways that I find irritating like speaking in loud voices, taking up a lot of public space with their bodies, and act immaturely. I know I would have wanted the kind of unharassed boyhood that Malatino talks about. I also have always found Fall Out Boy annoying. But Fall Out Boy is consistently brought up in the conversations I have with these young people as something that brings them joy.

Malatino (2020) defines trans care as the ways trans people show up for one another, whether through faithfulness and perceived obligations to or because of genuinely caring deeply for each other. Trans care, for me, is practiced through setting aside grief, not writing off people who bring up these reflections in me and conversing across different trans experiences. Rather than continuing to hold trans folks to an impossible standard of knowing oneself or rejecting gender (or of feeling and doing gender in a way I can recognize and make sense of[6]), I want us as trans people and us as scholars to think about what gender might be like outside of a cisgender imagining. What would our conversations about gender look like if

[6] Sometimes because the younger trans boys I work with are being misogynistic and advancing white middle class masculinity in which I try to intervene as part of socially just social work. Other times because I am an older trans man and find it increasingly difficult to relate to other genders and identities on the masculine continuum.

we did not operate from cisness as a default experience from which trans folks deviate? Would the stories we tell of transition be impacted? How? Maybe then we, as trans people, can be seen "beyond the clinic as the primary site of inscription" (Snorton, 2009, p. 84). How might approaching personal narratives regarding medical transition situate gender as multiple, partial, inconsistent, messy, and contradictory to our understandings of our own work to repair our relationships as trans people to others?

Making meaning of gender

For many, being trans is traumatizing, for a wide range of factors. Sometimes, the ways that one individual spoke about their transness contradicted the ways that another had made sense of their own existence—for Valerie, gender is an "essence of being" whereas for Grey it is a layer separate to but on top of who we are. At times, the ways that some folks spoke about gender troubled my own sense of self and gender—Ginger and Judith articulate their gender as just, simply, being woman, whereas my body viscerally recoils when I think about being misrecognized as a cis man. While the focus in research about medical transition is so often about the ways that trans people orient themselves to cisness, this study called up questions about how trans people orient themselves to what gender means and their relationship to the term 'trans'. The conversations I had begged for consideration of the implications of politicizing trans lives by default and to remember to attend to how people feel about themselves, their lives, and how they've made sense of themselves as individuals. I argue that by beginning research from an assumption of a universal understanding of gender and transition, individual stories have been overshadowed in ways that have complicated how people who medically transition relate to gender (and being trans) as an identity.

While some of the folks I spoke with did have an internal sense of gender from a young age, it is important to note that this is not everyone's experience. To believe that trans narratives are categorizable and generalizable experiences is, as Shawn mentioned in our conversation together, "the reduction of trans identity to a binary." For Shawn, this means that he is expected to have always been male, that he is male, and that he is "just like every *other* cis man" (emphasis added). In this view, cis and trans become binary opposites: Confining, restricting, and oppressive. The tensions between cis and trans experiences of gender exist not within any form of "truth" about gender itself, but almost exclusively in interpretations of why other people feel gender differently than us. Our social tendency to homogenize experiences within specific labels and identities allows for the assumption of a universal intention that undergirds the things that we do. As Stryker (2006) makes clear that "'difference' and 'hierarchy' are never mere abstractions… [they] reveal the operations of systems and institutions that simultaneously produce various possibilities of viable personhood and eliminate others" (p. 3). The assumption that others experience the world in the same ways as we do is predicated on the idea of a 'universal human nature' that helps us feel less abnormal and less alone. It makes sense, then, that destabilizing these assumptions translates into an attack against who we fundamentally *are*.

When Shawn reflects on missing "the queer female community" in *Chapter Three*, he is rejecting what Cameron Awkward-Rich describes in *Reading like a Depressed Transsexual* as the "impossible narrative of having never been a child." (2018, p. 820). Like Shawn, I think it's important for us as trans people to reparatively read our pasts as still living, but ever growing and changing, parts of who we are and who we become. If we do not attend to our pasts, we are rootless and explode into being like the Big Trans Bang. And I've seen and heard this from people in positions of legislative and political power when they talk about

how being trans is a youthful phenomenon of the present social and cultural times. As if trans people haven't existed for as long as any concept of gender has. The bigger picture of trans history requires us to allow ourselves to have personal histories, too. When we are consistently told that trans lives are unlivable, it's almost like we pre-emptively kill the trans parts of ourselves off so that we can survive. Fragmenting the self as a condition of existence means that existence begins from a traumatizing place.

For me, being trans is a critical component of how I make sense of my gender. Like Shawn, I do not think I know what it feels like to be a cis man; it actually makes me incredibly unsettled to be assumed to be cis. And I approached this project from that place: that gender, as understood through cisness, is unattainable for trans people. But for several of the individuals I had the pleasure of interviewing, they very much feel as though being trans is "a process," (Judith) or "like paperwork" (Crystal) with a fixed end-point. They feel as though they are cis, that being trans is not a core part of who they are but rather, an experience. Trans becomes disability or disabling—something to be treated and corrected. While true for some, it's important to emphasize that this is not the only or most legitimizing possibility of trans existence. Similarly, to reject this as possibility for anyone because it does not align with everyone falls into the same trap.

In *Sex, Power, and the Politics of Identity* Michel Foucault (1997) argues that power is characterized by "the fact that it is a strategic relation which has been stabilized through institutions" (p. 169). He argues that when something is institutionalized it sets into motion a set of codes, rules, and restrictions that allow for its recognition as an official and legitimate identity (Foucault, 1997). When man becomes an identity that is juxtaposed to woman on a binary of

gender, when trans is opposing cis, or when being nonbinary is the binary opposite of being binary, one becomes a beacon of liberation from institutionalized ways of being and the other trapped within the clutches of their own subjection. Anyone outside of these two categories is simply confused or in transit to one or the other. Foucault cautions us that "we can always be sure *it will happen*, and that everything that has been created or acquired, any ground that has been gained will, at a certain moment be used in such a way" (1997, p. 169, emphasis in original)—as a means of social control.

As soon as being trans became part of the discourse, it lost its disruptive potential and, instead, became another categorical and generalizable way of experiencing gender. As Hammers states in *The Unruly Queer Figure's Phallic Seductions and the Re/Production of Sexual (In)Difference*, "as soon as perversion or queerness becomes ontologized as an identity… perversion loses its disruptive potential" (2015 p. 163). It is not necessarily disruptive to be trans and/or nonbinary, just as being cis is not necessarily oppressive. And when conversations tend to stay in these more broad, discursive dimensions, we tend to forget about what gender might feel like and how people feel about transitioning and how they feel about their gendered embodiment. Hammers (2015) argues that "gay liberationists seek to purify sex" making it "signify 'good' things like egalitarianism, self-transformation, and relationality and community" (p. 56). According to Bradford and Syed's findings, "resisting transnormativity appeared to, itself, become a hegemonic expectation" (2019, p. 319). Purifying transness in this way—by implying that the rejection of transnormativity is the only way to be politically just—effectively *normalizes* it, placing it in direct contrast to the oppressive (only) other option: *compulsory* cisness. In much the same way that Hammers (2015) argues that gay liberationists' arguments sanitize gay sex and rid it of its gayness, lumping trans experiences of gender all within the same

categorical experience in opposition to cisness as a binary way of being not only forecloses the inner peace and comfort with one's body and one's gender that is attributed to cis alignment, it also sanitizes the potentiality of innumerable ways of experiencing gender and medically transitioning as a trans person. Transitioning, then, can never hold space for grief, mourning, doubt, or anxiety. Informed consent becomes the gold standard because being trans is as clear, as purified, as cis is clear and purified: identifiable, correctable, logical, rational. This relies on the assumption that to be trans necessitates the rejection of *any* relationship to the genders we were assigned at birth, and to gender as a structure of feeling. For several of the individuals I spoke with, feeling cis wasn't compulsory. It just simply felt good for them. Failing to realize that the logic implicit in suggesting that to embrace gender is morally suspect, controlling, and/or oppressive employs the same pattern of subjection and conformity that we, as trans folks, are trying to escape from in the first place.

The presumption that medically transitioning makes Frankensteins[7] highlights a socio-cultural tendency to defensively read others critically to preserve our stable senses of self. As Sedgwick highlights, "paranoia requires that bad news be always already known" (2003, p. 130). A paranoid reading of gender means that rejecting gender as a concept all together becomes a "mandatory injunction rather than a possibility among possibilities" (Sedgwick, 2003, p. 125). A paranoid reading of gender views it as inescapably monstrous. Sedgwick (2003) pre-emptively disrupts a generalizing train of thought, pausing for us to consider that "for someone to have an unmystified, angry view of large and genuinely systemic oppressions does not intrinsically or necessarily enjoin that person to any specific train of epistemological or narrative consequence"

[7] Cambridge Dictionary defines Frankenstein as "something that destroys or harms the person or people who created it" (n.d.).

(p. 124). In other words, there needs to be room for multiple messy and often directly conflicting experiences of gender because one person understanding themselves as "essentially cis but with a medical condition" does not *necessarily* foreclose someone else identifying deeply with the concept of being trans.

The ways that gender is experienced and felt does not *necessarily* foreclose any other way of feeling—or not feeling—it. Resisting the impulse to accept that there is only one truth, one possibility of existence, is how we create and recreate new ways of being. It is a process of breaking out of a continuing pattern of discursive practices. Rather, as Samia Vasa argues in *Toward an S/M Theory of MacKinnon*, "we are all always [carrying the potential to be] both [disruptive and oppressive] and everything between" (2019, p. 103). In my conversation with Judith, she told me that she doesn't feel cis because it's easier or the dominant way of being. She told me that she doesn't feel jealous of cis people. She told me she feels exactly like what she assumes a cis woman feels like. That she tends to have much more in common with cis women than trans women. She identifies herself as a woman of "trans experience." Likewise, Valerie told me that while on an intellectual level she can understand how this conclusion has been drawn, she finds it "incredibly offensive" to have ascribed. She told me it feels similar to how she felt when she was refusing to acknowledge her womanhood. She told me about how this seems like a standard we only seem to hold trans people to. She talked about how yes, she gets how gender has had immense cultural, social, and political implications. She told me how she understands that everything is gendered and gets assigned value in much the same way that race and disability have structured who is perceived as more human. However, these bigger conversations about the implications of gender continue to perpetuate a standard through which

trans people's genders are always fighting for validity and legitimacy rather than, simply, existing.

How we make meanings out of the ways other people perform gender must always be understood as a mediated process reliant on our assumptions of *why*. In doing so, we ensure that difference can only ever be understood through an external definition. In *Orientalism*, Edward Said argues that "[t]he principle product of this exteriority is of course representation" (1994, p. 21). What we recognize in how other people do things is an interpretation of a (re)presentation, a palimpsestic fabrication of what we think their intentions *could be* rather than what 'actually' or 'truly' is. In this way, "[w]hat is commonly circulated is not 'truth' but representations… there is no such thing as a delivered presence, but a *re-presence*" (Said, 1994, p. 21, emphasis in original). When I asked Valerie what gender meant for her, she told me, "Gender is such a loaded term and such a vague term as well. Mostly, at the end of the day, it is a feeling. This feels right." She took a moment to organize her thoughts and told me about how she doesn't like how there's an insistence on understanding trans experiences of gender as a universal one. She said:

> We don't come from the same place. We don't all want to go through the same steps. Tell me at what point it makes sense to be together on the same boat? It doesn't mean we should be enemies, but we need to understand that there are differences.

Conscious of Sedgwick's notion that even by critiquing dualistic thought we are recreating dualism through a binary of non/dualism, I am not suggesting that we obliterate categories or binaries as useful in making sense of ourselves. Rather, I am interested in understanding how and why we feel entitled to impose an exterior understanding of others as

their lived truths. A paranoid reading of difference situates their conceptual beginnings as already threatening and monstrous. The trans monster not only creating havoc for cisnormative discourses of gender essentialism, but of transnormative ones as well. Like for the younger trans people I worked with as a community mental health support, the trans monster, then, must only ever speak correctly or risk being ousted from community.

Navigating community

Crystal told me that she doesn't really know a lot of other trans people and that she feels like she should "give back", but that she also doesn't necessarily want to be associated with being trans because it reminds her of her grief. She told me, "It makes it all come out sometimes. Thinking about why did this have to happen to me, why couldn't I have done anything sooner?" For Crystal, trans community spaces serve as a reminder that, for her, "things aren't the way they should have been." Her voice shakes as she tells me. She interlocks her fingers and looks away. There's a pause from both of us as she shifts in her chair, seemingly unable to get comfortable. She tells me about how she feels ashamed of feeling this way. She tells me about the person she wishes she could be. My eyes well up with tears just as hers do. There is a shared sense of struggle between us. How do you go back to a place that holds memories with so much unfinished grief?

In *Fire, Passion, and Politics: The creation of Blockorama as black queer diasporic space in the Toronto pride festivities*, Beverly Bain (2016), explores how Blockorama offered a reprieve from a nationalist desire to confine black queer diasporic desire. However, after being targeted as a site perceived as threatening to the sanctity and truthfulness of queer struggle being over because white queers have been naturalized and depoliticized, Blockorama exists as a

counter-archive of trauma, loss, change, survival, community, and resistance. Bain (2016) argues that the re-opening of Blockorama in its original site is a "paradox of re-entering a space shaped and marked by black queer diasporic bodies and having to submit to racialized regulatory processes of searches and proof of documentation" (p. 95). Trans community groups can often feel a lot like this. These are spaces and places that exist as reprieves from the pervasive and pathologizing medical world. But over time, trans community groups became trans support groups. They are places where we go to get information, to share tips and tricks for existing as trans people. These are places suggested to us as we navigate our medical transitions and have become, themselves, part of the process. These are often spaces that are marked by trauma.

Re-entering, or returning to, these spaces identified as specifically for trans people after time away can drudge up all the grief and the memories that have been haunting us. These are the places we existed when we were grappling with whether we are who we think we are and whether it's possible to exist. So often I hear younger trans people ask why they never see older trans people. They ask why trans people seem to fade away from these places. Ginger told me that when she started her medical transition she had heard from trans people that people "go off into the woodwork" and become invisible. She told me with tears in her eyes and her voice unsteady, "I said I'll never be that person, I'm never go into the woodwork and just hide. And eventually I realized I'm that person I didn't want to become." For Ginger, re-entering is the next step in her transition. When we spoke, she had only just decided that this was something she needed to do. She told me about how she shut off from community because she needed to get to a place, physically, where she could process her own grief and trauma.

Ginger told me about how she, at one time, was an important member of her church. She told me about how she used to actively preach about how trans people should not exist. And she told me about how much this haunted her as she sat in the waiting room for her first appointment with a doctor about starting hormones. Her voice caught in her throat as she talked about just how much it hurt to know that she had this past. She told me about how she would meet up with various community groups and said:

> When they talk about that original name they had and they called it dead name and all that kind of stuff, right? My viewpoint on that's a little bit different. I look back on his life, right, and even when I go back into different areas of where I've lived it's like going into somebody else's life. It's not my life. And I always look at it like, you know, he sacrificed his life—he gave his life so that I could live. Because he had a choice and he allowed me to come out.

She could not relate to the trans experiences of other individuals in community groups, which made it difficult for her to hold space for her own. But now that she describes her transition as "done," the next step for Ginger is to repair her connection to trans community.

In the preface to the collection *This Bridge Called my Back*, Cherrie Moraga asserts that "it is not a matter of the actual bodies in the room, but of a life dedicated to a growing awareness of who and what is *missing* in that room; and responding to that absence" (2015, p. xix). Moragara goes on to say, "the divide between generations widen[s] with time… we need a political memory, so that we are not always imagining ourself the ever-inventors of our revolutions" (2015, p. xix). Ginger spoke about feeling "relegated to the margins of [her] own communities" (Moraga, 2015, p. xxiii) in mourning the loss of the life she could have had. For

Ginger, grieving her past self is healing. It gives her the space to process the compounding losses of a past she never got to have and a future her past self won't get to see. In situating herself in relation to her past, Ginger is building a political memory, one where she does not need to deny having existed differently. While Ginger's past might be incompatible with her present, Ginger highlights how this mutual exclusivity does not translate into a foreclosure of having ever been possible.

Judith told me about how she stays involved in trans community because she wants people to know that it is possible to be trans and to transition and to be happy. But when I asked her if she related to the ways trans people in these spaces talk about and understand gender, she told me:

> On a conceptual level. Like, I have no desire to become a chef. None. And a good buddy of mine, he's getting into it to the nth degree. And while I have no desire to get into it, I can and have listened to him for hours. Fascinating, but doesn't appeal to me. I find it interesting, but not for me. The gender conversations that happen are like that. Virtually all of them are interesting and on like a one step removed, relatability. OK, not the same route down the mountain, but a parallel route.

For Judith, trans support groups have been like sanctuary. For Judith, community groups are trans care: they're how we show up for each other. She told me about how when she was first telling people she was a woman, these spaces were a means of staying connected to others when the outside world felt scary. She said, "When I was with the group. I knew the responses that I was going to get. When you're coming out to the general public, there's a bit of a variety out there." She told me about how these groups helped her organize what she needed to do. She

would hear about the same issues “week after week” and she made mental notes. She told me, “I realized that I didn't want to get stuck in the middle. I wanted to go through this process. I want to keep going forwards.”

In *Mourning and Militancy*, Crimp (1989) argues that for many whose lives are politicized, mourning and grief are disregarded as unproductive and self-indulgent. Support groups give us space to make sense of the injustices we face by “objectifying” (p. 16) them as enemies outside of our inner worlds rather than part of the grief that accompanies lost possibilities of lives and selves that could have been. Indeed, “by making violence external, we fail to confront ourselves” (Crimp, 1989, p. 17). Crimp suggests that “the rage we direct [against the external world], justified as it is, may function as the very mechanism of our disavowal” (1989, p. 17-18). Simply, if we do not attend to our grief and process our trauma, we get stuck in the middle. We are traumatized.

Stepping back and showing up: Transformative possibilities of for change

Through life histories and narrative research involving myself and other trans people who have pursued medical transition, I tried to be accountable to how “knowledge production is a political process” (Strega & Brown, 2015, p. 9). I did so by weaving critical reflexivity throughout this thesis, inserting myself throughout my analysis and presentation of stories. Rather than engaging with critical reflexivity as an event, it plays a central role in my project, rejecting the possibility of objectivity (Strega & Brown, 2015). As Strega & Brown (2015) assert:

> It is only when we reverse the gaze and investigate and problematize the other side of the equation—that is, the behaviours, discourses, and perceptions of the dominant—that we create possibilities for change that are transformative rather than incremental. (p. 6)

I responded to how "reflexivity is the recognition that the researcher is not separate from, but exists in relationship with what [they are] trying to understand" (Strega & Brown, 2015, p. 8). This project was about how our shared histories of medical transition created a specific context allowing for a consideration of the role difference plays in opening us up to possibilities for transformative change because I made every attempt possible to hold myself relationally accountable through reciprocal vulnerability (Ball, 2005).

Putting my life in conversation with participants was central to my approach because it held space for me to highlight how and why I attended to the parts of the stories shared with me that I did. Rather than attempting to generate a common meaning of complicated and contextually specific concepts, I situated myself to unearth "what knowledge is already present and shaping what we think we know or want to know" (Wright, 2015, p.392). I did not only look at how people narrated their medical transitions but attended to how their life histories and relationships played a role in each person's unique way of making sense of gender. I also attended to nonverbal emotional cues as a means of reading personal medical transition narratives reparatively and without pre-emptively defending my own through anticipation. These sometimes subtle sometimes quite overt shifts in bodies made space to engage with our differences through curiosity rather than anxiety, responding to messiness and inconsistencies as possibilities and surprises (Wright, 2015).

Now what?

What does it mean to be trans and what brings some of us to medically transition? This thesis contributes to a better understanding of trans lives. More specifically, my work attends to how we situate ourselves within each other's stories to determine their validity and their humanity. Through narrative research with differently situated trans adults in Canada and the United States, I critically reflect on the stories trans adults tell about medical transition, about gender, and the social contexts in which these stories become possibilities.

Moving forward, research that considers how time operates in multiple ways for trans people who pursue medical transitions is needed to get a clearer understanding of the role that age, amount of time spent medically transitioning, and the relationship between the two plays in how gender gets understood. As well, more research is needed that considers how immigration and race play a role in not only whether people are able to pursue medical transitions and for what reasons, but also to critically reflect on the varying ways gender is understood as always in negotiation with racial power dynamics. The limitations of language inevitably mean that something gets "lost in translation", as Crystal put it, when trying to articulate how others make meaning. As well, Valerie emphasized the need to consider Francophone experiences given that there is a cultural difference between Francophone and Anglophone culture in North America.

What my study adds is that there's more than one story because not everyone orients to gender in the same ways. These stories and orientations are enmeshed with relationships and relationships vary. This variation is not because of any one identifiable thing and these variations tell us things about the way we see and think about gender, as well as our orientations to it. Situating grief, loss, and mourning as thru-lines, we see how the effects of trauma get under our

skin and shape what we do to stay safe—to survive. There is a compounding sense of loss embedded in realizing what one never had and what one could have become. Through airing our grief and mourning our losses, we can interrogate why trans people are expected to embrace gender is a particular way that requires a divorce from other possibilities and pasts. This thesis is a call for research regarding transition to return to considering what gender means, starting from the perspective of trans lives and voices.

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