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## Social Transition, Coming Out, and Challenging Transnormativity: Non-Binary Experiences in Healthcare

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**Social Transition, Coming Out, and Challenging Transnormativity: Non-Binary  
Experiences in Healthcare**

by

Drew Burchell

B.Sc. Psychology and Environmental Science, Dalhousie University, 2018

THESIS

Submitted to the Department of Psychology in partial fulfilment of requirements for Master of  
Arts in Community Psychology

Wilfrid Laurier University

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### **Abstract**

Transgender and non-binary individuals are highly stigmatized in North America, and this has staggering adverse effects on their physical and mental health. This stigma is structured and driven by cisnormativity and transnormativity, ubiquitous sets of social rules that determine “right” and “wrong” ways to do gender. Non-binary people experience excess stigma from cisgender (i.e. not transgender) people for “deviating” from the rules, but also from within the transgender community for not adhering to medical and binary definitions of transness. Specifically, non-binary people may choose not to transition medically, but very little research has been done on this. A sample of 12 non-binary participants was selected from a larger qualitative study about transgender experiences of discrimination. Interviews about healthcare experiences and thoughts on transition were thematically coded. Themes emerged relating to transnormativity, transition (medical and social), and coming out in healthcare environments. Participants felt pressure in medical settings to adhere to the gender binary and transition medically. However, many participants chose not to transition medically or desired to “mix and match” their medical transition. Social transition was important for most participants, including changing name, pronouns, and gender expression. In medical settings, participants were constantly assessing cues of safety in weighing their decision to come out as non-binary to their provider or not.

**Keywords:** Transgender, non-binary, healthcare, medical transition, social transition, transnormativity, cisnormativity, stigma

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### **Overview and Context of the Document**

This document is made up of two major parts. The first part is my Master's thesis proposal, written before data collection and analysis. The second part is a publication-style manuscript written after data collection and analysis, including my findings and implications. You can skip to page 26 if you'd like to read just the final document. The proposal will directly follow this statement.

You may notice a discrepancy between the two documents. The proposal aims to explore the experiences of non-binary people in healthcare settings, including access, resilience and resistance, and general positive and negative experiences. The final manuscript has slightly different objectives: to examine experiences of transnormativity and coming out in healthcare settings, and to explore what transition means to non-binary people in this context. To explain this change, it's easiest to share some things about myself and my experience.

I am a non-binary master's student. As a non-binary person, social transition was and is important and life-changing for me. Naturally, when I was deciding on a topic to research with the trans and non-binary community for my thesis, I had passion for the topic of social transition. However, my supervisor wanted to make my master's project as easy for me as possible, so he advised me to research a topic that fit into a study that was already funded and going to be conducted that year. This existing project had three domains: community inclusion, employment, and healthcare. I chose non-binary healthcare experiences as my thesis topic, as this seemed to be both important and topical. However, as I conducted interviews with non-binary individuals about healthcare, social transition naturally bubbled up into conversation, as my intuition and lived experience predicted. Participants spoke about their journeys finding themselves and their identities through social, rather than medical, processes. Participants also discussed the pressure

on them to be trans in the “right” way. I wanted my results to authentically show these perspectives, and this caused me to shift direction in my research.

I have since realized that many of the “research dollars” in the field of trans research are in healthcare. That is, people doing health research with the trans population may be more likely to be funded than say, a researcher doing a project on social transition or non-binary identity. This high-level research trend trickles down to the level of student projects at universities and this could be part of the reason my initial research passion seemed “off the table”. The strong healthcare focus in research is partially because access to gender-affirming healthcare is an important, life-saving thing for many trans people. But this focus also comes from a historic tradition of researchers and practitioners medicalizing the lives and bodies of trans people. In my final document, I wanted to speak to this medicalization, and bring a critical perspective on why non-binary and non-medical narratives are not as often heard.

**Abstract**

Transgender and non-binary individuals are highly stigmatized in North America, and this has staggering impacts on their physical and mental health. However, structural and individual stigma in the healthcare system leads trans and non-binary individuals to avoid necessary healthcare. Some healthcare providers espouse transphobic attitudes, and many lack education and knowledge to treat trans patients. In addition, the healthcare system has structural barriers that prevent the proper care of trans and non-binary people. Specifically, non-binary people are unique from binary trans people in theoretical and practical ways, and experience worse health outcomes for some measures. The proposed research is nested within a qualitative study of the discrimination and victimization of trans people in Ontario. This study follows Trans PULSE, a large quantitative study in Ontario which collected key statistics on the health of transgender people in the province. Qualitative research is needed to learn more about the unique healthcare experiences of non-binary individuals, as well as the providers that treat them. This research is in partnership with the Crime Prevention Council, who seek to use the data to inform systems and policy change.

*Keywords:* non-binary, transgender, trans, healthcare, stigma, discrimination

## **Resisting Stigma, Resisting Conformity: The Experiences of Non-Binary Individuals in Healthcare**

### **Transgender, Non-Binary, and Two-Spirit**

“Transgender” (short form: trans) is a word used to describe a person “whose gender identity or expression varies from their sex assigned at birth” (Scheim et al., 2017). It is an umbrella term encompassing many different gender identities. Trans people are the T in LGBTQ2S+ (Lesbian, Gay, Bisexual, Trans, Queer, Two-Spirit, and more). “Non-binary” is “an umbrella term that encompasses any gender identity outside of the binary construct of girl/woman or boy/man” (Goldhammer et al., 2018). This umbrella term also includes many gender identities including agender (no gender), genderfluid (gender identity fluctuating over time), bigender (having two genders), genderqueer (synonym for non-binary), transfeminine (a gender leaning toward female), and transmasculine (a gender leaning toward male), among others. Not all non-binary people identify as transgender, but for the purposes of this paper, I will include non-binary people under the umbrella of transgender people, as is done in much of the literature about this population.

A study in 2016 estimated that trans people make up 0.6% of the U.S. population (Flores et al., 2016). This is likely a low estimate, as many trans people may not be comfortable coming out in an interview with a stranger. Even so, 0.6% would mean that almost 2 million people in the U.S. are trans. In addition, as awareness spreads about what it means to be trans, it is likely that more people will begin to use the label for themselves, and this number will rise. A national survey of the trans population in the U.S. found that 31% of their sample of trans people identified as non-binary (James et al., 2015).

It is also important to note that non-binary gender is not a new or solely Western concept, as many cultures around the world have a third gender category, such as the Polynesian Fa'afafine (Poasa, 1992) or the Indian Hijra (Hossain, 2012). In particular, North American indigenous peoples have many words in their languages to describe those who are not straight or cisgender (to use Western terms; Egale Canada Human Rights Trust, 2016). One of these words, “niizh manidoowag”, translates to “two spirits”- a person who has both a male and a female spirit. Two-spirit people were traditionally important spiritual figures in indigenous societies, however, European colonization disrupted this practice when the gender binary was imposed through violence (Brotman, Ryan, Jalbert, & Rowe, 2002; Smith, 2010). Colonizers referred to men who occupied feminine gender roles as “Berdache”, or “kept boy” in French (Them, 2018). This term is now widely viewed as pejorative, and coining “two-spirit” was an act of self-determination to reclaim LGBTQ2S+ identity in indigenous culture. It is now an umbrella term that many indigenous LGBTQ2S+ folks use to describe themselves. This complex history and deep cultural meaning of the term means it is not easily collapsible into any particular western LGBTQ+ identity. Those who identify as two-spirit may or may not also identify as transgender or non-binary. Most large quantitative studies on trans people include two-spirit people who identify as trans as part of their sample. Not all of the studies in the following review gave information on whether non-binary and two-spirit people were included, but it can be assumed that those non-binary or two-spirit people who identified as trans were part of these studies.

### **Stigma Theories and Application**

Stigma can be defined as “the co-occurrence of labeling, stereotyping, separation, status loss, and discrimination in a context in which power is exercised” (Hatzenbuehler et al., 2013). Hatzenbuehler et al. (2013) explain that stigma is a broad concept that includes both individual

and structural discrimination. In contrast to this rather broad definition, Parker & Aggleton (2003) draw on the writings of critical theorists to conceptualize stigma as a systematic devaluing of differences, which functions to create and maintain power structures. Stigmatization is a tool for inserting people into these power structures, and identity is highly implicated in this. Parker and Aggleton (2003) outline three types of identities: legitimizing identities (introduced to rationalize domination), resistance identities (identities created by stigmatized people), and project identities (new identities built to transform social structures). Phelan, Link, & Dovidio (2008) echo some of these arguments by writing that stigma serves a purpose in society: to keep people down (domination), keep people in (conformity), or keep people away (avoidance of disease).

When combined, these theories of stigma are highly applicable to the ways trans and non-binary people are stigmatized in Western society. Trans people are stereotyped as mentally ill and confused, and labeled as “odd” or “outcasts” (Gazzola & Morrison, 2014). Trans people experience individual discrimination such as harassment and assault, and structural discrimination such as denial of employment and housing (Grant et al., 2010). The stigmatization of transgender people functions to “keep people in”- that is, make sure individuals conform to a strict gender binary, and this binary serves to “keep people down”- to use gender as the foundation of a hierarchical power structure that facilitates white male domination. Smith (2010) writes that a heteropatriarchy (i.e. a society that is founded on male dominance) relies on the gender binary as a tool to enforce this dominance. We also see identity as a key part of the LGBTQ2S+ revolution, with the very acronym serving as evidence of this. The legitimizing identity is the straight and cisgender identity, while those who are stigmatized create resistance identities like non-binary. Further, “queer” could be seen as a project identity- it reclaims a slur

and is not only a sexuality or gender identity but also a political identity. Individuals use queer to mean they are critical of and seek to dismantle the power structures that made queer a slur in the first place (Rand, 2014).

Hatzenbuehler et al. (2013) states that stigma is a fundamental cause of health inequalities, in that it remains persistently associated with these inequalities over time. Health inequalities can only be solved by going to the source of the issue—stigma—and not by addressing the mechanisms between stigma and health (Link & Phelan, 1995). However, it is still illuminating to discuss the mechanisms that link stigma to health. Hatzenbuehler et al. (2013) outline four main mechanisms: resources, social isolation, psychological and behavioural responses, and stress. In the following sections, I will apply this framework to transgender stigma using empirical evidence from the literature.

### ***Resources***

Financial, educational, social, and status resources are powerful determinants of health (Link & Phelan, 1995). Being of low socioeconomic status and having limited access to resources creates stress, which in turn is associated with negative health outcomes (Link & Phelan, 1995). Despite being more highly educated than the average citizen (Bauer & Scheim, 2014) transgender people in North America live in extreme poverty (Grant et al., 2010). An Ontario survey found that half of trans respondents had a personal income of less than \$15,000 annually (Bauer et al., 2010). This disparity between education and income is evidence of severe underemployment. Trans people experience underemployment at twice the average rate (Grant et al., 2010), are fired or not hired for being trans (Bauer et al., 2011), and overwhelmingly experience on-the-job harassment or mistreatment (Grant et al., 2010). Grant et al. (2010) also found that respondents who had lost a job due to transphobia or were currently unemployed were

more likely to be HIV positive, to smoke or drink, and to attempt suicide. Some trans people also resort to sex work for income, and this is a risk factor for HIV (Grant et al., 2010).

Unemployment is also linked to homelessness; a U.S. survey found that one-third experienced homelessness at some point in their lives (Grant et al., 2010). Additionally, trans people experience housing discrimination, and have half the rate of home-ownership as the general population (James et al., 2015).

### ***Social isolation***

Trans people experience high rates of violence, harassment, and assault (James et al., 2015). They also experience rejection from family members upon coming out (Grant et al., 2010; Yadegarfar, Meinhold-Bergmann, & Ho, 2014) and high rates of intimate partner violence (James et al., 2015). In an Ontario survey, 42% of respondents reported moving away from family or friends because of their gender identity (Luu et al., 2017). Many trans people have been part of a faith community, but left because of fear of rejection or actual rejection (James et al., 2015). These may all be reasons that trans people report low levels of social support (Boza & Nicholson Perry, 2014; Maguen, Shipherd, & Harris, 2005). This, in turn, can be a risk factor for negative health outcomes, such as depression (Boza & Nicholson Perry, 2014; Rotondi, 2012), anxiety (Pflum et al., 2015) and suicide (Yadegarfar et al., 2014).

### ***Psychological and behavioural responses***

In addition to the depression and anxiety aforementioned, other psychological and behavioural responses to stigma include internalized transphobia, using substances to cope, and suicidal ideation and attempts. Internalized transphobia is linked to lower self-esteem (Austin & Goodman, 2017) and lower perceived effectiveness of coping skills (Mizock & Mueser, 2014). To cope with internal and external transphobia as well as mental illness, trans people may use

substances to cope, such as drinking and smoking (Burgess et al., 2007). Trans youth are more likely than cisgender youth to engage in risky sexual behaviours, to self-harm, to consider suicide, and to attempt suicide (Eisenberg et al., 2017). A large U.S. survey found that 41% of respondents had attempted suicide in their lifetime, whereas the national average was 1.6% (Grant et al., 2010).

### ***Stress***

Minority stress theory (Meyer, 1995; 2003) posits that individuals in a minority group experience excess stress due to the stigmatization of their minority status, and this stress causes negative health outcomes. This theory has been applied liberally with the LGBTQ2S+ population. There is empirical evidence for mental distress caused by experiences of discrimination, expected rejection, internalized homo/transphobia, and concealment (Kelleher, 2009). These same factors are linked to depression and suicide in trans people (Tebbe & Moradi, 2016). These studies show minority stress as a relatively individual process, and it's important to remember that all of the aforementioned discrimination can result in minority stress, including structural discrimination. In addition, the focus on the link between stress and negative health outcomes can be myopic in the literature. As Link & Phelan (1995) discuss, the social circumstances that create stress must be considered and action must be taken to eliminate these circumstances in order to address health inequalities.

### **Stigma and Discrimination in Health Care**

The previous sections have outlined in detail how stigma and discrimination put trans people at high risk for negative mental and physical health outcomes. These outcomes mean that healthcare is vitally important for trans people. Healthcare is also important for the purpose of physical transition, which is life-saving and life-improving for many trans people (Bauer,

Scheim, Pyne, Travers, & Hammond, 2015; Hess et al., n.d.). Of course, the healthcare system itself is not immune to stigma and discrimination, which manifest structurally and individually.

Structurally, trans people are twice as likely as their LGB counterparts to be denied care, and are more likely than the general population to lack health insurance (Kcomt, 2018; Sperber, Landers, & Lawrence, 2005). About a quarter of trans patients who seek health coverage for hormones are denied, and this rate rises to over half for surgery (James et al., 2015). These may be reasons that trans people report less availability of healthcare services in their community, and are much more likely than their cisgender (i.e. not transgender) counterparts to report an unmet healthcare need in the past year (Giblon & Bauer, 2017). Trans Ontarians are also less likely than the general population to have a family doctor, and this may be predicted by other types of structural discrimination, such as lack of housing (Scheim et al., 2017).

On the topic of individual discrimination, there are troubling statistics on the way trans patients are treated by their physicians. A review by Kcomt (2018) found that 20-50% of trans people had to educate their healthcare provider on proper care. Trans people also report health care professionals using abusive language, and even being physically abusive (Grant et al., 2010; James et al., 2015; Kcomt, 2018; Shires & Jaffee, 2015). This causes trans people to avoid or postpone necessary healthcare, and use substances to cope (Kcomt, 2018; Reisner et al., 2015).

### **Intersectionality**

The first writing on intersectionality by Crenshaw (1989) was a commentary on the ways black women are erased from civil rights movements, with feminism focusing on the struggles of white women, and the black liberation movement centering black men. Activists have applied the concept of intersectionality to other forms of identity, including LGBTQ2S+ identities. To

apply it here is to acknowledge that trans people of colour experience unique and often compounded effects of stigma. For example, in the U.S., black and indigenous trans women are more likely than their white counterparts to have experienced arrest or incarceration, and were more likely to be profiled as sex workers by police (James et al., 2015). Trans people of colour also experience more discrimination in the workplace, and are more at risk of HIV than white trans people (Grant et al., 2010). Indigenous trans women and trans women of colour in Ontario are less likely to have a family doctor than white trans women (Scheim et al., 2017), and trans people of colour are also more likely to be refused care (Grant et al., 2010). In addition, two-spirit people occupy a unique space in terms of stigmatization; they may be excluded from their indigenous community for being LGBTQ2S+, rejected from the LGBTQ2S+ community for being indigenous, *and* stigmatized in mainstream society for being LGBTQ2S+ and indigenous (Brotman et al., 2002). It will be important in this study to examine the intersections of LGBTQ2S+ identity and race, as well as other traits that are stigmatized such as age, income, ability, body size, and others.

### **Resilience and Resistance**

While stigma causes some trans people to avoid or postpone healthcare, a significant portion (76%) of transgender people do succeed in accessing healthcare to meet their transition needs (Grant et al., 2010). Many studies on trans discrimination comment on the “resiliency” of trans people. Most definitions of resilience frame it as positive adaptation in the face of adversity (Wilder, 2018). In the framework of minority stress, resilience buffers the link between stress and negative health outcomes (Breslow et al., 2015). In recent research on resilience, there has been a move away from individual traits and more focus on environmental factors. Runswick-Cole & Goodley (2013) propose that there are resources individuals can draw on in order to help

them express resilience, such as relationships, material resources, social justice, power, and identity (Figure 1). Indeed, many of the more recent studies on resilience examine factors like community connectedness, pride in identity, social support, activism, and collective action (Breslow et al., 2015; Wilder, 2018; Frost, Fine, Torre, & Cabana, 2019). These factors of resilience could easily be classified under resistance as well. Case & Hunter (2012) define resistance as “the concerted efforts of marginalized individuals to change oppressive conditions and/or not be changed by those conditions”. These authors also name coping, resilience, and resistance as different conceptualizations of essentially the same process, terming this process “adaptive responding”. When faced with discrimination and stigma, transgender people may cope individually, use the resources around them to express resilience, or choose to resist through action and protest. Figure 2 shows my interpretation of the literature thus far in the form of a diagram.

### **Healthcare Providers**

Seeking to make transformational change for non-binary people in the healthcare system relies on more than just their individual perspectives. The perspectives of healthcare providers play a key role. Examining the literature, there appear to be three main problems: transphobic attitudes; lack of education; and structural problems in the healthcare system. Firstly, many healthcare providers are uncomfortable interacting with and treating trans patients, and showed evidence of transphobic attitudes such as shaming, blaming, othering, and discriminating (Poteat et al., 2013). A study on 268 nurses in the U.S. unearthed disturbing quotes where nurses referred to trans patients as “it”, admitted to laughing and joking about trans patients with colleagues in private, and felt that trans people often had mental illness stemming from their gender identity rather than from stigma (R. M. Carabez et al., 2016). This is obviously not the

case with all healthcare providers, as other studies showed more progressive attitudes and understandings (Snelgrove et al., 2012). Secondly, there is a pervasive lack of education on interacting with and treating trans patients, across all types of providers (Manzer, O’Sullivan, & Doucet, 2018; Unger, 2015; Schabath et al., 2019), and this reflects in their low levels of knowledge (Schabath et al., 2019; R. Carabez, Pellegrini, Mankovitz, Eliason, & Scott, 2015). Thirdly, there seem to be structural issues in the system. Snelgrove et al. (2012) discuss that providers do not know where to refer trans patients for specialized care, either because this care is not available or because the provider is unsure whether those professionals will be transphobic or not. Snelgrove et al. (2012) also discusses “two-gender medicine”, where a certain sex is required for certain procedures. For example, a clinic may not allow a woman to get a prostate ultrasound. This presents a structural barrier for both patients and healthcare providers.

It is important to consider all three of these issues together, rather than focusing solely on education. Stroumsa, Shires, Richardson, Jaffee, & Woodford (2019), who found that hours of formal or informal education on trans care was not associated with higher knowledge of trans care (e.g. pronoun use, hormone therapy, and gender-affirming surgeries). Transphobia, however, was negatively associated with knowledge of trans care. This shows that more education is needed, but education in itself is not enough to fix the issue.

### **Non-Binary as a Unique Subpopulation**

Although in all of the literature aforementioned, non-binary people are grouped in with the transgender population, there is evidence to suggest that their experiences are unique. Matsuno & Budge (2017) explain that non-binary people differ from binary trans people in a number of ways. Firstly, non-binary identity often does not fit the linear models commonly used

to describe trans people's lives and transitions, because many non-binary people do not transition "from one gender to the other". Secondly, non-binary people experience unique types of stigma: many non-binary people use "they/them" or other neutral pronouns which others are not used to using, leading to persistent and frequent misgendering; many spaces are designed in a binary way, such as public bathrooms, demographic information on paperwork, or even clothing stores; and microaggressions that their identity is not real due to their rejection of the gender binary (Matsuno & Budge, 2017). Harrison, Grant, & Herman (2012) found that compared to the binary respondents, respondents who wrote in their gender were more likely to be physically or sexually assaulted, to be harassed by police, and to be harassed or assaulted in K-12 schools due to gender bias. This excess stigma also leads to worse health outcomes, with non-binary people more likely to be HIV positive, to attempt suicide, to avoid necessary medical care (Matsuno & Budge, 2017; Harrison et al., 2012), to self-harm and to consider suicide (Clark et al., 2018). Non-binary individuals are less likely to seek hormone therapy, but those who do report more barriers to access (Clark et al., 2018).

Lykens, LeBlanc, & Bockting (2018) conducted a qualitative study with non-binary and two-spirit participants about their healthcare experiences. They found that non-binary individuals' providers often pushed a binary narrative in treatment, such as assuming the patient had genital dysphoria, or assuming they wanted to transition to the "other sex" medically. Some participants went so far as to "borrow" a binary identity for the purpose of treatment, or avoid treatment altogether. This clearly shows the way the non-binary experience is unique in a healthcare setting.

### **Gaps in literature**

Though the study by Lykens et al. (2018) is highly relevant, it is one of very few of its kind. Non-binary identity in colonial western society is relatively new and little research has been done on it, especially in the Canadian context. There is also no research done with healthcare providers that asks them specifically about non-binary people. In addition, much of the current literature on trans people is quantitative in nature. These statistics, while important, fail to answer “why?” and “how?” questions. How are some trans people successful in navigating a system that is structured against them? Why do some trans people choose to persevere through terrible experiences? I aim to address these questions with a unique subpopulation (non-binary individuals and their healthcare providers) in a unique context (the Canadian context; specifically, a small town in Ontario).

### **Research Questions**

The objective of my research is to qualitatively examine the healthcare experiences of non-binary people in Waterloo Region, Ontario. It will fill the gap in research on non-binary individuals in Canada’s healthcare system. My research questions are as follows:

1. What positive (i.e. empowering, affirming) and negative (i.e. discriminatory, invalidating) experiences do non-binary people have in health care settings?
2. Where do non-binary people draw resilience from (resources, social support, etc) in the face of adversity and discrimination in health care?
3. How do non-binary people use or relate to resistance (i.e. activism, protest) in the context of the healthcare system?
4. How do healthcare providers think and feel about working with non-binary people? What

are their attitudes?

5. What interventions are needed to make the healthcare system work better for non-binary people?

## **Methods**

### **Rationale for Qualitative**

As discussed above, large quantitative studies have been done on trans people in this region, and those results are detailed in the literature review. In addition to the fact that qualitative work allows us to ask different types of questions, it also facilitates participant empowerment. Qualitative research showcases the narratives and nuanced experiences of participants, and investigating these experiences can inform policy and system change. Trans people in our society are stigmatized, stereotyped, and seen as “others”, and using qualitative methods humanizes trans participants in a way that is sorely needed. It allows others to relate to their experiences and have empathy for this group, rather than seeing them as a statistic or a stereotype.

### **Nested Research**

My thesis project is nested within a larger project headed by Dr. Todd Coleman in Health Sciences at Laurier. The research team on this project includes Drs. Robb Travers, Simon Coulombe, Ciann Wilson, and Michael Woodford. In addition, these academics have partnered with the Crime Prevention Council, whose goal from this project is to better understand experiences of discrimination and violence against trans people in Waterloo Region in order to inform equitable policy change. Also collaborating is a registered social worker, Washington Silk, and a Community Psychology Ph.D. student, Charlie Davis, both of whom are advocates

for trans rights. This interdisciplinary team will ensure that the project is ethical, has practical policy implications, and works toward transformative change for the trans community. This research team will influence my research in my methodologies and the types of questions I ask, as they may have recommendations or a particular interest in a certain area. I will consult them in the generation of my interview guides and other major project decisions.

I am the student coordinator for this project, and I am working with a fellow Community Psychology Master's student, Emily Schmid. Lauren Munro, a Ph.D. student in Community Psychology, will be a mentor and guide to us, especially during the interview and data analysis phase. Emily and I are both trans and we will both be recruiting, conducting interviews, performing data analysis, and doing knowledge mobilization.

### **Participants and Recruitment**

The larger study will recruit 30 transgender participants in the Waterloo Region. Recruitment will cease when theoretical saturation is reached (i.e. additional interviews do not reveal new information and the theory is well developed; "Theoretical Saturation," 2004). The inclusion criteria are as follows: 1) participants must self-identify as being transgender, an umbrella term that includes trans women, trans men, non-binary individuals, two-spirit folks, genderqueer, genderfluid, agender, transmasculine, transfeminine, or any other identity that does not fit traditional masculine and feminine gender roles; 2) participants must live, work, or go to school in the Waterloo Region, which includes Waterloo, Kitchener and Cambridge; 3) participants must be over the age of 16. Trans participants will be recruited through flyers and ads put up in general public spaces as well as LGBTQ+ spaces (e.g. SPECTRUM, the LGBTQ+ safe space in Kitchener; The Rainbow Centre at Wilfrid Laurier). In addition, our collaborator

Charlie Davis is affiliated with the Rainbow Community Council (RCC), which has connections with several LGBTQ+ organizations in Waterloo. This connection, as well as other connections the research team has with local LGBTQ2S+ organizations, will be leveraged to find willing participants.

We will use a stratified sampling method (Robinson, 2014) to start, by using a screening survey to gather participants with diverse gender identities. The larger study will aim for a quota of about 10 non-binary individuals, 10 trans men, and 10 trans women, so as to explore the diversity of lived experiences. As many two-spirit people as possible who identify as trans will be recruited, and they will be asked which group they would like to be analyzed with- trans women, trans men, non-binary people, or if they would like to be considered as their own category. This will allow self-determination of each participant so they are not labeled in a way that doesn't fit for them. My thesis will focus specifically on the non-binary participants, and those two-spirit people who feel their identity aligns with being non-binary. Iterative theoretical sampling (Marshall, 1996) will be used. This means analysis will begin early and emerging themes and gaps will be determined, and based on this, new participants will be sampled in order to fill in gaps and inform the theory further. For example, if the first wave of participants is highly educated, but theoretically it becomes important to know the experiences of those with less education, people with less education will then be selected for by using the screening survey.

For the broader study, we will also recruit 10 stakeholders from service organizations who interact with trans people (e.g. health care, government, social services). Specifically for this study's data, at least three health care providers will be recruited. "Health care provider" is broadly defined for this purpose- it could be primary care, mental health, sexual health,

emergency care, endocrinologists, etc. As the trans population is relatively small and it may be difficult to find health care providers who are willing to be interviewed, snowball sampling will be used (Biernacki & Waldorf, 1981). That is, participants may be asked if they know anyone who would be willing to be interviewed. As this method may make the sample more homogenous, it will only be employed if there is difficulty reaching the quota of participants.

### **Paradigms**

The goals of my research are to create awareness and change in the healthcare system in order to benefit non-binary and trans people, and this aligns with the transformative paradigm (Nelson & Prilleltensky, 2010). The transformative paradigm is based in values of self-determination, empowerment, community, social justice, and reflexivity. These values are integral to this research, and will be demonstrated in each aspect of the research, including methods, ethics, writing, theorizing, and analysis. Transformative methods are participatory and action-based, and “research is done with people rather than on people” (Nelson & Prilleltensky, 2010). My work will be participatory action research as it involves the trans and non-binary community, as well as organizations (e.g. the Crime Prevention Council) and healthcare providers. These community partnerships will allow knowledge to be mobilized into policy or social change.

Another relevant paradigm is the constructivist paradigm. Constructivist paradigms hold in their ontology that reality is subjective, and therefore there are multiple realities. The goal of research, then, is to understand each participant’s reality, and to generate data through interactions between the researcher and the participant (Nelson & Prilliltensky, 2010). These

goals align with the goals of this research: to understand the multiple realities of non-binary individuals in the context of healthcare.

My ontology (what can be known in the world; (Guba & Lincoln, 1994) is the state of power systems in health care and how non-binary and trans people relate to those systems, and how the healthcare system positively or negatively affects them. This draws on both critical theory and constructivism, as it sees the power structure of healthcare in society as real, but the way participants relate to that system can be subjective and multiple. Some may have good experiences, others may have bad experiences, and all of these are valid and important to know.

My epistemology (how I can know) is to seek feedback from the people who work in and are users of this system. In doing this qualitative work, I can understand what people think and feel about the system, and I can better understand the system itself and how it works to empower or oppress people.

My axiology (underlying value; Nelson & Prilleltensky, 2010) is that all humans have the right to adequate, safe, accessible, fair, and validating health care that is tailored to their specific needs. We can find out how the health care system is or is not serving its purpose of providing this type of care to trans people, and where it is not, we can seek change.

## **Procedure**

First, participants will be recruited using the methods previously discussed. Each participant will schedule a 1-hour interview with either myself or another Master's student researcher. Interviews will be conducted in an accessible private place where the participant feels comfortable. Participants will sign a consent form before the interview begins. The interviews will be recorded using an audio recorder and participants will be informed of this in the consent

form and verbally. The interview will consist of questions about the participant's experiences in the community, in employment, and in the healthcare system. My thesis will focus on only the healthcare part of the interview, in which participants will be asked about their access to healthcare, their healthcare experiences, and what resilience and resistance means to them in this context. After the interview, participants will be given a debrief form and a list of mental health resources they can access if needed. At this point, they will also be compensated for their time with a \$25 gift card. After the interview, their audio recording will be transcribed by an undergraduate student. Transcriptions will be double-checked for accuracy by another student researcher. After a few interviews have been transcribed, the researcher will begin grounded theory analysis.

### **Data Analysis**

A grounded theory approach to data analysis will be used because there is not yet a theory that pertains specifically to the relationship of non-binary people to the healthcare system. The process of grounded theory employs coding, memo-writing (i.e. writing down and dating thoughts about the emerging themes in the data), theoretical sampling, constant comparison (i.e. always comparing new themes with data already gathered), and abstraction of ideas (i.e. drawing diagrams to show relationships between processes) to generate a theory from qualitative data (Ward et al., 2017). Initial coding is line-by-line to limit any logical leaps made by the researcher, and later codes are grouped into larger categories, which the researcher connects (i.e. axial coding) and creates a "story" from (i.e. selective coding; Creswell, 2007). The theory can be presented as a diagram or as a discussion of hypotheses or relationships. These steps and methods will be followed carefully, starting early in the data collection process.

### **Establishing Quality of the Data**

In qualitative work, the quality of the data is assessed as how reflective the final conclusions are to the participants' lived experiences. To ensure that the researcher's voice is not dominating those of participants, member checking can be used (Birt et al., 2016), where participants are consulted about the emerging results. For the purpose of this study being a thesis project, it may be too time consuming to conduct a second interview with each participant to discuss the findings of the first interview. A focus group would be less time-intensive, and still has the potential to empower participants and spark important discussion that can be used as further data to inform the final products. This will be done after the results are partially analyzed.

### **Reflexivity**

#### ***Positionality***

I am a young, white academic. I am a settler. I am queer, transgender, and non-binary. My positions of power and privilege are a double-edged sword: they can make me blind to certain things, but they also make it possible for me to leverage my power and empower others. In doing this work, I want to continually acknowledge my privilege and figure out the best way to use it to help others. In addition, I will seek the advice of scholars who know better than me and have different lived experience and theoretical knowledge. I will constantly re-assess that the work I am doing is actually going to be transformative for the transgender community, and not just the white transgender community, but also trans people of colour and black and indigenous trans people. I will pay mind to the different positions my participants (as well as the folks on the research team) occupy in their lives and how this influences their experiences.

In addition, I have essential lived experience in queer, transgender, and activist communities that keeps me highly informed. I also have my own experiences as a non-binary

trans and queer person to draw from. This knowledge and wisdom that I have acquired over the years will aid me in working with my participants and will keep me critical of my own work. In addition, sharing a community with my participants holds me more accountable to them (Wilson, 2008). I am the right person to be doing this work because I have this lived experience, and I also have an array of research skills and theoretical knowledge acquired over several years of university.

### ***Institutional Fit***

I came to Wilfrid Laurier for my Master's degree precisely to do this research. This is the only program with the values and culture to facilitate me and aid me in this research. Inherent in the program's philosophy is the importance of ART: Action, Theory, and Research. All the faculty in the program embody that no one of those things should happen without the other two. The incorporation of action is a key piece that is unique from so many other graduate programs, and is immensely important to me as a new researcher. As for the area of study, my co-supervisors, Drs. Robb Travers and Simon Coulombe, have extensive research experience with LGBTQ+ populations. Dr. Robb Travers, specifically, has been part of many of the works I cite in this proposal on trans health. In addition, community psychology is focused on research that is done with, by, and for community. In this case, I do not want to do research "on" trans people, I want to do research "with" and "for" trans people. This program helps me to make connections and create partnerships for a foundation of Community Based Research that facilitates action.

### **Ethical Considerations**

Participants will be asked to share their thoughts and feelings about their experiences with the healthcare system. In talking about this, participants may recall painful memories or feel emotional when recalling discrimination or other negative events. To mitigate the escalation of

those emotions, in this event the interviewer will acknowledge the emotions and hold space for the participant before continuing. After the interview, the participant will be given a list of resources including mental health services if they need help with negative emotions or trauma.

Another risk is to do with privacy and anonymity. As the transgender community is a small one, there is a chance that even after de-identifying the data, the inclusion of quotes or demographic information in a publication could identify a participant. Measures will be taken to summarize and aggregate the data in such a way that no one participant “sticks out” in future publications. In addition, the researchers and participants may know each other outside of the study. In this case, the participant would be interviewed by someone else whom they don’t know, so the participant can be completely open and honest without fear of repercussions.

A larger ethical concern is the question of whether the trans population is over-studied, especially with regard to healthcare. There is a large body of literature on the subject for this population, and it raises the question of whether this research is making tangible change for trans people. The participatory nature of my study will ensure that trans people are involved and can make recommendations for change. My knowledge mobilization strategy, discussed above, will ensure that the voices of my participants are amplified for relevant stakeholders to hear and consider in their work.

### **Potential Limitations**

Measures will be taken to ensure that the sample is diverse in terms of gender identity, age, race, ethnicity, and other demographic traits. However, as the sample is small and not entirely random, it will not be a representative sample of all transgender people. A description of

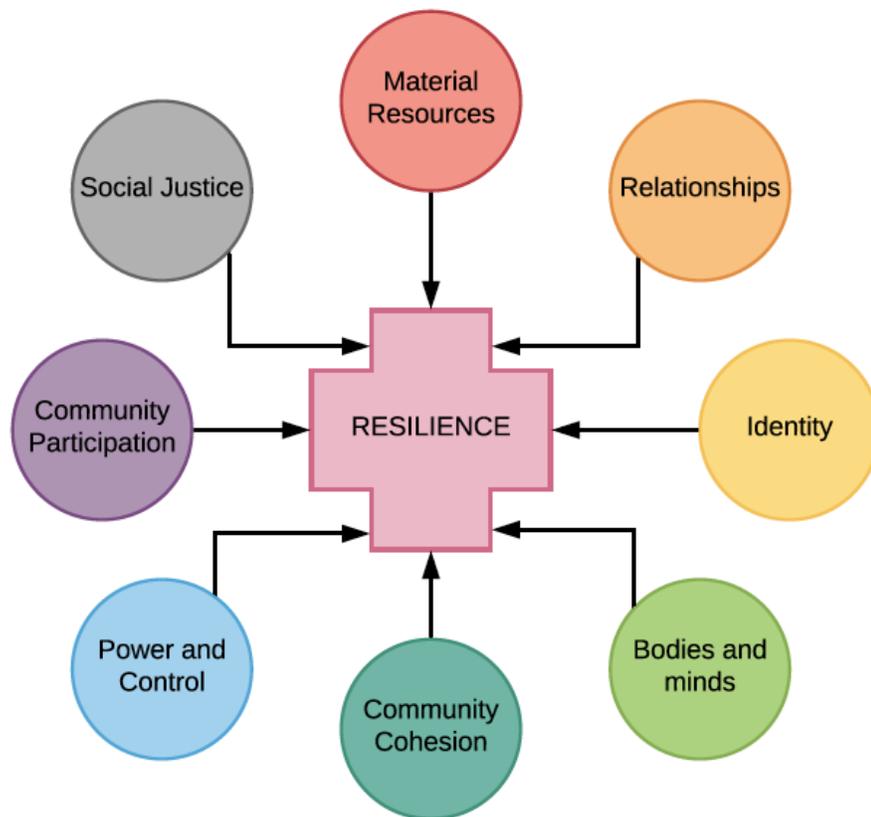
the context of the study will be given in the final paper and caution will be used when interpreting the results so as not to generalize them.

As my study is nested in a larger study on which I am not the principal investigator, I do not make the decisions on how the money on the project is spent. In addition, the budget is limited. For these reasons, I may not be able to provide employment opportunities for the participants in my study, as is good practice in participatory research. However, all participants will be compensated for their time, and participants will be consulted on their thoughts on the results via member checking.

## Figures

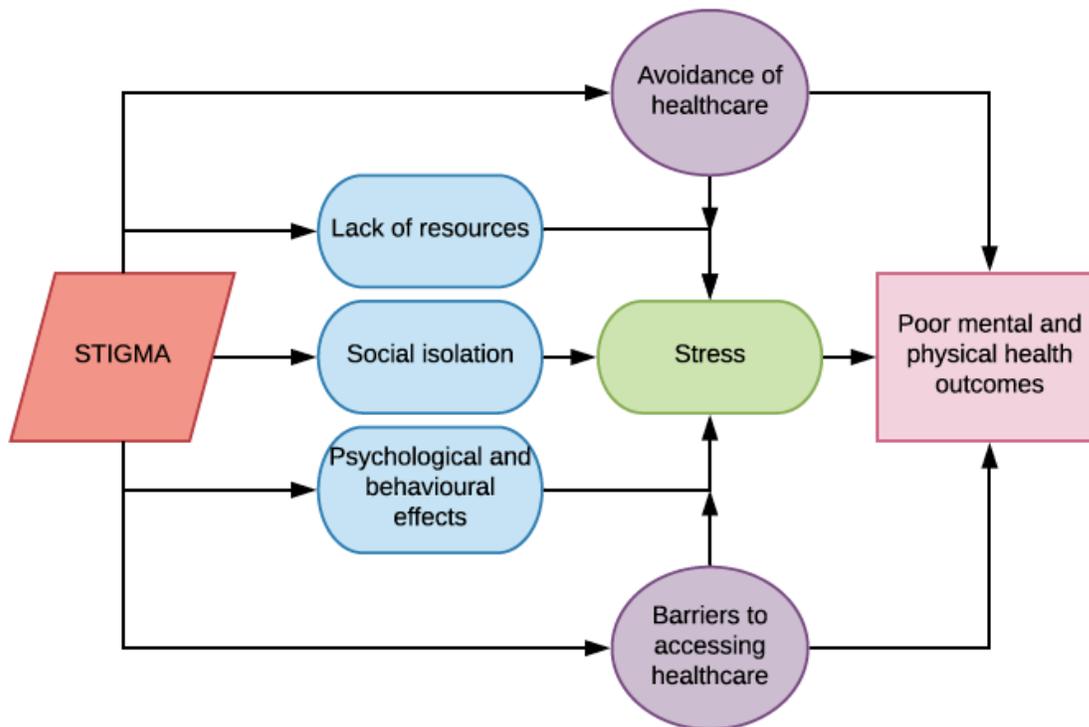
Figure 1

*A constructionist model of resilience, adapted from Runswick-Cole & Goodley (2013)*



**Figure 2**

*A preliminary model of the effects of stigma based on literature review*



### Abstract

Transgender and non-binary individuals are highly stigmatized in North America, and this has staggering adverse effects on their physical and mental health. This stigma is structured and driven by cisnormativity and transnormativity, ubiquitous sets of social rules that determine “right” and “wrong” ways to do gender. Non-binary people experience excess stigma from cisgender (i.e. not transgender) people for “deviating” from the rules, but also from within the transgender community for not adhering to medical and binary definitions of transness. Specifically, non-binary people may choose not to transition medically, but very little research has been done on this. A sample of 12 non-binary participants was selected from a larger qualitative study about transgender experiences of discrimination. Interviews about healthcare experiences and thoughts on transition were thematically coded. Themes emerged relating to transnormativity, transition (medical and social), and coming out in healthcare environments. Participants felt pressure in medical settings to adhere to the gender binary and transition medically. However, many participants chose not to transition medically or desired to “mix and match” their medical transition. Social transition was important for most participants, including changing name, pronouns, and gender expression. In medical settings, participants were constantly assessing cues of safety in weighing their decision to come out as non-binary to their provider or not.

*Keywords:* Transgender, non-binary, healthcare, medical transition, social transition, transnormativity, cisnormativity, stigma

## **Social Transition, Coming Out, and Challenging Transnormativity: Non-Binary Experiences in Healthcare**

### **Transgender and Non-Binary**

“Transgender” (short form: trans) is a word used to describe a person “whose gender identity or expression varies from their sex assigned at birth” (Scheim et al., 2017). It is an umbrella term encompassing many different gender identities. Trans people are the “T” in LGBTQ2S+ (Lesbian, Gay, Bisexual, Trans, Queer, Two-Spirit, and more). “Non-binary” is “an umbrella term that encompasses any gender identity outside of the binary construct of girl/woman or boy/man” (Goldhammer et al., 2018). This umbrella term also includes many gender identities including agender (no gender), genderfluid (gender identity fluctuating over time), bigender (having two genders), and genderqueer (synonym for non-binary), among others (*Gender Identity Terms*, n.d.). Not all non-binary people identify as transgender (Darwin, 2020), but for the purposes of this paper, non-binary people are included under the umbrella of transgender people, as is done in much of the literature about this population.

A study in 2016 estimated that trans people make up 0.6% of the U.S. population (Flores et al., 2016). Similarly, a systematic review of prevalence studies in different countries including the US, Belgium, and the Netherlands estimated a range of 0.1%-0.7% of people self-identified as trans (Collin et al., 2016). A national survey of the trans population in the U.S. found that 31% of their sample of trans people identified as non-binary (James et al., 2015). Most large quantitative studies on trans people include non-binary people who identify as trans as part of their sample (Bauer & Scheim, 2014; Grant et al., 2010; James et al., 2015). Not all of the studies in the following review gave information on whether non-binary people were included, but it can be assumed that non-binary people who identified as trans were part of these studies.

## Stigma

### *Stigma Theories and Application*

Transgender and non-binary people are highly stigmatized by the dominant culture in society. Stigma can be defined as “the co-occurrence of labeling, stereotyping, separation, status loss, and discrimination in a context in which power is exercised” (Hatzenbuehler et al., 2013). Hatzenbuehler et al. (2013) explain that stigma is a broad concept that includes both individual and structural discrimination. Parker & Aggleton (2003) draw on the writings of critical theorists to conceptualize stigma as a systematic devaluing of differences, which functions to create and maintain power structures. Stigmatization is a tool for inserting people into these power structures. Phelan, Link, & Dovidio (2008) echo some of these arguments in maintaining that stigma serves a purpose in society: to keep people down (domination), keep people in (conformity), or keep people away (avoidance of disease).

Hatzenbuehler et al. (2013) states that stigma is a fundamental cause of health inequalities, in that it remains persistently associated with these inequalities over time. Health inequalities can only be solved by going to the source of the issue—stigma—and not by simply addressing the mechanisms between stigma and health (Link & Phelan, 1995). However, it is still illuminating to discuss the mechanisms that link stigma to health. Hatzenbuehler et al. (2013) outline four main mechanisms: resources, social isolation, psychological and behavioural responses, and stress. In the following sections, I will apply this framework to transgender stigma using empirical evidence from the literature.

**Resources.** Financial, educational, social, and status resources are powerful determinants of health (Link & Phelan, 1995). Being of low socioeconomic status and having limited access to resources creates stress, which in turn is associated with negative health outcomes (Link &

Phelan, 1995). Despite being more highly educated than cisgender (i.e. not transgender) people (Bauer & Scheim, 2014) transgender people in North America live in extreme poverty (Grant et al., 2010). An Ontario population-based survey estimates that half of trans people in the province had a personal income of less than \$15,000 annually (Bauer et al., 2010). This disparity between education and income is evidence of severe underemployment. Trans people experience underemployment at twice the average rate (Grant et al., 2010), are fired or not hired for being trans (Bauer et al., 2011), and overwhelmingly experience on-the-job harassment or mistreatment (Grant et al., 2010). Grant et al. (2010) also found that respondents who had lost a job due to transphobia or were currently unemployed were more likely to be HIV positive, to smoke or drink, and to attempt suicide. Some trans people also perform sex work for income, and this is a risk factor for HIV (Grant et al., 2010). Unemployment is also linked to homelessness; a U.S. survey found that one-third experienced homelessness at some point in their lives (Grant et al., 2010). Additionally, trans people experience housing discrimination, and have half the rate of home-ownership as the cisgender population (James et al., 2015).

**Social isolation.** Trans people experience high rates of violence, harassment, and assault (James et al., 2015). They also experience rejection from family members upon coming out (Grant et al., 2010; Yadegarfar, Meinhold-Bergmann, & Ho, 2014) and high rates of intimate partner violence (James et al., 2015). In an Ontario survey, 42% of respondents reported moving away from family or friends because of their gender identity (Luu et al., 2017). Many trans people have been part of a faith community, but left because of fear of rejection or actual rejection (James et al., 2015). These may all be reasons that trans people report low levels of social support (Boza & Nicholson Perry, 2014; Maguen, Shipherd, & Harris, 2005). This, in turn,

can be a risk factor for negative health outcomes, such as depression (Boza & Nicholson Perry, 2014; Rotondi, 2012), anxiety (Pflum et al., 2015) and suicide (Yadegarfarid et al., 2014).

**Psychological and behavioural responses.** In addition to the depression and anxiety aforementioned, other psychological and behavioural responses to stigma include internalized transphobia (defined as “discomfort with one’s transgender identity as a result of internalizing society’s normative gender expectations”; Bockting et al., 2020), using substances to cope, and suicidal ideation and attempts. Internalized transphobia is linked to lower self-esteem (Austin & Goodman, 2017) and lower perceived effectiveness of coping skills (Mizock & Mueser, 2014). To cope with internal and external transphobia as well as mental illness, trans people may use substances to cope, such as alcohol and cigarettes (Burgess et al., 2007). Trans youth are more likely than cisgender youth to engage in risky sexual behaviours, to self-harm, to consider suicide, and to attempt suicide (Eisenberg et al., 2017). A large U.S. survey found that 41% of transgender respondents had attempted suicide in their lifetime, whereas the national average was 1.6% (Grant et al., 2010).

**Stress.** Minority Stress Theory (Meyer, 1995; 2003) posits that individuals in a minority group experience excess stress due to the stigmatization of their minority status, and this stress leads to negative health outcomes. This theory has been applied extensively with the LGBTQ2S+ population (i.e. Burgess et al., 2007; Lehavot & Simoni, 2011). There is empirical evidence for mental distress caused by experiences of discrimination, expected rejection, internalized homo/transphobia, and identity concealment (Kelleher, 2009). These same factors are linked to depression and suicide in trans people (Tebbe & Moradi, 2016). These studies show minority stress as a relatively individual process, and it is important to remember that all of the aforementioned discrimination can result in minority stress, including structural discrimination.

In addition, the focus on the link between stress and negative health outcomes can be myopic in the literature, not looking at more distal or broad social causes of stress. As Link & Phelan (1995) discuss, the social circumstances that create stress must be considered and action must be taken to eliminate these circumstances in order to address health inequalities.

### **Cisnormativity and Transnormativity**

Much of the stigma against transgender people is driven by cisnormativity, which is the dominant belief in society that all people are cisgender, and all people should be cisgender (Bauer et al., 2009; Bradford & Syed, 2019). Gender comes with a set of normative rules that are taught to all people from a young age, and deviation from these rules is punished. Kate Bornstein (2016) outlines the “Eight Rules of Gender” first published by Harold Garfinkel (1967), including “there are two, and only two, genders”, “one’s gender is invariant”, and “everyone is one gender or the other”. These hegemonic social rules are taken for granted and used as the foundations of our collective worldviews. Similar to the way everyone knows the earth is round, everyone also knows that there are two genders, and to suggest otherwise would seem absurd. The existence of transgender and non-binary people is clearly in opposition to these rules, and transphobic views and rhetoric tend to come from the desire to enforce these rules of gender. Bradford and Syed (2019) describe cisnormativity as a “master narrative”, defined as “a culturally shared story that informs thoughts, beliefs, values, and behaviors”. Master narratives are defined by five qualities: 1) utility- they serve a purpose; 2) ubiquity- they are known by the majority of people in a culture; 3) invisibility- they are internalized subconsciously; 4) compulsory- they have a moral component; and 5) rigidity- they are resistant to change (Bradford & Syed, 2019). Cisnormativity and the rules of gender hold all of these qualities.

Transnormativity is described by Johnson (2016) as “a hegemonic ideology that structures transgender experience, identification, and narratives into a hierarchy of legitimacy that is dependent upon a binary medical model”. In other words, transnormativity is the idea that there is a “right” and a “wrong” way to be trans. Specifically, “full” medical transition and conformity to the gender binary are both “right”. This is because “transness” has historically been defined medically through the Diagnostic and Statistical Manual for Mental Disorders (DSM) as a psychological disorder or “condition” requiring treatment (Johnson, 2016; MacKinnon, 2018). Similar to stigma, Mackinnon (2018) describes medicalization as a tool for social control. Further, medical transition is in some places required in order to change one’s legal gender. Therefore, medical and legal institutions have defined criteria by which some trans people are legitimate and others are not. In order to be deemed legitimate and access gender affirming healthcare, trans people are forced to conform to specific narratives (Vipond, 2015). Transnormative narratives include: medicalization-- transness as a disorder that can be cured through medical transition; gender binarism-- emphasis on transitioning to the “opposite” gender; “born in the wrong body” discourse-- always having known you were trans from a young age; and legitimacy-- whose trans identities are legitimate and whose are not (Bradford & Syed, 2019; Johnson, 2016; Vipond, 2015). These narratives are internalized by trans people and dominate trans-related media and storytelling (Jones, 2019).

### **Non-Binary Stigma**

Non-binary people exist not only in opposition to cisnormative rules, but often do not live according to transnormative narratives. This means non-binary people may encounter more stigma than binary trans people, not just from cisgender people viewing their gender as outside of the realm of possibility, but also from within the transgender community for not being

“legitimate” or “trans enough” (Miller, 2019). While there is still a dearth of research on non-binary trans people specifically (Matsuno & Budge, 2017), research has shown persistent risks compared to binary trans people. Harrison, Grant, & Herman (2012) found that compared to the binary trans respondents in a study, those who wrote in a unique identifier for their gender identity were more likely to be physically or sexually assaulted, to be harassed by police, and to be harassed or assaulted in K-12 schools. This excess stigma also leads to worse health outcomes, with non-binary people more likely than binary trans people to be HIV positive, to attempt suicide, to avoid necessary medical care (Matsuno & Budge, 2017; Harrison et al., 2012), to self-harm, and to consider suicide (Clark et al., 2018). This evidence suggests particular forms of vulnerability for non-binary people requiring further research.

### **Trans and Non-Binary Experiences in Healthcare**

The previous sections have outlined in detail how stigma and discrimination put trans and non-binary people at high risk for negative mental and physical health outcomes. These outcomes mean that healthcare is vitally important for trans and non-binary people. However, the healthcare system is not immune to stigma.

Trans people are twice as likely as their cisgender LGB counterparts to be denied care, and are more likely than cisgender people to lack health insurance in the US context (Kcomt, 2018; Sperber, Landers, & Lawrence, 2005). About a quarter of trans patients who seek health coverage for hormones in the US are denied, and this rate rises to over half for surgery (James et al., 2015). These may be reasons that trans people report less availability of healthcare services in their community, and are much more likely than their cisgender counterparts to report an unmet healthcare need in the past year (Giblon & Bauer, 2017). Trans Ontarians are also less

likely than the cisgender population to have a family doctor, and this may be predicted by other types of structural discrimination, such as lack of housing (Scheim et al., 2017).

Other researchers have focused on how trans patients are treated by physicians. A review by Kcomt (2018) found that 20-50% of trans people had to educate their healthcare provider on proper care. Trans people also report health care professionals using abusive language, and even being physically abusive (Grant et al., 2010; James et al., 2015; Kcomt, 2018; Shires & Jaffee, 2015). This causes trans people to avoid or postpone necessary healthcare, and to use substances to cope (Kcomt, 2018; Reisner et al., 2015).

Non-binary individuals may have different experiences in healthcare than trans people in general, considering that some defy more of the “gender rules” by not having a gender that fits the binary, not using she or he pronouns, or not choosing to medically transition. Lykens, LeBlanc, & Bockting (2018) conducted a qualitative study with non-binary and two-spirit participants about their healthcare experiences. They found that non-binary individuals’ providers often pushed a binary narrative in treatment, such as assuming the patient had genital dysphoria, or assuming they wanted to transition to the “other sex” medically. Some participants went so far as to “borrow” a binary identity to access gender-affirming care, or avoid care altogether. Puopolo (2018) analyzed online discourses of non-binary individuals and found similarly that non-binary individuals were denied healthcare if they did not adhere to a doctor’s transnormative expectations of their gender. They also found that non-binary people delayed medical transition due to internalizing dominant discourses about transition.

## Literature Gap

Much of the literature on trans and non-binary access to healthcare has focused on access to medical transition. However, some non-binary people choose not to medically transition (Clark et al., 2018), and for these individuals, social transition (affirming one's gender by changing name, pronouns, clothing, hair, grooming, etc.) may be more significant. A literature search yields dozens of peer-reviewed publications about medical transition, but next to nothing about social transition. Nieder et al. (2019) conducted a search for peer-reviewed articles about trans people who are not seeking medical transition, or only intend to socially transition, and found only one article that met their criteria. This large gap in the literature is evidence of a strong focus on medical transition, with little research examining the importance of social transition or even acknowledging the trans people who do not choose to medically transition. This could lead to practitioners assuming that all trans people want to medically transition, which could negatively affect the healthcare experiences of those who do not desire this.

This study aims to answer the following questions:

1. What positive and negative experiences do non-binary individuals have in healthcare settings?
2. What does transition mean to non-binary trans people? Is it social, medical, neither, both? How do they make transition decisions?
3. Do non-binary trans people use the healthcare system to support their transition wants and needs?
4. Do non-binary trans individuals experience transnormativity in their lives, and if so, how?

## **Methods**

### **Nested Research**

This study was nested within a larger research project at Wilfrid Laurier University exploring the experiences of trans people in Waterloo Region, Ontario in the domains of healthcare, employment, and community inclusion. Waterloo Region lies west of Toronto in southwestern Ontario and consists of three small cities; Waterloo, Kitchener, Cambridge, and their surrounding areas. The Region has a population of about 618,000 (Region of Waterloo, 2020). The larger study was approved by Laurier's Research Ethics Board. The research team partnered with the Crime Prevention Council, a local organization whose goal from this project is to better understand experiences of discrimination and violence against trans people in Waterloo Region in order to inform equitable policy change. It is important to note that several people on the research team, including the project coordinator and both of the interviewers, were transgender. The researcher who conducted most of the interviews with non-binary participants was non-binary. This made recruitment easier and made interview data richer, as participants could relate to the interviewers and thus were more comfortable sharing their life experiences.

The larger study recruited trans people generally, including binary, non-binary, and two-spirit people who self-identified as trans. The sample of non-binary individuals in this paper is drawn from this larger sample, and the data in this paper is drawn from the healthcare sections of the interviews.

### **Participants and Recruitment**

To recruit participants, organizations that work with the LGBTQ+ community were contacted by email or in person and asked if they could share the advertisement on social media

or through email. Flyers were also posted on bulletin spaces in Wilfrid Laurier University, and in local community centres and community health centres.

The inclusion criteria were as follows: 1) participants must self-identify as being transgender, an umbrella term that includes trans women, trans men, non-binary individuals, and two-spirit individuals; 2) participants must live, work, or go to school in Waterloo Region, which includes Waterloo, Kitchener and Cambridge and surrounding areas; 3) participants must be over the age of 16.

Forty transgender participants were initially screened and recruited for the larger study. Of these, 33 were interviewed. Participants were then further selected for inclusion in this paper based on whether they identified primarily as non-binary or two-spirit in the initial screening survey. Twelve participants identified as non-binary and were included in the analysis for this paper. Researchers made efforts to recruit two-spirit individuals, but unfortunately the two individuals who were recruited were unable to complete interviews due to time constraints and logistical issues such as transportation and accessible private spaces.

## **Procedure**

As each participant emailed the study coordinator to express interest, they were asked to complete an online survey to assess eligibility and gather demographic data (age, level of education, racial identity, gender identity, etc). The research coordinator then scheduled a two-hour interview for the participant with one of the two interviewers based on availability. Interviews were conducted in a private university office or private room in a local community centre. Participants signed a consent form before the interview began. The interviews were audio-recorded. Each participant answered questions from two of the following three domains

based on their interest: community inclusion, employment, and healthcare. Healthcare was a popular topic, and most non-binary participants self-selected to discuss healthcare in their interview. Those who did not select it were first interviewed about their area of interest, then healthcare was discussed as the second topic. This study draws data from the healthcare section of the interviews, in which participants were asked about their access to healthcare, their healthcare experiences (positive and negative), how they cope with negative healthcare experiences, what transition means to them, and what they would change about the healthcare system. After the interview, participants were given a debrief form and a list of mental health resources they could access if needed. At this point, they were compensated for their time with a \$30 grocery store gift card. After the interview, their audio recording was transcribed. Transcripts were double-checked for accuracy by another student researcher.

### **Data Analysis**

The researcher was immersed in most of the data while conducting interviews, so once the interview phase was complete, an initial thematic framework was built as a mind-map using scraps of paper with topics written on each piece. These pieces were assembled in groups based on their similarity, and this visualization allowed the researcher to draw further connections between ideas that may have otherwise seemed unrelated. This mind-map was iteratively changed and added to as analysis continued. The transcribed interviews were analyzed using NVivo software. Thematic coding was undertaken according to Braun and Clarke's method (Braun & Clarke, 2006, 2012), where codes were assigned to pieces of data, then similar codes were grouped together into larger themes. To enhance credibility of the findings (Connelly, 2016; Lincoln & Guba, 1986), the researcher kept memo logs throughout analysis, and met weekly with their supervisor as a "peer debrief" to discuss progress and findings. The researcher

also discussed themes with transgender colleagues, one of whom named “transnormativity” as a possible lens of understanding. Themes were visualized using NVivo’s “Hierarchy Chart” feature, showing which themes contained the highest number of codes. Themes with a higher number of unique codes (including the codes in subthemes) are shown as larger in the chart. This gave the researcher an idea of the topics discussed the most by participants.

## **Results**

### **Sample Characteristics**

All participants were non-binary and assigned female at birth (AFAB). Participants were aged 18-38 (mean age 26.17). No participants identified as First Nations, Inuit or Métis. Most (67%) self-identified as White, one participant identified as mixed race, and two said they did not identify with a racialized group. Five participants (42%) identified as pansexual and five identified as queer. Other identities mentioned or written as “other” on the form were lesbian, grey asexual, aromantic, and panromantic. All had at least a high school education, with three (25%) having completed some college or university, five (42%) holding a Bachelor’s degree, and three (25%) completing or holding a Master’s degree. Half of the sample was comprised of students, and more than half of the participants were employed, either full-time (33%) or part-time (25%).

### **Scope of results**

The healthcare sections of the interviews produced hundreds of codes spanning several broad themes including transition, coming out, erasure, accessibility and barriers to access, positive provider experiences, transnormativity, and recommendations. However, this paper will focus on the themes that speak specifically to the non-binary experience of healthcare. For

example, barriers to access was a major theme, but many trans people of varying gender identities experience barriers to accessing healthcare, and this is well-documented in the literature (Giblon & Bauer, 2017; Kcomt, 2018; Vermeir et al., 2018), so it will not be discussed here. Transition, transnormativity, and coming out, on the other hand, were experienced in a particular way by these participants, primarily because of their non-binary identity. For the sake of brevity and novelty, I will focus on these three themes.

## **Themes**

### ***Transnormative Expectations***

Transnormative narratives tended to manifest in healthcare environments, usually in the form of provider assumptions. For example, some participants felt pressure from providers to conform to the binary, or pressure to “prove” their transness in medical settings to get access to gender-affirming treatment:

I’m not trying to be binary-passing, you know? [...] the therapist was helpful but he also kind of – he would try to get me to think about like well – basically, if you had to pick for society to see you one way or the other, what would you prefer? – P28 (age 26)

One participant’s provider assumed they were a binary trans man:

The doctor kind of just assumed I was male. [...] “so how long have you known”, I guess in their head assuming that I thought I was a guy. [...] That idea of there must, you have to have dysphoria [...] or you should’ve known since you were a kid, or that whole, those kinds of narratives [...] you kind of know what you need to say to get top surgery, you know what I mean, even if it’s not true. – P20 (age 38)

The same participant said another provider assumed they wanted a prescription for testosterone:

But like, we didn't even have a conversation with it, she just assumed that and was like, "Okay, I'm prescribing you testosterone" (laughs) [...] we didn't even talk about that really, she just assumed that's why I was there. – P20 (age 38)

Some participants felt pressure to be "trans enough"- for example, one participant felt they had to wear certain clothing in healthcare environments to "live up to" a gender dysphoria diagnosis:

It makes me feel like I have to be very careful about how I act my gender when I go to see medical professionals because I want to make sure that I'm living up to the diagnosis they've given me or whatever. – P37 (age 30)

Participants also noticed the tendency of providers to over-pathologize transness, which one participant dubbed "the trans elbow effect":

Yeah, and then you get like the "trans elbow effect" where like if you are vocal about your identity and being respected for your identity, everything about your medical care becomes about your identity. Even if you broke your fucking arm suddenly it's, because it's a trans arm it has to be treated differently and that's so stupid. – P6 (age 29)

Participants also discussed transnormativity in a more general sense (i.e. not specific to healthcare). They cited the preference cisgender people have for the binary and how this negatively impacts the way non-binary people are treated:

Cis people reward the binary. So if your goals are within the binary, you are at least, like something they can wrap their head around. Whereas if you're non-binary, it's such a different experience than what they've had that I find people are really nervous about it or angry about it. Like it's very tenuous and pretty readily leads to conflict. Which is not

to say that all trans identities don't readily lead to conflict, uh, I just think that cis people have an easier time wrapping their head around anything within the binary. – P6 (age 29)

Another participant felt similarly that binary identities are better understood, and that non-binary people deciding not to medically transition can affect the way their identities are seen:

I feel like they're just better understood and more mainstream [...] They're heard more often. Whereas non-binary people I feel like we're a little underrepresented and the main thing is a lot of non-binary people – or some non-binary people don't want to transition either. So, like, medically it's not really seen as an important thing. So we're just kind of like – been like oh yeah, you're a non-binary whatever. You know, and it's not seen as an integral part of who we are. – P30 (age 19)

Several participants cited the narratives of “being born in the wrong body” or “I always knew I was trans”, but did not feel these narratives applied to them:

I feel like those are the stories that you hear most about and that's the representation that we do get is like my whole life, I always knew, I always knew and it's like, “What? You know? What? You knew since you were 5? [...] oh my god.” – P26 (age 22)

Participants were critical of and resistant to transnormative narratives. Participants asserted that being non-binary is valid, and that they didn't need to follow certain “rules” in order to be trans. For example, one participant asserted that being genderfluid means sometimes they dress feminine, but that doesn't make them any less trans:

Trying to explain that to people, um, that I'm not always gonna look the same and just because I continue to look feminine in one way that doesn't mean that I'm like, going

back on my transness which is often how it's perceived, right? That I'm like not really trans 'cuz I'm doing that. – P3 (age 24)

Another participant pushed back against the idea that all trans people are unhappy before transition:

Not everyone has to have a sob story of all the time before their transition, some people were very happy, even though they weren't quite being true to themselves, they didn't know it and they were happy, like until they realized they were trans. That doesn't make it less valid. – P28 (age 26)

In sum, participants were aware of transnormativity, and in healthcare settings felt pressure to conform to a certain trans narrative. Participants resisted transnormativity in general and asserted their own definitions of transness.

### *Transition*

**Medical Transition.** Counter to the transnormative narrative that all trans people medically transition or feel the need to do so, several participants chose not to: “Well personally I don't see myself ever actually physically transitioning because it doesn't really matter to me because some days I'll be unhappy with my body either way. That's just something I have to deal with.” – P30 (age 19)

Other participants felt unsure about whether they wanted to medically transition or not: “I might [laughs] I'm considering it but, um I don't know, so yeah. It's just a lot of back and forth and if I'm going to do it, I want to make sure that I'm like 100%” – P12 (age 20)

Participants cited many reasons for not wanting to medically transition or for being unsure. Like the participant above, a few said their gender identity fluctuates, so it was important to be able to change their appearance to look either masculine or feminine on a given day. “With me being gender-fluid I’m like, you know, with my very feminine days, are there going to be days where if I got top surgery then I would be upset by not having my breasts or things like that?” – P3 (age 24)

Other reasons included participants being happy with their bodies and not desiring the physical changes of hormones or surgery, or wanting some changes but not others:

... for example, I don’t like my voice. I want a lower voice. But you know if I did like hormone therapy or whatever, like if that’s a route I decided to go – like I definitely don’t want facial hair. – P38 (age 31)

Some participants cited a desire to “mix and match” their transition, such as getting top surgery but not taking testosterone, or taking a low dose of testosterone:

I think especially because if I want to go on hormones I think I just want to either microdose it or I want to just take it for a little bit and then stop. I think that’s something that would be harder for people to understand [...] I want to be able to kind of like pick and choose that, I don’t want to have to take it for a really long time if I’m on it. - P12 (age 20)

This participant seemed apprehensive about what doctors would think of their decision to microdose hormones, which may reflect their internalizations of transnormative ideas about transition.

**Social Transition.** Social transition was an important thing for many participants. Most participants had socially transitioned in one way or another, such as cutting their hair, wearing different clothing, or changing their name or pronouns. This was often what participants brought up when asked about transition broadly:

I don't think that transition process for me is medical [...] For me, transition has a lot more to do with social transition, and, [...] I don't really feel like I wanna change my name but I have decided to change my pronouns, um, so for me transition has a lot to do with letting people know my pronouns and feeling comfortable to dress the way I want to. – P3 (age 24)

For this and other participants, pronouns were very important, as well as expressing themselves with clothing. A few participants talked about cutting their hair as euphoric, and a pivotal moment in defining their identity:

One of the decisions in my life that made me the most happy was when I finally worked up the courage to cut my hair, because it was always, you know, “Oh, but you know I can cut it short, but it would never grow this long again,” kind of thing. Like, “Oh, like this is an irreversible step.” And like, “Do I want to do or not want to.” And then after I did it, I was like, “Why didn't I do this years ago?” – P38 (age 31)

Most participants expressed a desire to socially transition in some way, but some cited a fear of discrimination if they did so:

I'm cool with my legal name. I do want to change my gender marker on my health card. But then I worry about that too. Like I worry about going to the hospital and getting interrogated about it. [...] I won't change my passport, just because people are running

into a lot of problems with the X on the passport. But, I thought like driver's license and health card could be really cool, but I worry about being in situations with like cops or in the hospital and that being used against me. – P6 (age 29)

### *Deciding Whether to Come Out*

Coming out in healthcare settings, for these participants, was a matter of safety. Since several participants did not necessarily need to come out as they were not accessing gender-affirming care, their decision hinged on other factors. The main subthemes were “assessing safety” and “choice to come out or not”.

**Assessing Safety.** Participants were consistently observing cues in the healthcare environment to decide whether it was safe enough to come out in. Participants noted several different important aspects of a healthcare setting in terms of safety. Several participants cited the importance of preferred name and pronouns policies:

I would definitely feel like if they asked for preferred name and maybe pronouns too that it would be a more inclusive environment because they took the time out of their day to ask. It doesn't necessarily imply that the person who's, like, taking it is inclusive, but it does imply that the environment would protect me [...] it would make me feel more safe.  
– P30 (age 19)

Participants noted whether the provider was knowledgeable about the LGBTQ+ community or had experience treating queer, trans, and non-binary patients:

I wanted to continue with her because even though she wasn't trans I still felt that she had this understanding, you know, maybe not as deep as somebody who's experienced it but

that she had clearly worked with other trans folks who, you know, it was clear she was sensitive to it. And that for me is the most important thing. – P3 (age 24)

Participants also noticed when providers put up rainbow stickers or flags, and some felt empowered by this: “They have a lot of like rainbow things. They have a rainbow flag up there all year round. Like that for me it's something I didn't realize impacted me so much but it definitely did.” – P26 (age 22)

Participants’ relationships with their individual providers also played a role in feelings of safety and the decision of coming out:

I do stress out about it and I don't feel comfortable talking to my doctor about it. [...]

Ideally if I had a different doctor with whom I had a different relationship – then I would like to be able to talk about that [...] And just be a little more comfortable with, I guess being vulnerable in that respect. – P38 (age 31)

**Choosing to come out or not.** Coming out was situational based on perceptions of safety. Participants who did not need to come out to their primary care provider to access medical transition most often chose not to, whereas participants who had counsellors or therapists usually felt safe to come out in those settings. The above safety cues were most often what contributed to participants’ decision of whether to come out in a given setting, but there was also a fear of potential discrimination or negative reactions from providers:

If I'm just living like my daily like regular life I'm perfectly cool with who I am, it's not an issue, I'm very comfortable with my identity. But, when I'm accessing medical spaces, um, I feel as though I can't be vocal about it, I can't, sometimes I don't even say

anything about it because I worry about getting like worse care or, I mean, you know as a person accessing care when the person suddenly feels uncomfortable. – P6 (age 29)

Some participants also seemed to weigh the costs, benefits, and risks of coming out vs. not coming out. Participants noted that coming out or not, there would be a level of discomfort and unpleasantness either way. They weighed the levels of discomfort they currently experience being misgendered against the risk of coming out and not knowing the outcome.

Like I'm kind of stuck between ... I could have that conversation and then I don't necessarily know how that will turn out and if anything would change. If it didn't that would be pretty demoralizing. [...] So now I'm just sort of stuck in like low-grade uncomfortableness. – P31 (age 18)

### **Discussion**

These data illustrate how some non-binary people relate to and resist transnormativity in healthcare settings. Instead of conceding to a medicalized and binary narrative, these participants resisted and created their own narratives that emphasized the importance of safety and social transition. This paper offers a non-binary perspective not yet heard in research: social transition can be transformative, medical transition is optional, and there are many valid ways to be trans outside of the medical model.

The themes about transnormativity echo what has been found by Lykens et al. (2018) and Puopolo (2018), where non-binary people feel pressure from their providers to conform to binary assumptions about their gender identity and levels of body dysphoria. Participants in both studies felt the need to prove their transness in order to access care. The fact that healthcare providers seem to unconsciously look for transnormative criteria in patients shows that transnormativity

may be ubiquitous (known by the majority)—one of the criteria of a “master narrative”. Similar to participants in Bradford and Syed’s (2019) work, participants in this study chose to reject rigid definitions of transness and assert the validity of their own trans identities.

Research on social transition and the choice not to medically transition is in its infancy (Nieder et al., 2019). Participants in this study discussed their hesitancy to medically transition and their desire to “mix and match”—for example, to have top surgery but not take hormones, or to take a low dose of hormones for a while and then stop. Transnormative narratives might define these actions as a form of de-transition, or highlight uncertainty related to medical transition as reasoning that someone is not “truly” trans. However, it was clear that these participants were completely comfortable in their trans identities and were not going to change their minds. Rather, participants wanted to express their gender in a way that felt good for them. Social transition was instrumental for them in defining their identities and expressing themselves to others.

Since several participants were not planning to medically transition in the near future, the choice of whether or not to come out to their provider hinged on their perceptions of safety and acceptance in a given environment. This is consistent with “personal risking theory” originally written about in a study by Hitchcock and Wilson (1992) where lesbians engaged in a cost-benefit analysis of disclosure and sought cues of safety in the healthcare environment. Hitchcock and Wilson (1992) also identify four main factors of whether lesbians will disclose: patient attributes, such as internalized homophobia; perceived relevancy, whether there is a good reason to disclose; healthcare context, including cues of safety; and healthcare provider. It is clear from

the results that this theory and these factors, which have since been validated by other studies (St. Pierre, 2012) also apply to non-binary trans people coming out in healthcare environments.

Overall, these results show that non-binary people experience a type of stigma that is specific to being non-binary. This stigma comes from broad hegemonic social rules and ideas about gender which serve to “keep people in”, or conform, and to “keep people down”, or disempower (Phelan et al., 2008). The pressure these non-binary participants feel to embody a specific trans narrative is blatant evidence of a social pressure to conform. In this study, disempowerment manifests as the fear participants have of coming out, or of correcting people who refer to them incorrectly. This non-binary specific stigma, like any other stigma, can also lead to negative health outcomes through the mechanisms of constrained resources, social isolation, psychological effects, and stress (Hatzenbuehler et al., 2013). This helps us better understand why non-binary people may have worse health outcomes than their binary trans counterparts (Clark et al., 2018; Harrison et al., 2012; Matsuno & Budge, 2017).

### **Implications**

It is important not to villainize healthcare providers in this work. The DSM sets out gender dysphoria as a diagnosis that trans people need to meet criteria for, and the World Professional Association of Transgender Health Standards of Care (WPATH-SOC) set out protocols for practitioners to assess and diagnose gender dysphoria and recommend options for treatment (K. R. MacKinnon et al., 2020). In an attempt to follow this protocol and give trans patients access to gender-affirming care, providers may make assumptions or otherwise try to ensure the patient fits certain criteria, unintentionally perpetuating transnormativity. More thorough education and curriculum is needed to teach providers how to apply the WPATH-SOC

in a patient-centred way. Providers also need to be made aware of non-binary people and their unique life experiences in order to improve care and reduce stigma for this population. In order to ensure the curriculum developed for healthcare providers is evidence-based, further research needs to be done on non-binary experiences and what they want and need from their healthcare providers. Research could also focus on how to create safe spaces in healthcare environments for trans and non-binary people, including policy and institutional changes.

### **Limitations**

The data from this sample cannot speak to the specific experiences of transfeminine non-binary people (assigned male at birth) or the experiences of Queer and Trans Black people, Indigenous people, and People of Colour (QTBIPOC). This study may have been able to include more diverse voices if more planning was done ahead of time to ensure access for all participants (such as ethics approval for online video or phone call interviews for those who were unable to travel). It is important to state that transnormativity privileges the narratives of white, masculine-presenting trans people, and most of the participants in this study held these qualities. Future research should investigate counter-narratives to transnormativity from the perspectives of transfeminine or BIPOC non-binary people.

This sample is also geographically contained in a region in Ontario, Canada. The Canadian healthcare system is markedly different from that in the U.S. This in-depth view of experiences in a specific city in Canada is both a strength and a limitation.

Member-checking the findings with a group of participants would have been ideal to enhance the credibility of the results, however, time and budget limitations prevented this. An infographic will be created for the larger study to communicate results back to the community.

The original intent of this study was to interview non-binary individuals and healthcare providers, in order to hear from all stakeholders and get multiple perspectives. Due to the timing of the COVID-19 pandemic, we were not able to recruit and interview healthcare providers. Future research should investigate the experiences and opinions of healthcare providers who work with trans and non-binary individuals.

### **Conclusion**

Though this project originally was intended to explore non-binary people's experiences in healthcare, it seems some things of great importance to the non-binary experience happen outside of healthcare entirely, and in order to truly challenge transnormativity, research institutions need to challenge the structural bias of medicalization by amplifying lesser-heard voices and experience.

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