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### **Beyond the Binary: How Discourses Affect Non-Binary People's Access to Gender-Affirming Healthcare**

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Beyond the Binary: How Discourses Affect Non-Binary People's Access to Gender-Affirming Healthcare

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**Abstract**

Sociological literature on the medicalization of trans people has looked at how medical providers use a medical model of trans identity to determine which trans people may have access to gender-affirming healthcare. This study adds to the conversation by looking at how discourses affect non-binary people's access to gender-affirming healthcare. While medical providers use a dominant discourse on trans people to regulate non-binary people's bodies, non-binary people internalize these same discourses to either delay their own care. Online, non-binary people discuss among one another to inform themselves of their options. As they gather more information, they become more willing to seek medical care.

**INTRODUCTION**

Over the past decade, research on trans people's experiences has increased exponentially (Schilt and Lagos 2017). Known as trans sociology, this collection of scholarly work focuses on trans and non-binary people's lived experiences. Much of this scholarship (e.g. Dewey 2008; Vipond 2015; Davis et al. 2016) examines the medicalization of trans bodies, paying particular attention to how medical providers limit which trans people may transition medically. Medical providers use a medical model of trans identity to evaluate which trans people are really trans (Spade 2003). Only clients whom doctors believe to be 'trans enough' may have access to transition-related healthcare (Johnson 2015).

There are several problems with medical providers' decision-making process. First of all, doctors, most of whom are cisgender, or not trans, act as if they know more about trans identities and trans experiences than trans people. Furthermore, this standardized process grants doctors the power to deny trans people the agency to define themselves for themselves (Gehi and Arkles 2007). The criteria that doctors use to grant access are also problematic. Vipond (2015) explains

how the medical model of trans identity invokes transnormative scripts to declare who is trans and who is not. Transnormative scripts are embedded with cissexist assumptions that treat being trans as a problem (Vipond 2015).

In reality, many trans people exist outside this medical model. Trans people respond to transnormative scripts in different ways: they educated providers (Dewey 2008), validate transnormative scripts for medical access (Vipond 2015; Burke 2011), or share strategies with one another to prepare for interactions with doctors (Johnson 2015). Some trans people who are denied access find other methods to acquire hormones, such as through friends or foreign or black markets (Gehi and Arkles 2007:14). Others have had family or friends perform surgeries on their bodies, including silicon injections, or binded or tucked (Gehi and Arkles 2007). Alternative methods increase the risk of HIV/AIDS, hepatitis, physical injury, and death (Spade 2010:498–9). Trans people have died from medically unsupervised silicon injections and bottom surgeries, and the people who perform the surgeries risk imprisonment for practicing without a license (Gehi and Arkles 2007). Lastly, trans people who have not tried to or were denied the opportunity to transition medically are more vulnerable to transphobia and cissexism. Some trans people have avoided speaking, entering spaces like restrooms, or interacting with certain people to avoid transphobic or cissexist reactions (Gehi and Arkles 2007:13). Others have resorted to sex work. As a result, they are more vulnerable to rape, STIs, and murder (Gehi and Arkles 2007:11). Even if trans women and femmes of color are not sex workers, police presume them to be and arrest them (James et al. 2016:163).

The consequences of barred access to trans healthcare have become increasingly clear as over time more and more medical institutions, including the American Medical Association and the American Psychological Association, have publicly stated that medical transition is important

for the health of those who seek it (Lambda Legal 2016). Gender affirming healthcare alleviates gender dysphoria for those who have it, and research shows that denial of coverage to depression, anxiety, and suicide and attempted suicide (Spade 2010:498–9). Yet, trans people experience difficulties that cisgender people need not experience for access to hormone replacement therapy and gender-affirming surgeries, even when hormone treatments and surgeries are unrelated to transition-related healthcare (Spade 2011).

Procedures created by cisgender people in power also limit who may transition medically. Although some requirements have changed or disappeared over the years, trans people must still go through what can be a time-consuming and expensive process before they may access hormones or surgery. One requirement in the *Standards of Care for the Health of Transsexual, Transgender, and Gender Non-Conforming People* is that trans people be assessed by mental health providers (Davis et al. 2015:510). Since most insurance companies do not cover trans healthcare expenses, merely paying for a therapist is not financially affordable for many trans people (Spade 2010), especially those who are low-income or of color. Because only a handful of trans people can afford to pay out-of-pocket, especially for surgery, denial of coverage means that those who wish to medically transition must either give up or utilize alternative methods that can lead to imprisonment, the transmission of diseases, or death (Spade 2010).

As shown, scholarly literature has gone into extensive detail on trans people's healthcare experiences as they seek to medically transition. Whereas these studies have focused on the experiences of trans people in general or on trans men or trans women, this study examines exclusively the experiences of non-binary people. Non-binary gender identities fit outside the binary gender system. In other words, non-binary people do not identify exclusively as men or

women but as a different gender, multiple genders, or as no gender at all. Non-binary people's experiences and voices are scarce in trans scholarship. Hence, research on non-binary people's experiences in healthcare is vital and urgent as medical and psychiatric institutions currently reform curricula, texts, and strategies to better meet the health needs of *all* trans people. For this study, I analyzed documents and videos created by non-binary people who have met with doctors for access to gender affirming healthcare. I will argue how transnormative discourses delay or deny gender affirming healthcare to non-binary people. First, I will address how medical providers affect access. Then, I will show how non-binary people use transnormative discourses to delay their own care. I will then go into what happens when non-binary people seek further information online about the effects of medical transitioning. I finish with how non-binary people are using the Internet to dispel misconceptions that may be a result of transnormative discourses.

## **LITERATURE REVIEW**

The pervasive medical way of thinking is that trans bodies are abnormal and unhealthy (Davis et al. 2016:492–493). According to the medical model of trans identity trans people are “really trans” only if they are gender dysphoric (Johnson 2015; Spade 2003). The criteria for gender dysphoria are outlined in *The Diagnostic and Statistical Manual of Mental Disorders* (American Psychological Association 2013). If trans children meet at least six of eight criteria, or two of six criteria for adolescents and adults, then they meet the diagnosis (American Psychological Association:452). The criteria for children are as followed:

1. A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender).
2. In boys (assigned gender), a strong preference for cross-dressing or simulating female attire: or in girls (assigned gender), a strong preference for wearing only typical

- masculine clothing and a strong resistance to the wearing of typical feminine clothing.
3. A strong preference for cross-gender roles in make-believe play or fantasy play.
  4. A strong preference for the toys, games, or activities stereotypically used or engaged in by the other gender.
  5. A strong preference for playmates of the other gender.
  6. In boys (assigned gender), a strong rejection of typically masculine toys, games, and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games, and activities.
  7. A strong dislike of one's sexual anatomy.
  8. A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender (American Psychological Association 2013:452).

Here are the criteria for adolescents and adults (American Psychological Association:452):

1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
3. A strong desire for the primary and/or secondary sex characteristics of the other gender.
4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender) (American Psychological Association 2013:452).

The criteria outlined helps construct a narrow understanding of what trans means (Vipond 2015). Other indicators include that trans patients believe that they were born in the wrong body, that they identify as a binary gender identity, and that they identified as the same gender since a young age (Johnson 2016; Vipond 2015). Also, the indicators above suggest that trans and non-binary people cannot exhibit both masculine and feminine behaviors or like both masculine and feminine things. See, for example, the indicator to reject toys that associate with one's assigned

gender at birth. Together, the medical model of trans identity constitutes a transnormative conceptualization. Transnormativity "...is a hegemonic ideology that structures transgender experience, identification, and narratives into a hierarchy of discourses" (Johnson 2016:466). Because it is disseminated through the media (Johnson 2016), it (mis)informs people on who counts as trans. When trans people go to mental health professionals for access to gender-affirming healthcare, they must supply narratives that convince providers that they are trans (Davis et al. 2016). Embedded in the narratives are indicators, some of which are mentioned above, that frame being trans as a problem (Johnson 2016:804). Medical providers look for trans people to regurgitate transnormative narratives for access to gender-affirming healthcare (Spade 2003). Thus, trans people must ultimately reinforce the same medical model that problematizes being trans in order to get the care that they seek (Vipond 2015).

Changes have been made to help remedy these problems. For example, the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) lists gender dysphoria, instead of gender identity disorder (Johnson 2015:803). Furthermore, it acknowledges that more than two genders exist and that dysphoria is the problem, not identity (American Psychiatric Association 2013:451). Another text, the *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People*, which provides guidelines for mental health professionals to meet trans people's health needs, no longer recommends that trans people be diagnosed with gender dysphoria before receiving access hormones (Davis et al. 2016:510). However, it still requires that a mental health professional conduct an assessment (Davis et al. 2016:510). Also, mental health professionals do not always adhere to either document. Medical providers do not need to listen to the SOC-7 because the document is non-binding. In addition, some providers ignore DSM protocol when it conflicts with their experiential knowledge (Brown



1987). This finding is important because providers' knowledge about trans healthcare comes mostly from experiences with trans patients. As a result, mental health professionals who have had few if any trans patients may still use outdated practices that restrict access to hormones and surgery. The data I collected suggests that this phenomenon is still common.

As of now, much literature on how trans people are medicalized focus on doctor-patient interactions. However, over the years, insurance and pharmaceutical companies have acquired an increasing amount of medical authority and today, are more powerful than doctors themselves (Conrad 2005). Doctors are still gatekeepers, though (Conrad 2005). Yet, without state laws in place, insurance companies can continue to refuse to cover transition-related services, and with laws in place, companies still refuse. Since a disproportionate percentage of trans people are low-income (Gehi and Arkles 2007:10), any service that falls under gender-affirming healthcare can be financially unaffordable. In several states, including California, Oregon, Massachusetts, and Connecticut health insurance companies are required to provide coverage for gender-affirming healthcare (Molloy 2013; Fox 2014). That being said, there is no guarantee that insurance companies comply with nondiscrimination laws: in 2016, a trans person sued their insurance agency in California because it refused to cover gender-affirming healthcare. (Hedden 2016).

Even so, some doctors may want to collaborate with patients to coordinate patient-centered treatments (Dewey 2013). When doctors sense that patients do not judge them, doctors take on a more authoritative approach (Dewey 2013). Other times, doctors employ a question-answer format to interviews, directing conversations with little room for patients to share what they think is important (Mishler 1982). In other words, patients might not get the quality care they paid for, particularly when they possess knowledge that is important to decision-making processes.

All in all, various institutions and actors collectively regulate trans bodies, that is various policies and practices determine which trans people may transition medically through a standardized medico-legal process. Foucault (1978/1990) explains that since the 1800s, medical providers have regulated sex by producing discourses of truth. These discourses become dominant, and they determine how sex is performed and for what function (Foucault 1978/1990). Thus, medical providers exercise power through what becomes a multiplicity of discourse (Foucault 1978/1990:32).

Foucault's (1978/1990) repressive hypothesis can be used to better understand non-binary people's healthcare access. During doctor-patient interactions, patients must confess information about their gender. The doctors, the listeners, then tell their own truth about the patient's truth (Foucault 1978/1990:69). In other words, transnormative scripts constitute the discourses used by medical providers to determine *their* truth about their patients' gender (Davis et al. 2016; Vipond 2015). I use Foucault's repressive hypothesis to examine how multiple actors, not just medical providers, use dominant discourses on non-binary people in ways that affect their access to gender-affirming healthcare.

I find that whereas dominant discourses are expressed in healthcare settings with medical providers as a medium, alternative discourses are presented via the Internet. In fact, the Internet repeatedly came up as a way for non-binary people to contact other non-binary people for information on how they could transition in a way that satisfied their needs. Furthermore, I find that non-binary people can internalize dominant discourses and then use these discourses to either invalidate other non-binary people's gender identities or justify delaying their own care.

## METHODS

For this study, I collected secondary interview data from texts created by non-binary people as they medical transitioned or sought access to gender affirming healthcare. Texts include one academic article, one magazine article, two blog posts, and four YouTube videos. Initially, I had planned to review only written pieces. However, the small amount of published research on non-binary people in the United States is low made finding scholarly literature on the topic difficult. Finding non-academic written sources was also a difficulty. Interestingly, using the *Sociological Abstracts* database, most academic sources I came across that focused on non-binary people were published in the United Kingdom, but they were not necessarily focused on healthcare. A professor referred me to the web site where I found the blog posts. Because written work on the topic is scarce, I eventually referred to YouTube, since videos on the topic are more abundant. Most authors and all video publishers, were white. One author was Chinese.

It was important that I used information provided only by non-binary people. The first step to understanding a social group's experiences is to talk with them (Namaste 2000; Smith 1987), so information from cis authors describing trans people's experiences was ignored. Although sometimes, people's perceived experiences do not match reality (e.g. white men who say they are oppressed for being white; women who deny that patriarchy exists), it is still vital to socially locate respondents in their social world (Namaste 2000; Smith 1987).

The problem with using cis people as a medium through which to learn of trans people's experiences is that cis people interpret data through a cis normative lens. Psychiatrists, feminist theorists, and anthropologists have a tendency reduce trans people to patients, examples, and natives, respectively (Wilchins 1997:21–22), and they do so from the social positions that they occupy (Smith 1987). Sociologists are not immune, either. Sharing that trans people are “post-

opt” and including deadnames are just some of the cissexist practices that sociologists have adopted (Johnson 2015). At first, trans people’s experiences were studied not to learn about trans people but to learn more about gender (Serano 2007; Schilt and Lago 2017). Garfinkel (1967) and West and Zimmerman (1987) are notorious for this practice. Both parties reduce Agnus to an example and objectify her by treating her as if she were being examined in a lab through a microscope. Their analyses on gender performances also come into conflict with trans people’s lived experiences: trans women who “pass” as women need not do femininity to be accepted as women, and there are cis people who refuse to grant trans women cis privilege, regardless of their gender performances (Serano 2007).

Studies on trans people’s experiences must be important to trans people (Namaste 2000). Studies on marginalized people should also be verified by the population under study (Collins 1990). However, many studies on trans people, they align more with Seidman’s (1991) description of a sociological theory. Even if the studies are not themselves sociological, the purpose is based more in the curiosity of academics who wish to share their finds with other academics (Seidman 1991). On the other hand, social theories are meant to be shared with members of oppressed groups in order to provide them with knowledge to use to address social inequalities (Seidman 1991). I provide this information not so much to criticize past studies but to present a guiding principle for this study and future studies: research on trans people should be seen as important to trans people and should be primarily for their benefit.

Experiences must be analyzed as part of a larger process to map the ontological relations between non-binary people and the rest of the social world (Smith 1987). Furthermore, interactions inside medical settings between doctors and trans patients have already received much attention (see Spade 2003; Dewey 2008; Dewey 2013), so I made sure that, in addition to

these interactions, I look at factors outside these settings as well. Factors outside the medical setting help constitute the experiences that non-binary people and trans people go through, including structural factors. For example, James et al. (2016:99) finds that 45 percent of trans people travel up to 10 miles from their home to receive transition-related care and that trans people are three times more likely to travel over 50 miles for transgender-related care than for routine care. Long distances can make trans people less able to see doctors for gender-affirming healthcare.

The data I collected focused more decision-making processes and discourses than on structural factors. For example, one aspect I thought would be mentioned more often was transportation due to data from the *The Report of the 2015 U.S. Transgender Survey*. Anything concerning insurance or financial matters were also not mentioned. This absence is a surprise because a lack of insurance coverage is cited as one reason why many trans people do not have access to gender-affirming healthcare (Dewey 2008; Spade 2010). That being said, many authors and videographers at some point did not know much about whether transitioning would be possible or what it would look like and turned to the Internet for help. Thus, one finding was that, whereas transnormative discourses are disseminated through movies and television (Johnson 2016), more expansive discourses were present online.

Lastly, this study is meant for a trans and non-binary audience. Therefore, I refrain from providing a trans 101 lesson in this paper. The one exception is that I define what non-binary means because there are even trans people who are not aware of or do not understand what this term means. I recommend to cisgender readers who have questions about non-binary gender identities to look at the legion of texts and videos on the Internet. The abundance of publicly available information that addresses rudimentary questions about trans and non-binary people

warrants that I do not expend time or energy iterating what others have already said countless times.

## **FINDINGS**

Inside medical settings, both doctors and staff acted as gatekeepers. If patients could get to the doctor, their doctor either determined access based on how close they approximated a Transnormative trans person or utilized a more patient-centered approach. Some authors and videographers delayed seeking care. Prior to deciding to seek access to gender-affirming healthcare, authors and videographers gathered information from other trans and non-binary people who already acquired access. Oftentimes, the internet was a source to collect information. As they collected more information, they became more willing to seek care. Other factors that prolonged seeking care were internalized trans normative discourses and a concern over hormonal effects on the body and of having to explain their decisions to family members.

### *Denial of Care in Healthcare Settings*

Despite revisions in medical texts and increased attention of non-binary people and identities in the media, there are still medical staff with a gender binarist understanding of gender. Merkel recounts when they were denied care because they were a non-binary trans person. When they requested testosterone, their endocrinologist responded that “unless [Merkel] ‘wanted to be a man,’ he would not prescribe [them] hormones” (Merkel 2017:43). Merkel had to come back for a second visit and lie to get the care they needed. His ultimatum kept intact the medical understanding of trans identity. Merkel had to reproduce, to use Foucault’s term, what

has become a discourse of truth of trans bodies in order to get access to gender-affirming healthcare.

Medical staff were also complicit in denying Merkel care. When Merkel visited the clinic to learn how to self-inject, the receptionist clocked her. “Oh no, we can’t help you with that”, she said without an explanation. Thus, even if doctors are willing to provide access to gender-affirming healthcare, staff can still act as gatekeepers and intervene. This observation is important because even if doctors are trans-friendly, their staff can prevent trans and non-binary patients from even reaching them.

Celeste had a different experience than did Merkel. Responding to a question posted by a commenter, Celeste M (2017) elaborates that:

When I went in to see the doctor for the first time, I asked if he knew what nonbinary meant. He seemed familiar with the term but not necessarily what it meant exactly, so I just explained my particular goals to him and that I wanted to take a low dose for a temporary period. My doctor happened to be pretty chill about things and took the approach of it being my transition so I should be able to guide things.

Celeste (2017) adds that “not all doctors are like that”. Their experience is different because their doctor provided a more patient-centered approach. Celeste had some control over how fast they would acquire access. Yet, one of the authors, Chang (2017), who is a genderqueer psychologist and educator, reveals that Merkel’s experience is more representative than is Celeste’s:

Although the SOC7 made a significant departure from previous versions of the SOC in that it no longer *requires psychotherapy* prior to approval for transition-related or gender-affirming medical interventions, it still places the mental health provider in a gatekeeping role.

Chang (2017) confirms that medical providers still act as gatekeepers and that they use gender assessments to determine the “appropriateness and readiness for care”, and it “often

involves a detailed gender history”. What Chang (2017) says also suggests that the effects of updated medical texts are small and that trans and non-binary patients are still treated as objects of study and must continue to provide confessions for access to care. However, whereas Foucault (1978/1990:66–67) attests that scientists use confessions, not to test patients, but as signs to produce discourses of truth, medical providers use non-binary people’s confessions as part of an evaluation, and patients are the test-takers.

### *Consequences of Internalizing Dominant Discourses*

Many authors and videographers delayed seeking care for various reasons: they did not think they were “trans enough”, were concerned over the bodily effects, or had an aversion toward having to later explain to family members their reason for transitioning or their gender. For example, Micah (2014) writes that they “frantically questioned” whether to get top surgery. For some time, Jamie Richards (2015), one of the videographers, delayed care because they did not know what they would say to their grandmother.

Although authors at some point had doubts of not being “trans enough”, they also expressed a strong desire of bodily autonomy. They wanted to decide if, when, and how they medically transition. Their prerogative over their body, identity, and more broadly, life outcomes, was repeatedly cited as a reason to transition. To Ashley (2016), transitioning is a way to claim ownership over a body with which they feel comfortable. For Celeste M (2017) wanted to be make the choices that they wanted to make while they still could.

I’m like 35 years old, so I just feel like this is my life and you know, I’ll probably only get one life, so my curiosity, my interest, and what I feel like—I felt like I would be much more likely later on to regret not trying this and not seeing what happens and not sort of satisfying my curiosity...



Furthermore, several videographers explained that they wanted to transition slowly in order to better control the hormonal effects on their body. Bodily agency is not limited to having the sole prerogative over whether to transition; it also encapsulates controlling biological processes. At some point, their desire to transition was more influential than any doubts that had earlier delayed care.

### *The Internet as a Source for Alternative Information*

Some respondents did not know much about whether gender-affirming healthcare was a possibility for non-binary people until they found information on the Internet or talked to other trans or non-binary people who had transitioned medically. In fact, in the comments section of written sources and videos were dialogues between non-binary people where they answered one another's questions or shared experiences. When Celeste talked about their first appointment with their doctor, they were responding to a comment made by another non-binary person who had watched their video and wanted to know more about their experience. In their video, Celeste (2017) explains:

I knew a little bit about [T] from some things that I had read, but I didn't know kind of all the details or really hadn't heard that many different people's experiences, just a couple. The more people's experiences that I heard of—of taking testosterone, either low-dose or short term or just anything other than the usual ...like... FTM path of fully transitioning to presenting as male...like the more I read of that, the more interested I was in the idea even though there were certain effects that I really did not want and still do not want...

In addition to reading blog posts and watching You Tube videos, other web sites provided the information that authors and videographers sought. Ashley (2016) recalls:

...the first time that I really understood that dysphoria was a part of my life was around a year ago [2015] when I came up with the Gender Tag Project. While I was researching for the project, I came across [a] little paragraph of information on a website called "nonbinary.org...Prior to that, I had thought that dysphoria meant you want your breasts

removed, you want your penis removed, you want a penis constructed, you want all of these very specific physical characteristics to be changed...

Ashley (2016) explains that because their dysphoria was not linked to surgical intervention, they thought that their dysphoria was not “real”. Coming across the website changed their viewpoint. Ashley’s (2016) prior understanding of gender dysphoria speaks to the narrow construction perpetuated by the media of what gender dysphoria looks like. TV shows and films rarely display non-binary people. From the Internet, they were able to learn that their dysphoria does not fit within a transnormative narrative in order to be valid.

Other trans and non-binary people do not know much about whether and how non-binary people transition. Cam, who commented on Micah’s (2017) article that trans people and other genderqueer people in their social circle did not understand why, they, a genderqueer person would medically transition (Micah 2014). To their peers, only trans men and trans women seek access to gender-affirming healthcare. Cam’s experience indicates something else though: non-binary transition was used as an overriding indicator to invalidate their identity. Research from the 1990s reveals that even in trans communities, transnormative trans people are seen as more trans than those who do not fit the medical model of trans identity (Johnson 2015:807). Cam’s experience means that there are still trans and non-binary people who internalize the dominant discourse on how counts as trans and supports findings from the 1990s that even trans and non-binary people use one another’s gender history to evaluate the validity of one another’s gender identities.

### *Debunking Myths*

Several authors wished to debunk false notions of trans people and gender-affirming healthcare. By debunking myths, as Micah (2014) called them, these authors challenge transnormative

discourses. In other words, each provides an alternative consciousness. Like with other articles and videos that I reviewed, their messages were meant for non-binary audiences. For example, Chandler (2017) thought it necessary to notify their audience about two misconceptions about non-binary people:

I'm going to talk about a misconception that non-binary people never experience dysphoria or body dysphoria in particular, which 1) you don't need body dysphoria to be trans and there are lots of binary trans people who don't have body dysphoria and 2) a lot of non-binary people can have gender dysphoria.

Other falsehoods perpetuated by the medical model on trans people were also dispelled. In an interview with Joshua Ferguson (2017), Jeffrey Marsh remembers that "I used to think I needed to appear to 'have it all together' and craft a narrative about a non-binary childhood and how I've always been non-binary. But that's not true". Here we see that there are non-binary people who are aware that the dominant discourses that medical providers reproduce and force trans and non-binary people to reproduce are not accurate. They want other non-binary people to be informed on what is actually possible for them.

## **Conclusion**

Foucault's repressive hypothesis helps us understand how medical providers engage with non-binary patients. There are still medical providers who expect their patients to provide information that is irrelevant to determining whether they need care but helps providers determine if their patients fit a transnormative understanding what trans means. However, whereas scientists demanded confessions from those who marginalized sexualities in order to produce discourses of truth, medical providers use indicators outlined in the DSM as an evaluation and ultimately maintain a discourse already in existence.

Outside medical settings, some non-binary people delay their own care for various reasons: including believing they are not trans enough and either having a concern for the effects of hormones on the body or of how they have to explain what could be private or confusing information to family. Where Foucault 's theory is most useful here is with the first reason. There were authors and commenters who doubted whether they should seek care because they had internalized the medical understanding of trans identity. According to this understanding only people with binary gender identities can be trans, and most information on gender-affirming healthcare are for this population, including through mainstream media outlets. Thus, non-binary people need to gather information from other sources on whether they are even able to medically transition and how that process will occur. Repeatedly, authors and videographers expressed that they had to resort to the Internet or talk to other non-binary people to acquire information. As they learned more, they became more willing to seek care. In short, the Internet serves as a virtual space where an alternative consciousness is produced. This finding becomes clearer with the fact that many authors and videographers took at least some time to dispel misconceptions about non-binary people's access to gender-affirming healthcare.

Also, future research should look at the experiences of black, brown, and poor non-binary people. Among my sample, no one talked about how medical care was paid for. Two people talked about how transportation was an issue. Research on non-binary people of color or of low-income can reveal more about how structural factors affect access. Such research has the potential to lead to policy reforms to expand access, specifically in states where non-binary is already acknowledged as a legal gender.

To address the lack of information that many non-binary people have about gender-affirming healthcare options, hopefully centralized sources, such as websites, can be created. The

website [mytranshealth.com](https://mytranshealth.com) already locates trans-friendly doctors and similar websites could help non-binary people navigate medical processes for access to gender-affirming healthcare.

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