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"I don't think they thought I was ready": How pre-transition assessments create care inequities for trans people with complex mental health in Canada

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ABSTRACT

Transgender (trans) people experience high rates of mental health issues including depression and suicidality. Improving access to transition-related medicine such as hormones and surgeries is suggested as an important mechanism to address these mental health issues. Yet clinicians experience challenges assessing and referring trans people for transition-related medicine. Standardized assessment protocols have been therefore recommended to optimize care. Although standardized protocols are purported to expand access to hormones and surgeries for trans people, it is unclear whether these tools achieve this goal. We therefore conducted an institutional ethnography to explicate how standardized readiness assessments coordinate access to hormones and surgeries in Canada. We analyzed key texts, talked with trans people, clinicians, clinician-educators, and administrators (total $n = 22$), and observed clinician-education workshops. In the context of determining transition readiness, standardized protocols direct clinicians to explore alternative diagnoses and assess the degree to which any complex mental health condition is "managed" prior to initiating hormones or surgeries. In response, we found that trans patients downplay or withhold mental health concerns from clinicians, or otherwise do additional work (e.g., take up unwanted psychiatric interventions) to convince providers they are "mentally ready" to transition. This phenomenon is paradoxical in that transition-related medicine is recommended to mitigate trans people's psychosocial distress, but when patients reveal symptoms of distress they encounter significant barriers to treatment. We conclude that the logic underpinning pre-transition "mental readiness" assessments discredits the claim that standardized protocols optimize access to hormones and surgeries.

KEYWORDS
Canada; institutional ethnography; mental health; sex reassignment surgery; sociology of medicine; transgender; transition-related surgery

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Introduction

Transgender (trans) people are recognized as a marginalized population experiencing health crises in Canada and beyond. Empirical research shows that trans people have particularly high rates of mental health issues such as depression, anxiety, substance dependence, suicidality, and self-harming behaviors (Bauer, Scheim, Pyne, Travers, & Hammond, 2015; Kattari, Walls, Speer & Kattari, 2016; Rotondi, Bauer, Travers, Scanlon, & Kaay, 2011a; Rotondi, Bauer, Travers, Scanlon & Kaay, 2011b; Santos et al., 2014). Although descriptive studies on trans people's mental health are grim, these data have also been used to argue that hormones and/or transition-related surgeries (TRS) are positively associated with better psychological outcomes (Bailey, Sonja, & McNeil, 2014; Tomita, Testa, & Balsam, 2019). Trans people's overall quality of life scores are also shown to improve after hormones or surgeries (Ainsworth & Spiegel, 2010; Murad et al., 2010; White Hughto & Reisner, 2016). Scholarship increasingly uses this empirical evidence to forecast that reducing barriers to hormones and TRS is likely to alleviate poor mental health outcomes amongst trans people (Bauer et al., 2015; Tomita et al., 2019). Yet clinicians experience ethical challenges or feel unprepared to engage in the work of assessing and referring trans people for hormones and TRS (Coutin, Wright, Li, & Fung, 2018; Snelgrove, Jasudavisius, Rowe, Head, & Bauer, 2012). Unsurprisingly, trans people also report mistreatment in clinical settings when pursuing transition-related medicine (von Vogelsang, Milton, Ericsson, & Stromberg, 2016).

In the North American context, clinicians are guided by two main standardized assessment protocols used in transition-related medicine – the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) and the *World Professional Association for Transgender Health Standards of Care* (WPATH-SOC) (Coleman et al., 2012; Dewey, 2015; Richards et al., 2016). The DSM is used to diagnose "gender dysphoria," the psychiatric condition associated with trans identity (American Psychiatric Association, 2013). DSM diagnostic criteria for gender dysphoria include an "incongruence" between one's expressed gender identity and birth-assigned gender (for a minimum of six months), which may contribute to "clinically significant distress or impairment in social, occupational, or other important areas of functioning" (American Psychiatric Association, 2013, p. 453). The WPATH-SOC is recommended to teach health professionals how to work with trans people, and to optimize care, including transition-related medicine (Coleman, 2009; Coleman et al., 2012). Even still, clinicians struggle to understand and apply these clinical protocols (Dewey, 2015; Ehrbar & Gorton, 2010; Shuster, 2016, 2019).

Tensions surrounding the gender dysphoria diagnosis exist within trans health scholarship due to the labeling of trans identities as mental illness, which pathologizes trans people in turn (Corneil, Eisfeld & Botzer, 2010; Suess, Espineira & Crego Walters, 2014). Pathologization, in this context, refers to the process of diagnosing trans people with gender dysphoria, which is technically considered mental illness despite much debate (American Psychiatric Association, 2013). Some scholars additionally challenge the conflation of mental illness with trans identities and reject the inclusion of gender dysphoria in the DSM (Dewey & Gesbeck, 2017; Inch, 2016; Kosenko, Rintamaki, Raney, & Maness, 2013; MacKinnon, 2018; Vipond, 2015). Davy, Sorlie, and Suess Schwend (2018) point out, however, that despite an organized international trans depathologization movement calling for removing gender dysphoria from the DSM, little has changed in terms of medical practices with trans people. For instance, irrespective of ongoing debate, diagnosing gender dysphoria is part of clinicians' scope of practice when working with trans people seeking hormones or TRS due to institutional factors. For example, prior to referring for hormones or TRS, the WPATH-SOC requires that clinicians assess trans patients' gender dysphoria using the DSM (Coleman et al., 2012). In response, scholars argue that trans patients rehearse dominant medical narratives reflected in DSM criteria for the sole purpose of convincing clinicians of their legitimacy as trans people (Shuster, 2016; Vipond, 2015). Advocacy and resistance have, therefore, focused on critiquing the inclusion of gender dysphoria in the DSM, and the pathologization of trans people that ensues (Kosenko et al., 2013; MacKinnon, Tarasoff, & Kia, 2016; Snelgrove et al., 2012).

Still, the WPATH-SOC presents itself as guiding the "best available science and expert professional consensus" in transition-related medicine (Coleman et al., 2012, p. 1). It is prudent to note that the current seventh edition was published in 2012 and the publication of the eighth edition is highly anticipated. While the WPATH-SOC promotes itself as supporting trans people to "maximize their overall health, psychological well-being, and self-fulfillment" (Coleman et al., 2012, p. 1), scholars debate whether this clinical care protocol achieves this stated goal. It has been argued that the WPATH-SOC contributes to the development of a poor therapeutic alliance because trans people who have hopes of accessing hormones and TRS enter therapy settings through mandatory pre-transition psychosocial readiness assessments (Budge, 2015; Budge & Dickey, 2017). Toivonen and Dobson (2017) add that trans people should not be pressured into "unnecessary" or "unwanted" assessments simply to obtain a referral for TRS (p. 181). However, there are few empirical investigations into the practices of health professionals who actually work with the WPATH-SOC, and other assessment protocols used in transition-related medicine. Research by

Shuster (2016, 2019), Dewey (2015), and Dewey and Gesbeck (2017) are notable exceptions. These studies reveal challenges that health professionals encounter when working with trans people in the context of transition-related medicine and they explore the subjective experiences and perspectives of clinicians. Our study extends this literature with a more explicit focus on how standardized assessment protocols used in transition-related medicine shape and constrain the work practices of both health professionals and trans people. Whereas a majority of the trans health research published to date exclusively targets critique at the DSM for pathologizing trans people, we broaden this focus by studying all texts that are identified as pertinent to people's work practices in transition-related medicine. As such, we conducted an institutional ethnography (IE) study, an alternative sociology that gives primacy to studying how daily activities, or work practices, are coordinated by texts.

This article first contextualizes the arguments in favor of using standardized protocols in transition-related medicine. Next, we describe our research methods; that is, our application of IE. We then discuss our findings, focusing on how the work of using pre-transition assessment protocols to determine hormone and surgery readiness creates barriers for trans people diagnosed with complex mental health issues such as depression, substance use concerns, borderline personality disorder (BPD), or psychosis.

Following standards of care promises to improve trans people's mental health outcomes

Scholarship in trans health advocates for mitigating mental health disparities in two primary ways: first, through improving psychological support services (Steele et al., 2017), particularly trans identity affirming mental health care that follows clinical standards of care (Jaffee, Shires, & Stroumsa, 2016; Kattari et al., 2016; Kosenko et al., 2013; Vanderleest & Galper, 2009); and second, by improving access to hormones or surgeries, which is shown to improve mental health outcomes (Bauer et al., 2015; Tomita et al., 2019). Complementary longitudinal research indicates significant reductions in anxiety, depression, psychoticism, and body uneasiness after a minimum of twelve months of hormones (Colizzi, Costa, & Todarello, 2014; Fisher et al., 2016).

Prior to hormones or surgeries, trans people must meet psycho-social readiness criteria. The WPATH-SOC sets out the minimum readiness indicators that trans people must meet prior to starting hormones or surgeries. Psychosocial assessment for both hormones (feminizing and masculinizing hormones), and for chest/breast TRS criteria include: "1. Persistent, well-documented gender dysphoria; 2. Capacity to make a fully informed decision and consent to treatment; 3. Age of majority in a given country; and 4. If any significant medical or mental concerns are present, they must be reasonably well-controlled" (Coleman et al., 2012, p. 104–105). For example, the WPATH-SOC states that "the presence of co-existing mental health concerns does not necessarily preclude access to feminizing/masculinizing hormones; rather, these concerns need to be managed prior to or concurrent with gender dysphoria" (Coleman et al., 2012, p. 34).

The WPATH-SOC states that psychosocial assessment procedures reflect the invasiveness and reversibility of specific treatments (Coleman et al., 2012). For example, hormones and chest/breast surgery requirements stipulate that "significant mental health concerns" be "reasonably well-controlled" (Coleman et al., 2012, p. 104–105). In contrast, due to the irreversibility of gonadectomies and genital surgeries, any significant mental health issues must be "well-controlled" prior to initiating these interventions (Coleman et al., 2012, p. 104–106). The WPATH-SOC authors Coleman et al. (2012) describe that "co-existing" mental health concerns may "complicate" the transition process and that addressing these issues may resolve gender dysphoria without requiring any transition medical intervention (p. 25). Psychosocial transition readiness criteria thus ostensibly take into account the invasiveness and reversibility of the medical intervention, while considering the patient's overall mental health status. To explicate how these standardized readiness assessments coordinate the work that people do in relation to the assessment and initiation of hormones and surgeries we conducted an IE.

Methods

Our methods are grounded in IE, an alternative sociological approach that extends political activist ethnography (Smith, 1990, 2005). IE projects study power relations that coordinate, rule, and ultimately constrain people's lives (Grace, 2015). IE researchers examine social problems happening in people's lives – also referred to as people's everyday work contexts. "Work" is generously defined to include anything from daily life that requires time, effort, and intent (Ng, Bisaillon, & Webster, 2017; Smith, 2005). For example, institutional ethnographers would define clinicians' time and efforts required to assess and facilitate access to transition-related medicine as "work," as well as the time and efforts required of trans patients to prepare for and attend transition-related medical appointments.

One of the explicit goals of IE is to map how institutional texts operating at the macro level govern everyday work happening at the local, or micro, level. "Texts" are paper or digital documents that coordinate "people's doings translocally" (Grace, 2013; Smith, 2005, p. 166). In other words, people's actions are reproduced translocally across multiple sites. For instance, standardized care protocols are texts designed to produce universal clinical responses in order to reduce practice inconsistencies happening at local clinic sites. The concept of "ruling relations" used here highlights how people's work practices are coordinated by, and rely on, texts (Smith, 2005). Smith (1999) states that "texts are the mediators and bases of discourses and ruling relations that regulate and coordinate beyond the particular local setting of their reading and writing" (p. 80). These ruling texts are identified by institutional ethnographers as "boss texts," which order specific people to carry out specific actions (Smith, 1999). Tensions and contradictions in people's daily work practices that are typically unconscious (but hooked into ruling relations) are made visible in IE. These contradictions in work practices have been termed "disjunctures" and are identified as ripe for empirical study for the purpose of making social change (Rankin, 2017). In summary, mapping how people's everyday work practices are ruled by institutional boss texts is a central aim of IE. As such, the translocal coordination of people's work in transition-related medicine may be an effect of boss texts. The goal of our IE project is to uncover and make explicit, the text-mediated ruling relations of the transition-related medicine system in Canada to advance more equitable care.

Data collection: Talking with key informants and uncovering ruling texts

Consistent with the IE strategy, data collection included interviews, participant observation, and identifying which texts were pertinent to people's work practices. To explicate the ruling relations that mediate health care providers' work of determining trans patients' suitability for transition-related medicine, we purposively sampled key informants ($n = 22$) to interview who had expertise within trans health care. Purposive sampling is defined by Maxwell (1997) as a method whereby "particular settings, persons, or events are deliberately selected for the important information they can provide" (p. 87). Our sample included: (a) trans people who had accessed mental and/or transition-related care in the past year ($\mathrm{n} = 9$); (b) clinicians and clinician-educators with a minimum of one year of experience working in trans health care ($n = 11$); and (c) hospital administrators currently working on trans health programing ($n = 2$). Clinicians and clinician-educators were trained in the specialties of family and emergency medicine, psychiatry, psychology, and social work. We obtained the research ethics board (REB) approval. Between June 2017 and January 2018, we recruited trans people using an REB-approved recruitment flyer, and health professionals using an REB-approved invitation script. Trans people received a gift card valued for twenty dollars to Honor their participation time, while health professionals participated during their regular work hours. All interviews were audio-recorded and transcribed verbatim. Interview questions were designed to understand how clinical protocols shaped the work that trans patients and clinicians do in mental health and transition-related medical settings. Although most interviews occurred around the Greater Toronto Area in Ontario, Canada, the first author also traveled to a Canadian transgender health conference where he talked with health professionals from other provinces. Interviews were analyzed iteratively and our interview guides amended frequently as each conversation revealed more about which clinical protocol texts were pertinent to work with trans individuals, and how informants' everyday actions were translocally ruled by these macro-level boss texts.

In addition to interviews, the first author observed two clinician-education workshops in the area of transition-related medicine and mental health. One workshop focused on teaching clinicians how to resist and work around pre-transition psychosocial mental health assessments. Another workshop targeted mental health professionals who were learning about gender dysphoria. Field notes from these workshops also served as data. Through talking with people in interviews, and observing clinician workshops, we identified and reviewed all of the texts noted as pertinent to transition-related medicine. These included the DSM, the WPATH-SOC, and other local clinical guidelines. We also reviewed provincial TRS funding policies in the ten Canadian provinces (e.g., Ontario Ministry of Health & Longterm Care, 2016). These clinical protocols and healthcare funding policies were included for analysis to make visible how transition-related medicine is organized in Canada, and to draw attention to the boss texts.

Data analysis

Informants' descriptions of their everyday work practices were mapped using Turner's (2006) work process mapping to highlight how activities at the local clinic level were shaped by translocal boss texts. We identified which clinical protocol texts directed informants' everyday work of conducting or preparing for assessments and referrals for hormones and TRS. Very early on when talking with informants, the topic of complex mental health issues emerged. Informants spoke about the arduous work that happens when mental health conditions such as depression, suicidality, substance use concerns, BPD, and psychosis, exist alongside trans identity. As a result, we began mapping how standardized clinical assessment protocol texts directed this mental health assessment work. The following sections delineate our findings with respect to the complications that arise when clinicians use standardized "one-size-fits-all" clinical texts to assess "complex" cases and the barriers to medical transition that emerge for trans people in response.

Results

We observed that providers who were responsible for determining transition readiness grappled with hesitations related to the work of assessing and referring trans patients for hormones and surgeries. These three-fold concerns mainly oscillated around determining: whether a patient was "authentically" trans and if they would benefit from hormones and/or TRS; if patients had the "mental capacity" to provide informed consent for hormones or TRS; and patients' overall psychosocial "readiness" for genital surgeries, in particular. These concerns represent a disjuncture confounding many of the providers' assertions that transition-related medicine ought to be regarded as promising treatments for poor mental health outcomes. Recognizing this disjuncture led us to further explore where provider-held hesitations originated, and how they might affect the work that clinicians and trans patients do.

The work of getting diagnosed with gender dysphoria without appearing "mentally unhealthy"

Some trans patients we interviewed commented on the delicate balancing act of presenting just enough distress related to their gender identity to tip the scales in favor of a clinician supporting medical treatments, without revealing so much psychological suffering that their mental capacity/readiness to transition could be called into question:

> When I first started transitioning, I was experiencing a lot of issues with, well I, don't want to misdiagnose myself in retrospect. But mainly depression and a lot of thoughts of suicide … I didn't quite want to say anything that would potentially be a barrier to me starting hormones … So I remember at the time thinking, how do I convey to the doctor … that I identify with these symptoms [of gender dysphoria] without appearing … mentally unhealthy.

Trans informants described a dilemma of identifying potential need for mental health supports but feeling they had to downplay this need or withhold symptoms, in order to avoid presenting as too "mentally unhealthy" to be considered good candidates for the transition. This concern was warranted, given that many provider-informants spoke about requiring that depression and suicidality be "well-managed" prior to facilitating access to transition-related medicine. Yet the current diagnostic criteria for gender dysphoria state that trans people may experience "significant distress and/or problems functioning" related to the conflict between their gender identity and their physical bodies (American Psychiatric Association, 2013, p. 453). Therefore, trans people's experiences of "significant distress" and psychosocial difficulties align with DSM diagnostic criteria for gender dysphoria. But according to the WPATH-SOC criteria, "any significant" mental health issues must be under control (Coleman et al., 2012, p. 104–106.). Precisely how much "significant distress" is necessary to receive a gender dysphoria diagnosis and the point at which distress enters a realm of "complicating" a patient's transition (via uncontrolled mental disorder) was muddled for many informants – patients and health professionals alike. Despite contradictions in these discrete texts, some trans people used a strategy to withhold symptoms of mental distress to avoid "complicating" their chances of accessing transition-related medicine, as described by the trans informant above.

For trans patients who disclosed mental health or substance use issues and/or whose life circumstances (e.g., not having stable housing or financial resources to take time off paid work) led providers to determine they were not ready to transition, gaining access to hormones or surgeries was significantly more time and resource consuming. For example, one clinician-informant spoke about assessing a patient for TRS who disclosed using cocaine. He determined that the patient's substance use was not significant to the point of being a barrier for treatment and accordingly made the referral in support of TRS. However, this patient was subsequently denied the required second referral by a local gender clinic explicitly because of cocaine use. Thus, despite drawing on the same standardized assessment text, these inconsistent interpretations created access inequities for the trans patient in question. Another trans informant candidly recalled that when she revealed to providers her dissatisfaction with a past TRS and her struggles with suicidality, she was labeled with body dysmorphia and encountered significant barriers to being referred for genital TRS:

> I don't think they thought I was ready for surgery because of all of the suicidal ideations and because of the body dysmorphia that they perceived I had… But they wouldn't hear me out… I felt like they didn't believe me. Until I was like "I'm in therapy, and I'm in this" and… I felt like at that point they can't deny me because I'm doing everything they asked and telling them everything they want to hear. And at that point I'd been presenting as female for almost 4 years.

This informant's readiness for surgery was questioned as a result of mental health diagnoses she received, and in effect, she had to become expert in transition readiness assessments to convince her providers that she was no longer struggling with symptoms of body dysmorphia, and was, therefore "ready" for TRS. She recounted: "I basically was saying that… I'm happy with the outcome of my past surgeries. And that's what I did. But it wasn't all true and I felt like I couldn't be 100% genuine with these people". The work of learning the script of what clinicians "want to hear" to be determined mentally fit enough for genital surgery was not insignificant. This participant engaged in years of additional therapy appointments, took psychotropic medications, and ultimately presented an embellished story to finally tip the scales in her favor to receive the required two recommendations from providers for publicly-funded genital TRS.

Trans informants who were considered to have complex mental health issues reported needing to be in "therapy" and "doing everything they asked," including taking medication, in order to show clinicians that any previously "uncontrolled" mental health concerns were currently being "well-controlled." This work is consistent with what the WPATH-SOC directs people to do. Why the WPATH-SOC requires that trans people's mental health must be "well-controlled," however, is an entirely different question. To address this, we talked with informants about how mental health status factored into determining readiness for transition-related medicine.

The work of testing alternative psychiatric diagnoses

Some clinician informants expressed challenges with differentiating between "authentic" trans people who would benefit from medical treatments, and other patients experiencing gender identity issues theorized to be caused by differential DSM diagnoses (e.g., BPD, psychosis, or transvestic disorder). One clinician described how alternative psychiatric diagnoses were tested and explored in conjunction with diagnosing gender dysphoria, and psychosocial transition readiness assessments.

> There have been cases where, with sexuality, like [patient says] "I'm afraid I'm gay." Gay-related obsessions in OCD. So it's trying to tease apart, is this gender dysphoria, is this OCD-spectrum related, or if it's psychosis. There's a piece about that. Then there's also, with the DSM specifically, whether if it's gender dysphoria, or if it's more fetishistic in nature, and so teasing apart those pieces. And if it is fetishistic, then are you sure that a surgery that has an *irreversible* outcome, is good for you? (emphasis added)

In other words, determining the correct diagnosis was a priority for clinicians conducting assessments with trans patients. The excerpt above highlights that surgery would not be an indicated treatment for individuals whose gender identities are primarily related to sexual desire. Conversely, this informant implies that surgery would be indicated in more authentic cases of gender dysphoria. Tracing this talk to a governing boss text, it is clear the WPATH-SOC writing on surgical interventions' irreversibility comprises part of the transition readiness assessment strategy. Moreover, the informant is also referring to the work of distinguishing gender dysphoria from "transvestic disorder" which is noted as a differential diagnosis in the DSM (American Psychiatric Association, 2013, p. 458). Transition-related medicine is generally recommended to relieve symptoms of gender dysphoria, not a transvestic disorder (American Psychiatric Association, 2013; Coleman et al., 2012).

To further explicate why the topic of sexuality surfaces in the context of gender transitions, we looked to older yet influential literature existing on the periphery of, and arguably in conflict with, current trans health research. Indeed, a body of psychiatric literature is dedicated to taxonomizing types of transsexuals who may be more likely to regret transitioning (Blanchard, Steiner, Clemmensen, & Dickey, 1989; Olsson & Moller, 2006; Smith, van Goozen, Kuiper, & Cohen-Kettenis, 2005). For instance, Olsson and Moller (2006) state that trans women who are sexually attracted to males are more likely to be satisfied with their TRS outcomes than trans women who are sexually attracted to females, or to both sexes. This may be, at least in part, connected to Harry Benjamin's pioneering work that developed typologies of trans people that attempted to identify "true" trans women who would benefit from medical treatments, as opposed to transvestites or gay men (Davy, 2015). This research is highly contested, however, as it has been argued that this typology is not conceptually sound (Bockting, 2009), is overly generalizing, and based on clinical populations of primarily white trans women (Davy, 2015). Interestingly, in both the third and fourth editions of the DSM the assessor is instructed to specify whether the patient is sexually attracted to males, females, both, or neither (American Psychiatric Association, 1980, 2000). And while the current DSM-V section on gender dysphoria does not explicitly direct assessors to investigate a patient's sexuality, the topic of sexuality was discussed by trans informants and some clinicians so this remains a salient issue with respect to assessing gender dysphoria.

Current and past editions of the DSM shape the work of exploring differential diagnoses in the context of pre-transition assessments. All editions of the DSM we reviewed discuss potential differential diagnoses for gender dysphoria. For instance, the DSM-III-R states that

> in Schizophrenia there may be delusions of belonging to the other sex, but this is rare. The insistence by a person with Transsexualism that he or she is the other sex, is, strictly speaking, not a delusion, since what is invariably meant is that the person *feels like* a member of the other sex rather than truly believes that he or she *is* a member of the other sex. In very rare cases, however, Schizophrenia and Transsexualism may coexist. (American Psychiatric Association, 1987, p. 75, emphasis in original).

This excerpt remains largely unchanged in the DSM IV-TR (American Psychiatric Association, 1994) and the DSM-V (American Psychiatric

Association, 2013). The practice of ruling out schizophrenia in an assessment emerged frequently when talking to clinicians. BPD was another diagnosis that was discussed by both clinician and patient informants frequently. This diagnosis created extensive work practices for trans people and was cited as a condition that required clinical "management" if trans patients were transitioning. Although BPD is not explicitly mentioned as a differential diagnosis or associated feature of gender dysphoria, "personality disorders" are referenced broadly. Furthermore, the DSM's diagnostic criteria for BPD includes "identity disturbance" and elaborates that this may include a change in "sexual identity" (American Psychiatric Association, 2013, p. 664). Several research studies have been published attempting to either substantiate the link between BPD and gender identity disorder/gender dysphoria (Murray, 1985; Singh, McMain, & Zucker, 2011) or to refute it (Seikowski, Golleck, Harth, & Reinhardt, 2008). Clinicians' work practices of assessing trans patients' readiness to transition, as well as patients' work of presenting as clinically ready to transition are thus directed by the DSM, specifically looking into the text's sections on associated features and differential diagnosis.

Clinicians' concerns that patients' gender identity may be rooted in BPD, rather than gender dysphoria, can be traced to the DSM. In the DSM-III-R, the description of "transsexualism" and its associated features includes "a moderate to severe coexisting personality disturbance" (American Psychiatric Association, 1987, p. 74). The DSM-IV-TR elaborates, suggesting that in "clinical samples, associated Personality Disorders are more common among males [trans women] than among females [trans men]" (American Psychiatric Association, 2000, p. 578). Said differently, samples of trans women (males, according to the APA) derived from psychiatric clinics may be more likely to receive a personality disorder diagnosis, such as BPD, than trans men. A clinician-informant with expertise in BPD interviewed in our study shed light on this phenomenon, asserting that the gendered signifiers associated with BPD mean that women, gay men, and trans people are categorically more likely to receive this diagnosis than non-trans heterosexual men. Approximately 75% of people given this diagnosis are female (American Psychiatric Association, 2013, p. 666). Moreover, a different clinician-informant explained how gender and sexual identity assessments emerge at a BPD treatment facility:

> So they only do 18 plus [adults] at the BPD clinic here. And they do have [an assessment] section on identity… So identity disturbance can include gender identity disturbance or not knowing what their sexual identity is. Which I think, might be problematic. But anyways it's one of the components of that assessment; Does your sexual orientation change, do you, are you certain what your sexual orientation is? Does your gender identity change?

This excerpt draws attention to the complex work that clinicians encounter when distinguishing trans identity from BPD, and how sexuality and gender identity remain salient issues in mental health assessments. Perhaps not coincidentally, of all the trans informants we interviewed, only trans women discussed being labeled with BPD. For example, a trans informant who was diagnosed with BPD years after medically transitioning reported feeling relieved that she did not get labeled with this diagnosis during her TRS assessment and referral phase. She predicted that certain attributes associated with BPD may shatter clinicians' trust in her as a suitable candidate for TRS.

The practice of exploring alternative psychiatric diagnoses alongside gender dysphoria is directed by the DSM and the WPATH-SOC, and informants described this work in the context of referring trans people for TRS. When writing TRS assessment and referral letters for publicly-funded procedures to the Ministries of Health, informants spoke about attesting to patients' diagnoses, and the subjective nature surrounding assessing how "well-controlled" patients' mental health is:

> It's [mental health readiness assessments] subjective, there's no doubt about it… There's the piece about, you know, do they meet all the criteria in the standards of care?… and then the diagnosis of gender dysphoria. So if all of those pieces are in place, then yeah. We make a referral.

When a clinician feels confident they have made an accurate diagnosis, and that any complex mental health issues are "well-controlled," the referral is sent to the Ministry of Health and to the surgeon. One clinician-educator informant showed us an example of a template used to teach clinician-learners how to write a referral letter for publicly-funded TRS. The referral letter template instructs assessors to confirm the patient suffers from gender dysphoria and to use the mental status exam (Martin, 1990) to assess the patient's overall mental health status and capacity to provide informed consent. In sum, informants explained that diagnostic accuracy was important to determine that patients were truly trans and that it was a crucial step to identify any psychosocial challenges prior to transitioning that were in need of "management."

No regrets: Being absolutely certain as an indication of authenticity and mental stability

Our fieldwork revealed that concerns around mental health status related to a desire to distinguish legitimate, or "authentic," trans people from individuals experiencing other mental health symptoms or acute crises involving gender identity questioning. For instance, informants discussed the risk of a patient ultimately regretting medical transition or needing to retransition (return to their natal sex). These outcomes were described as clinical failures. The first author observed a clinician-education workshop delivered at a mental health facility on the topic of trans identity and transitioning. None of the attendees specialized in transition-related medicine, but all were experienced, mental health practitioners. The workshop facilitators had expertise in working with trans patients, including in conducting transition readiness assessments. During the question and answer period, many participants revealed hesitations related to the assessment of gender dysphoria, and associated medical treatments. One learner in the group presented a theoretical case: what if a young person who had previously shown other significant shifts in identity, and had engaged in self-harming behavior such as cutting, is suddenly presenting with cross-sex gender identity? How does a clinician know that the trans identity is not, in fact, a symptom of BPD (as one of the core features of BPD relates to unstable self-identities)? This learner's stated fear was that the young person would later be dissatisfied with the outcome of hormones and TRS, and then retransition.

Of note, the clinician-educators leading the workshop addressed these concerns with a recommendation to follow the WPATH-SOC, which was cited as being the "gold standard" in determining whether patients are ready to transition. Moreover, it was reiterated more than once that no psychiatric diagnosis is a contraindication to transition, "not even schizophrenia," but that trans people who present with "co-occurring" mental health issues may not be "ready yet" for hormones and surgeries. The language of being "not ready yet" described cases in which patients' mental health challenges were not sufficiently "well-controlled" as directed by the WPATH-SOC criterion for hormones and TRS (Coleman et al., 2012). Thus, the WPATH-SOC's fourth criterion concerning "significant mental concerns" contributes to arduous work practices related to assessments and referrals for hormones and surgeries. Furthermore, the WPATH-SOC contains a short section on "surgery for persons with psychotic conditions and other serious mental illnesses" which states that if patients have "impaired reality testing" such as psychosis, bipolar disorder, or BPD, these conditions must be improved prior to contemplating TRS (Coleman et al., 2012, p. 61–62).

Our fieldwork also revealed that particular psychiatric diagnoses come to be understood as more "complex" or more "sticky," than other less stigmatized diagnoses. One clinician-informant commented that there are some "diagnoses that get lost in charts sometimes and others that are really sticky … [such as] borderline personality disorder, schizophrenia, bipolar disorder." Some clinicians may view these psychiatric conditions as limiting patients' decision-making capacities, making transition regret and retransitioning more likely, and therefore approval more clinically risky. Misdiagnosis on the part of a clinician, or regret or retransition on the part of a patient, is perceived as a failure because transition-related medicine is governed by standardized care protocols designed to remove uncertainty.

Trans informants engaged in extensive work to be perceived as absolutely certain and confident in their need to medically transition, and thus "authentic" trans patients. During assessments with clinicians, patients were not able to express any degree of uncertainty, despite the fact that some trans people do come to regret transitioning for myriad reasons (Levine, 2018; Turban & Keuroghlian, 2018). Existing as a trans person in the world, medically transitioned or not, is challenging in ways that can be difficult to fully anticipate through psychotherapy or gender role experiences alone. Cognizant, however, of clinicians' need to hear normative clinical narratives of gender dysphoria such as being absolutely certain, trans informants assuaged their assessors' fears of patient regret and subsequent retransitioning. For example, one trans individual explained downplaying any uncertainty to portray authenticity:

> … I thought that to be trans enough you had to have always felt like you were trans…. I thought you had to know before hand that you want to undergo hormone replacement therapy, to do top surgery, to do bottom surgery. Any kind of procedure, that you could possibly go through… So I remember checking yes for all of them, even if I wasn't quite sure at the time.

Other trans patients similarly explained that the best strategy to ensure successful access to hormones or surgeries is to provide clinicians with "the bullshit narrative." This narrative was described as a stereotype of trans identity, including features such as a strong cross-sex identification from a young age, and discomfort with genitalia. Informants' "bullshit narrative" was described as part of a strategy to protect against the risk that a clinician would respond to a clinical interview with doubts or hesitations. "The bullshit narrative" was also constructed to be consistent with gender dysphoria diagnostic criteria within the DSM-V (American Psychiatric Association, 2013). We connected what trans people told us about their pre-transition assessment experiences to the standardized protocols, and to the literature. We found that trans informants' work of preparing the "correct" narrative, which included an express desire for genital surgery, may have been shaped by earlier versions of the WPATH-SOC. For example, previous versions did not recommend administering hormones to trans patients who had no interest in genital TRS (Coleman, 2009). In response, trans people's use of the "bullshit narrative" comprised a strategy deployed to mitigate the risk of clinician rejection, and secure access to treatments.

Our findings have shown that concerns surrounding diagnostic accuracy can be directly traced to past and current versions of the DSM and the WPATH-SOC, as well as the mental status exam. Additionally, the scholarship that taxonomizes “true” and “authentic” trans identities predicted to be good candidates for medical interventions (e.g., trans women versus someone with “transvestic disorder”) contributes to the work of diagnosing and assessing trans people. Thus, the barriers that trans people with complex mental health issues experience in accessing hormones and surgeries are shaped by discursive psychiatric medical knowledge which pronounces certain people as being “true” trans people, while others are labeled with “impaired reality testing” (Coleman et al., 2012, p. 61–62). While the former is hailed as good candidates ready for the transition, the latter people diagnosed with complex mental health issues are declared fundamentally less capable of making medical decisions about their own bodies. For these reasons, trans patients strategically use the “bullshit narrative” to leverage access to treatments while assuaging clinician’s fears surrounding patient regret and retransitioning.

Discussion

Responding to trans health researchers’ calls to improve access to hormones and surgeries as a potential intervention to improve elevated mental health issues in the population, we wanted to understand the transition-related medical care system. In theory, access to TRS and hormones happens vis-à-vis medical and/or mental health care provider(s) who objectively assess whether a trans person meets standardized criteria defined by the DSM gender dysphoria diagnosis and the WPATH-SOC readiness checklists. This process is initiated by a trans person seeking hormones and/or surgeries. Despite the scholarship that cautions against gatekeeping and the roles that clinicians play in assessing trans people’s psychosocial readiness for these treatments, work related to pre-transition assessments is ubiquitous. Our IE of the transition-related medical system in Canada indicates that trans people must showcase their fitness to transition, particularly as it relates to mental health status. We thus noted a disjuncture: through our field research and textual analysis of the pertinent texts used in transition-related care settings, we found that the DSM was frequently used to consider any other mental health diagnoses that could be given as a differential diagnosis to gender dysphoria. Identifying legitimate “true” trans people who will not regret transitioning, or decide to retransition, was done through checks and balances directed by the DSM. Clinicians’ work of diagnosing patients with accuracy was shaped by research and clinical practice that seeks to taxonomize typologies of trans people predicted to be good candidates for transition-related medicine. Moreover, clinicians used the DSM and the mental status exam in conjunction with the WPATH-SOC to determine if the patient's overall mental health could be deemed stable enough to be treated using hormones or surgeries. These texts together have constructed patient regret and retransitioning as a medical failure, ignoring other social factors that may contribute to this outcome. Trans people, in response, recite the "bullshit narrative" to reduce the risk that clinicians will reject their requests for hormones or TRS.

Trans health researchers have previously identified the necessity that trans patients recite a normative medical narrative ("the bullshit narrative") to be perceived as authentic and to receive a diagnosis (Davy, 2015; Dewey & Gesbeck, 2017; Johnson, 2015; Vipond, 2015). This is a critical step required to trigger access to transition-related medical treatments. Shuster (2016) critiques how the WPATH-SOC coordinates trans people's need to present as absolutely certain, pointing out that clinicians are tasked with conducting "validation checks" to ensure that medical treatments are the right course of treatment (p. 325). Furthermore, the idea that a transitioned person may one day regret their decision to medically transition, and ultimately decide to retransition, is ubiquitous across Western cultures (Drescher, 2016). These beliefs are common to the extent that they can be defined as a trope of transition regret, and they have come to infiltrate what trans people say during assessments. Transnormative medical discourses shaped by the DSM are affiliated with tropes of transition regret, buttressing clinicians' work of conducting psychosocial transition readiness assessments to ensure that trans people prove their mental stability, ostensibly, to reduce the risk that a patient will be dissatisfied with the outcome and subsequently retransition.

Through talking with informants and connecting their everyday work practices to standardized readiness assessment texts, our study extends existing knowledge by revealing that this normative narrative is further shaped by clinicians' interpretations of retransitioning as a medical failure attributable to an inaccurate DSM diagnosis. In effect, when trans people decide that living as a transitioned person in the world is too challenging, or otherwise not quite right, retransitioning is seen as a categorical failure on the part of the clinicians who conducted the pre-transition readiness assessments, and of standardized protocols. For instance, Olsson and Moller (2006) cite the risk for transition regret as a primary rationale for strict adherence to the WPATH-SOC. On the contrary, McQueen (2017) argues that in medical-decision making on transition, regret is not an ethically sound reason to withhold treatment. The risk of regret or retransitioning is not a good argument for more extensive psychosocial assessments prior to initiating hormones or surgeries. For some trans people, being enabled to autonomously medically transition may, in fact, be the best way to decide if transitioning is the right treatment to relieve gender dysphoria. Retransitioning ought to be presented as a legitimate medical treatment option in transition-related medicine connected to broader self-determination in patient decision making.

Although they are designed to optimize and universalize care, our analysis shows that psychosocial readiness assessments actually create a medically risky and arguably unethical situation in which trans people experiencing mental health issues have to decide what is more important – transitioning at the potential expense of care for their mental health or disclosing significant mental health issues at the expense of being rendered not ready to transition (which in turn may produce or exacerbate mental distress). Dewey and Gesbeck (2017) similarly found that clinicians withheld transition-related medicine when trans patients were not able to "prove mental stability" (p. 62). Our research demonstrates that trans patients often feel that they must withhold, or downplay, any "significant" mental health challenges to leverage access to hormones and TRS. This is despite the fact that trans people's experiences of "significant distress and/or problems functioning" related to their gender identities technically align with the DSM-V's gender dysphoria diagnostic criteria (American Psychiatric Association, 2013, p. 453). According to the WPATH-SOC text, however, this "significant" mental distress may constitute an absolute contraindication to transition-related medicine. Important opportunities to promote positive mental health, and to offer treatments, may be missed due to the functions of these texts as some trans people – forced to choose between transition-related medicine, or receiving mental health supports – withhold symptoms of mental distress. Others are in fact unable to demonstrate mental stability or evade receiving a "complex" diagnosis. Medically transitioning for these individuals may take years of additional time and effort, if successful at all. Consequentially, the transition-related medical system operates as a two-tiered system defined by transnormative medical discourses that work alongside tropes of transition regret – constructing legitimate and illegitimate trans patients, who on this basis, are determined to be eligible or ineligible for hormones and surgeries.

Our analysis reveals that the DSM is a governing boss text that orchestrates psychosocial readiness assessments for the transition. Although the WPATH-SOC set the psychosocial readiness assessment criteria, these "universal" checklists governing access to transition cannot work without the DSM because this text is used to conduct checks and balances on trans people's overall mental status. This discursive text shapes transnormative medical discourses that circulate in transition-related medicine contexts, constructing authentic and "sane" trans people who perform normative narratives, while invalidating some trans identities as features of diagnoses such as schizophrenia, or BPD. While some clinician-informants espoused a critical stance toward the DSM, noting that trans people's psychological difficulties often stem from distress related to their gender identity, the WPATH-SOC explicitly requires clinicians to assess the degree to which patients' "significant" mental health issues are controlled. This is paradoxical, given that in order to transition, trans people must meet DSM criteria for gender dysphoria which includes demonstrating psychological distress related to the conflict between their bodies and their gender identity (American Psychiatric Association, 2013). Empirical research in trans health also consistently shows that trans people do experience elevated rates of mental health issues (Heylens et al., 2014; Mueller, De Cuypere, & T'Sjoen, 2017). Many of these mental health struggles, if identified by clinicians during transition readiness assessments, would be viewed as "significant" and insufficiently "controlled" to access hormones or surgeries (Coleman et al., 2012). Yet trans health research recommends these very treatments to relieve the symptoms of gender-related distress. For example, Colizzi et al. (2014) identify the positive effects of hormones on trans people's mental health outcomes. Our research reveals that trans people may be delayed or denied access to these interventions as a direct result of the condition they are intended to treat. In other words, trans people hoping to medically transition are caught in a double bind – they must convince clinicians they are mentally well enough to consent to treatment, while simultaneously being psychologically impacted by the conflict between their gender identity and physical bodies.

This study explicates the inequitable and pathologizing practice conditions created by standardized pre-transition assessment texts, underscoring the barriers that trans people perceived to have complex mental health inevitably face when trying to access hormones and surgeries. Consistent with the IE research strategy, our analysis identifies the boss texts that rule people's everyday actions, making future resistance and change possible. We join other researchers who call for ending the practice of mandatory pre-transition mental health assessments and diagnosing gender dysphoria (Ashley, 2019; Cavanaugh, Hopwood, & Lambert, 2016; Deutsch, 2012; Dewey, 2015; Reisner et al., 2015; Tomson, 2018). This is a critical step to achieve equitable and depathologized transition-related medicine that emphasizes patient self-determination. Explicitly, this call to action is not an endorsement for ending the standard medical practice of obtaining informed consent for treatments. When trans people are unable to demonstrate understanding surrounding anticipated risks, benefits, and alternatives to a particular treatment, whether due to an acute mental health crisis or another factor, initiating treatments may be risky and ethically tenuous. However, the standard practice of exploring treatment risks, benefits, and alternatives with patients is an entirely different practice than conducting pre-transition psychosocial readiness assessments, as our results have shown.

While this study of the transition-related medicine system in Canada provides a robust analysis of the boss texts that mediate the work of health professionals and trans people, its limitations should be noted. Due to resource constraints, a majority of interviews with informants took place in the Greater Toronto Area. We were not able to speak with informants from each of the provinces and territories across the country which would have strengthened our analysis of how boss texts shape and coordinate work happening at multiple local levels. Although our document analysis of provincial health care funding policies for TRS indicates that the WPATH-SOC functions the same in all jurisdictions across Canada, additional or different work practices may be required for patients and clinicians attempting to negotiate the transition-related medicine system outside of major urban centers, and in other regions.

Conclusions

Using IE methods, we conducted a study of how the transition-related medicine system works in Canada. We found that in the context of diagnosing gender dysphoria and determining transition readiness, clinicians explored alternative diagnoses and assessed the degree to which any complex mental health issue was "controlled." Clinicians' fears of patient regret and retransitioning contributed to the testing of differential psychiatric diagnoses listed in the DSM. This research underscores that, as a result of these text-mediated readiness assessments, clinicians' assessment and referral work involves more scrutiny and deference to protocols when trans people are perceived to have mental health issues. Consequentially, trans people with "complex" diagnoses encounter significant barriers to transition-related medicine. And when possible, trans people downplay or withhold significant mental distress from clinicians for the purpose of leveraging access to hormones and surgeries, potentially missing opportunities for needed supports and treatment. This contributes to the production of a medically risky, two-tiered system in which trans people are determined to be either eligible or ineligible for transition-related medicine on the basis of mental health status.

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