Anti-Fat Bias as a Barrier to Transition-Related Medical Care

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I. Introduction

Social media platforms have created powerful opportunities for social support and political organization for stigmatized groups. As a member of online groups for transgender people and fat athletes, I noticed that members in each group described very similar experiences of health care discrimination and quality of care issues. They talked about being unable to access appropriate care on various levels; about being harassed and blamed for their health problems; about having their concerns and even their symptoms ignored, and all health concerns blamed on their trans status or weight. Members talked about being afraid to even try to access the health care they needed. Fat members of trans groups who spoke about their experiences with the medical industry had even worse experiences, some being refused care altogether. These casual observations led me to wonder how anti-fat and anti-trans biases interact.

As I dug into the research on trans and fat health, more similarities emerged. One important similarity is the way fat and trans marginalization are socially justified according to health claims. The very existence of trans and fat people is politically contentious; in both cases, there is active controversy around whether it is possible to be both healthy and fat or to be healthy and transgender. Critics define fat and trans bodies as intractably ill, with the only solution to stop being fat or transgender; advocates claim that wellness is possible for fat and trans folks but in many cases only with considerable medical assistance. The medicalized ideologies around fat and trans subjects strongly link these figures with the medical and surgical interventions designed

specifically for them: weight-loss pills, bariatric surgeries, hormone replacement therapy, and various “sex reassignment” or “gender-affirming” surgeries (sometimes abbreviated SRS). Ironically, this highly medicalized status is accompanied by widespread barriers to appropriate and compassionate medical care for both groups. The controversy around medicalizing transgender and fat bodies comes down to two questions, applied to both groups: can fat or trans people be healthy; and what, therefore, are the duties of medical institutions toward them?

1.1 An Unusual Body of Literature

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

1.2 Intersectionality

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

literature are generally satisfied to investigate one type of marginalization at a time, the sociological theory of intersectionality proposes that experiences of multiple marginalization are not simply the experiences of each combined, but a unique and often magnified form of marginalization. This theory emerged and is most often deployed to study the intersections of race and womanhood, but has been adapted for other marginalized groups including trans or fat populations (but rarely this particular intersection). Using an intersectional approach allows researchers to understand the specific challenges of particular multiply marginalized populations.

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

1.3 Access to Care

Tracing the steps any patient takes to access care, there are many stages where barriers can and do occur. For a person to receive the medical care she needs, she must believe that she has a problem that can be addressed medically, that she could find a doctor or other health professional who would be willing to provide appropriate care, and that she could access such care in practical terms (eg can afford care, has transportation to reach the care facility). This determines whether a would-be patient will even seek care. On the provider side, appropriate care depends on factors such as

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

1.4 Thesis Outline

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

The third chapter outlines methods. I employed content analysis methods to analyze existing public narratives published online by trans people. Narratives addressed body issues and transition, including men, women, and nonbinary individuals. Public narratives include published personal essays, editorials, public blog posts, and advice columns. Whether self-published or part of a formal publication, these narratives are designed to be read by a wide audience and are not human research as

defined by the UCSB Office of Research. Narratives were analyzed according to qualitative content analysis methodology.

[Section on results]

[Section(s) on discussion and/or conclusions]

II. Background

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

One challenge of language in the discussion of trans identities in academic writing is pronouns for hypothetical pronouns. “He” or “she” center either the Victorian masculine default or trans women, who are the dominant subject in academic narratives generally and transgender narratives, respectively. “He or she” is appropriate only for binary-gendered subjects, while the singular “they” can give rise to syntactic ambiguity[1].

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

More complex constructions like “he/she/they” are cumbersome and nonetheless marginalize pronouns used by the subjects of this study. Therefore, I use neopronouns for neutral subjects. Neopronouns are invented gender-neutral or gender-inclusive pronouns. Neopronouns tend to follow the patterns of “he” and “she,” avoiding the syntactic confusion that “they” can provoke. Including them has the additional felicity of bringing pronouns into trans studies which are often erased. On the first use of a new set of pronouns, I have included a footnote indicating the declension of that pronoun set (e.g. they/them/their/themself) and the origin, if known.

2.1 Who is Transgender?

A transgender (trans) person is someone whose endorsed gender differs from the one assigned to aer[2] at birth[3]. A trans woman is a woman who was assigned male at birth. A trans man is a man who was assigned female at birth. A person who is not transgender is cisgender (cis). Broadly, a cisgender person is someone who identifies with the binary gender assigned to him or her at birth, but there are some cases which complicate this definition. For example, intersex people (those born with ambiguous genitalia) sometimes self-identify as transgender. Binary trans people understand their gender as occupying a discrete and usually fixed position within the male/masculine and female/feminine binary. There are also *nonbinary* (NB or enby) trans people, who may additionally identify as agender (having no gender), bigender (having two genders), genderqueer (having a gender which “queers” or challenges the gender binary),

[2] e/em/eir/emself (1990)
[3]

genderflux or genderfluid (having a flexible or fluid gender), or many other concepts. Many trans people use more than one term to capture their self-concept. For example, someone might self-describe as a nonbinary trans woman. Identity terms may also be compounded or modulated with prefixes and suffixes (e.g. biflux demigirl). The wide variety of terms reflects a value within the trans community of having language to capture subtle differences in the way individual people experience and express their gender.

Many, but not all, transgender people undergo a process (or processes) of gender transition. Gender transition is a deliberate renegotiation of a person's gendered social position. A transitioning person alters hir[4] social identity, legal identity, gender expression, and/or body to better align with hir subjectively experienced gender identity. Trans people and their health care providers usually describe transition as having several modular elements or subtypes. Social transition includes changing thon's[5] name of use, pronouns, and clothing; legal transition includes changing thon's legal name and gender marker; and medical transition includes hormonal and surgical interventions designed to change the body itself (Shultz, 2015). Not everyone goes through all changes; differences in preference, knowledge, "starting point" such as initial name or appearance, practical access, and resources can all influence the makeup of a person's transition.

Public discourse about transition both within trans spaces and in broader cultural contexts frequently understands medical transition and "passing" as the central and

[4] Ze/hir/hir/hirself (1996)
[5] Thon, thon, thons, thonsself (1858)

defining goals of transition. Passing refers to a person's intelligibility as their gender. For binary trans men and women, this means being recognized as a man or woman by others. This idea of transition tends to associate surgical transition and passing with legitimacy, which may create social pressure to pursue certain elements of transition independent of individual trans people's needs.

Within trans communities, there is some controversy about how broadly "transgender" should be defined. For the purposes of this study, a trans person is someone who has undergone, is undergoing, or wishes to undergo some form of gender transition, including both binary and nonbinary trans individuals. This definition is not meant to endorse an ideological position on who "counts" as trans, but to capture the subset of trans persons to whom access to transition care would be relevant.

2.2 Who is Fat?

Just as there are different ideas of who counts as trans, there are different ideas of who counts as fat. According to the CDC (2015), an adult is obese or overweight if cir [6] weight in kilograms is at least 25 times the square of cir height in meters ("Defining Adult Overweight and Obesity"). One criticism of BMI as a measure of fatness is that people with very different body types may have similar BMIs. Donald Trump received criticism throughout his 2016 presidential campaign regarding his weight, often specifically citing his BMI. At 6 foot 3 inches and either 263 or 263 pounds, Trump's BMI

[6] ce/cir/cirs/cirself

is between 30 and 33, at the low end of medical obesity[7]. Olympic athlete Lance Brooks has a similar BMI—about 31—but he would not be socially defined as fat[8].

Olympic discus thrower Lance Brooks (left) and reality TV star Donald Trump (right), both medically obese.

Although BMI varies only between adults and children, social standards of fatness are highly contextually sensitive. Differences appear between men and women, gay and straight men, and people of different professions. In an extreme example, one young woman made headlines when she was fired from her job for being “too fat” to work as a model. With a height of five foot eleven and a weight around 125 pounds, the teen’s BMI was 17.5—making her medically *underweight* (Weinstock, 2015). As Marilyn Wann (2009) argues,

> In a fat-hating society, everyone is fat. Fat functions as a floating signifier, attaching to individuals based on a power relationship, not a physical

[7] Trump weight source
[8] Brooks weight source

> measurement… A young woman who weighs eighty-seven pounds because of her anorexia knows something about fat oppression. (p. xv)

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

III. Literature Review

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

[9] per/per/pers/perself (1972)

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

A significant portion of this chapter is devoted to outlining the marginalization experienced by trans and fat people, respectively. However, side-by-side comparison of fat and trans marginalization is insufficient to understanding the experiences of people who are both fat and trans. Intersectionality theory provides a framework for studying the meeting point of two marginalized categories. While literature on fat-only and trans-only marginalization is well established, very little work examines the effects of both in concert. However, studies exist which examine trans or fat marginalization intersectionally with *other* traits (e.g. race). Findings from such studies demonstrate that trans status and fatness intersect with other marginalized statuses multiplicatively, lending support for the expectation that trans status and fatness will interact similarly with one another.

3.1 Fat & Trans Marginalization

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

Economic Inequalities

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

Unsurprisingly given the absence of consistent legal protections, employment discrimination and unequal pay are common. Gallup found that BMI is positively associated with long-term unemployment (Crabtree, 2014). A meta-analysis of twenty-nine studies found that women earn less as their weight increases, with wages

discounted as much as one fourth the earnings of thinner women (Cawley, 2000). The National Center for Transgender Equality (2016) finds that employment and pay inequalities exist in trans communities as well; trans individuals are twice as likely to be unemployed as the general public, and almost half report adverse treatment such as hiring discrimination, being denied a promotion, or being fired because of anti-trans discrimination.

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

Medical Inequalities

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

Institutional bodies including federal and state governments, professional associations, insurance companies, and hospital boards create policies which define who can receive care, on what timeline, and at what cost. Institutions such as medical schools and law-making bodies also determine who is educated about certain types of health needs and what they are taught. Institutional barriers to health care are the most far-reaching and in some ways the hardest to negotiate. As a result, these barriers often attract the most activist attention.

In terms of US law, health care policy has become more inclusive for trans patients in recent years. Until 2010, insurance carriers could limit coverage for procedures according to sex. This means a trans man could be denied coverage for a mammogram or Pap smear, while a trans woman could be denied coverage for a prostate exam[10]. The Affordable Care Act made this type of policy illegal, but it remains legal for insurance companies to deny coverage of transition-related expenses ("Transgender Health Care").

Conversely, health care policy in the US has become more hostile to fat patients. As I mentioned earlier, the declaration by the AMA that fatness is a disease but not a disability could remove the thin employment protections that exist, while also ensuring that additional state support available to disabled people is *not* available to fat people. An emerging paradigm for fat health care, piloted by the Endocrine Society (Apovian et al, 2015[11]), endorses a policy that Tucker (2015) summarizes as "treat the weight

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

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

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

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

Lack of training and unwelcoming clinic environments communicate to both providers and patients that trans and fat patients do not belong; overtly biased treatment is highly normalized. A study of provider attitudes found 45% of health care providers reported responding negatively to fat patients (Jay et al., 2009). A study of fat patient experiences found that a similar proportion of fat patients identified experiences of

anti-fat stigma at the hands of a medical professional (Mold & Forbes, 2013). Trans patients face “outrageous frequencies of anti-transgender bias in care” (Grant, Mottet, & Tanis, 2010). Lambda Legal (2010) found that over 70% of respondents had experienced some form of health care discrimination. Bias sometimes escalates to the level of harassment or even violence. Puhl and Brownell (2006) found that more than half of obese women experienced harassing comments from their doctors. The most recent National Transgender Discrimination Survey found that 19% of trans people reported being refused care as the result of their trans status; 28% reported experiences of verbal harassment in care environments; and 2% reported physical attacks (Grant, Mottet, & Tanis, 2016). Where care environments are usually ill-equipped and often hostile, patients may take on an educator or advocate role with clinicians, but many postpone care (Grant, Mottet, & Tanis, 2010; Drury & Louis, 2002).

Social Stigma

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

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

Outcomes of Marginalization

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

3.2 Theoretical Context

The present study is broadly situated within critical theory, drawing on the specific contributions of trans theory, fat studies, and intersectionality theory. Trans theory and fat studies are both interdisciplinary critical approaches emerging out of feminist theory; trans theory also draws from queer theory. They share similar foundational assumptions: first, that body diversity is a natural and value-neutral or

positive feature of human populations; second, that the perspectives and goals of mainstream society and especially industrialized medicine are often in conflict with the interests and dignity of trans and fat people (respectively). Intersectionality theory posits that vectors of marginalization combine in multiplicative ways, such that a person who experiences multiple types of marginalization experiences them in a way unique to that intersection, rather than experiencing each in a separable way.

Trans Theory & Fat Studies

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

One of the things critical theory does is challenge popular assumptions about causation. This features heavily in fat studies. For example, fatness is usually understood as the result of poverty via mechanisms including food deserts and differential food costs. Fat scholar Paul Ernsberger (2009) shows that fatness is a *cause* of poverty through mechanisms such as income inequality and employment discrimination. Of course, this could be two sides of a self-renewing cycle, but previously only one side was being discussed. Fatness and transgender status are both associated with poor health, leading many to conclude that being fat or transgender are inherently unhealthy or that these statuses are themselves diseases. A critical

interpretation would be that since fat and transgender people are marginalized, and marginalization is almost always associated with negative health outcomes, health inequalities are likely explained in large part by factors such as prejudicial medical care, income inequalities, stress, and social stigma (Ernsberger, 2009).

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

Intersectionality Theory

The marginalization of fat and trans people is similar in striking ways, raising the question of how these two vectors of marginalization interact. The thematic similarities suggest some outlines for what kinds of experiences a fat trans person might experience, but looking at each piece separately falls short of capturing vis[12] actual situation. The lived reality of occupying a space at the intersection of multiple marginalized groups is not additive but multiplicative; the nature of marginalization changes when new forms of oppression are added.

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[12] Ve, ver, vis, verself (1984).

Intersectional theory (or intersectionality) emerged in the late 1980s to examine the this function of marginalization. The classic position of intersectionality posits that Black women do not experience anti-Black and anti-woman marginalization separately, but in a way that is multiplicative and unique to Black women: when a Black woman experiences sexism, it is influenced by racism and when she experiences racism it is influenced by sexism. She experiences marginalization as a Black woman, not as only Black or only a woman. Intersectionality frequently focuses on the experiences of women of color, but this framework has also been adapted for use examining other intersectional identities. A large proportion of intersectional research continues to center race and womanhood, but some has considered other marginalized genders, queer sexualities, disability status, fatness, and others.

3.3 The Intersection of Fat and Trans

Literature specifically focused on the intersection of gender variance and fatness is very rare. One such study focuses primarily on law, but focuses in large part on the shared pressure on fat and trans people to assimilate and participate in fat and trans oppression and uphold norms which mark them as outsiders (Vade and Solovay, 2009). The authors present a list of “unspoken, false beliefs” which fat and transgender people are asked to support:

- There is exactly one good, natural, and healthy body size (thin).
- When a person behaves correctly, by consuming a reasonable amount of calories and exercising appropriately, a thin body will result.

- There are exactly two good, natural sexes/genders (female and male), which correspond in a direct and linear way to exactly two types of sexual organs (vagina and penis).
- When a person behaves correctly, a gender presentation that is obviously and exclusively female or male will result. (pp. 168-169)

Their analysis of legal cases in the US shows that trans and fat people who fail to support these assumptions have less access to social support in the form of legal protection. Fat and transgender people seeking access to legal protection are consistently asked to testify that they would rather be thin or cisgender; their protection is contingent on their consistent attempts to conform to thin and cis norms, even if those attempts ultimately fail “to transform themselves sufficiently to avoid discrimination” (p.173). The implication is that fat and trans people have a social debt to not be fat or trans, but they may be forgiven if they make sufficient effort.

In *Trans/Portraits*, Jackson Wright Shultz presents a rare emic narrative of fatness in trans experience. Body diversity is not a central theme of Shultz’s work, but several of his subjects discuss weight and fatness in brief. Their stories frequently feature frustrations with medical care. One theme of these narratives is medical gatekeeping preventing accessing care, especially transition care. Another theme is eating pathologies; some subjects conceptualize disordered eating as a means of controlling their bodies, either symbolically or (in one case) as a means of passing as female. One subject describes avoiding treatment for her eating disorder because she cannot access healthier means transition. “I’m still fighting to get on hormones, so I’m

trying to pass as a woman without any help. When I'm thinner, it's easier to do that" (qtd. Shultz, 2015, p. 94).

Although Shultz's work is more biographical than scientific in nature and only a few of his subjects described struggling with fat marginalization. Nonetheless, his work provides a glimpse of one possible area of intersectional marginalization for people who are both fat and trans. Specifically, it suggests that anti-fat discrimination in medical environments impacts trans people's access to transition care, and that this in turn encourages maladaptive coping strategies like self-starving. The present study uses personal narratives about gender identity, transition, and body image to investigate how anti-fat bias disrupts access to and quality of gender-affirming medical and surgical care for fat transgender people.

IV. Methods

This study employs qualitative content analysis methods to examine found data in the form of personal narratives posted online. A unit of data was a single narrative, whether a one-sentence social media post or a published five-page editorial. The unobtrusive method of data collection was chosen for several reasons. In her book on internet methodology, Hine (2015) identifies unobtrusive data collection as ideal when subjects might be hesitant to talk about a topic directly, or when it is mundane in a way that they might not remember it. This study contains both. Subjects may have discussed issues of stigma more openly in an anonymized internet environment than they would in

interviews. At the same time, some of the narratives reflect passing slights and insecurities that may have been forgotten later.

Subjects

Relevant subjects were transgender individuals or decision-makers in transition care (such as parents or physicians of transgender individuals) who have shared public narratives of fatness or body fat as relevant to gender transition. Subjects were found in multiple ways. General web searches for “trans+fat,” “transgender+fat,” and similar combinations of terms associated with gender and size diversity turned up blogs, editorials, and peer-to-peer transition resources. On trans-specific web groups (Susan’s Place, GenderLife Information Exchange, True Selves Forum), I used native search engines to identify threads discussing fatness or weight. On broader sites (Reddit, Tumblr) I looked for trans-specific groups and then searched for fat tags or topics within them. Groups or pages where membership is limited to certain users were excluded.

Ethical considerations

Given that I used only public materials that were accessible to anyone, this research fell outside the scope of human research according to UCSB’s Office of Research. Nevertheless, the sensitive content demands certain care. Where narratives were clearly designed to be consumed by a wide audience—periodicals, resource sites, and more professional blogs—no special care was taken. Where narratives were more conversational in nature—forum posts and personal blogs—authors were anonymized.

Coding

Narratives were analyzed using qualitative content analysis methods. Content was evaluated for information on beliefs about fat, especially as it relates to gender and gender transition; on the source of such beliefs; and on the impact (if any) on access to or quality of medical care. Certain demographic information, if available, was also collected. Specifically, I recorded gender, race, and relationship to the transitioning person (i.e. self, partner, child, patient). I used multi-level thematic coding to structure data analysis. First-level codes were determined in advance, and second-level codes emerged during analysis of early data. After the coding scheme was fully developed, early data was re-coded to ensure validity.

I identified four first-level codes: “health and health care,” “body,” “barriers to transition,” and “conceptual.” There were 18 second-level codes. Under “health and health care,” the second-level codes were “medical and surgical intervention,” “formal care,” “coping,” “support,” “depression and distress,” “dysphoria,” and “suicidality.” Under “body,” the second-level codes were “physical parts” and “abstract and descriptive terms.” Under “barriers to transition,” the second-level codes were “gatekeeping,” “violence,” “rejection and validity,” “attractiveness,” and “agency.” Finally, under “conceptual,” the second-level codes were “sources of information and belief,” “norms,” “values,” “language,” and “causation.” The code book, including descriptions of codes, can be found in Appendix A.

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Appendix A: Code Book

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

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

Author Information:
1. Gender
2. Race
3. Relationship to trans person (if cis)

Content:
1. Health and Health Care
    a. Medical and surgical intervention (e.g. hormone therapy, SRS, weight loss program)
    b. Formal care (e.g. administered in a mainstream clinical environment)
    c. Coping (e.g. informal self-care strategies)
    d. Support (social, family)
    e. Depression and distress
    f. Dysphoria
    g. Suicidality and self harm
    h. Eating pathology
2. Body
    a. Physical parts
    b. Abstract and descriptive terms (e.g. “beautiful,” “flat,” “hairy”)
3. Barriers to transition
    a. Gatekeeping (by provider, parent, or other person)
    b. Violence
    c. Rejection and validity (these concepts appear to be closely linked)
    d. Attractiveness
    e. Agency
    f. Passing
    g. Own concept of gender (in the abstract)
4. Conceptual
    a. Sources of information and belief (e.g. provider, peer, family)
    b. Norms and values
    c. Causation (e.g. “I am fat because…”)
    d. Identity
    e. Language