

**Non-Binary Gender Identity Negotiations:
Interactions with Queer Communities and
Medical Practice**

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The candidate confirms that the work submitted is their own and that appropriate credit has been given where reference has been made to the work of others.

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Abstract

Over the last decade, studies of trans people have somewhat shifted away from essentialising and pathologising narratives, whilst recognition of gender plurality has grown. However to date, gender identities outside of the binary of male/female have received little specific sociological attention. This thesis considers negotiation of non-binary gender identities, in a UK context. Examining how non-binary individuals are involved with and integrated into LGBTQ communities exposes important nuances. This is also true regarding the negotiation of medical practice by non-binary people in relation to gender transitions, and more generally.

Eighteen participants with non-binary gender identities were recruited to record 'mixed media diaries' for a four month period. These diaries allowed participants to use any methods they wished to express themselves. Follow-up semi-structured interviews were then conducted with the same participants in order to discuss their experiences and views, relating to broad conceptions of queer communities and medical practice. The objectives were to understand how non-binary people are integrated into queer communities and negotiate medical practice, as well as what the emergence of non-binary gender identities implies for these contexts.

Symbolic interactionism provided the project's theoretical framework, as this effectively allowed space for a multiplicity of participant interpretations resulting from interactions with the social world. The findings of this study illustrate both commonalities and difference between binary and non-binary trans experiences. Non-binary identities can present in static or fluidic forms, which may be associated with differential needs. Access to gender affirming medical services is varied, and not always pursued. Non-binary identities may be associated with discourses and practices of reduced legitimisation in both medical contexts and some queer communities. The study concludes that the improvement of a wide range of medical policies and practice is needed, together with community support initiatives to better recognise and serve non-binary people.

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Abbreviations

ACTUP – AIDS Coalition to Unleash Power

ADHD – Attention Deficit Hyperactivity Disorder

AFAB – Assigned Female at Birth

AMAB – Assigned Male at Birth

BDSM – Bondage and Discipline, Dominance and Submission, Sadism and Masochism

CFS – Chronic Fatigue Syndrome

DSM – Diagnostic and Statistical Manual of Mental Disorders

EEG – Electroencephalogram

FtM/FTM – Female to Male

GIC – Gender Identity Clinic

GP – General Practitioner

GRS – Genital Reassignment Surgery

HRT – Hormone Replacement Therapy

ICD – International Classification of Diseases

ICP – Individual Care Plan

LGBT/LGBTQ – Lesbian, Gay, Bisexual, Transgender, Queer

ME – Myalgic Encephalomyelitis

MtF/MTF – Male to Female

NHS – National Health Service

PALS – Patient Advice and Liaison Service

RLE – Real Life Experience

SCR – Summary Care Record

SI – Symbolic Interactionism

SRS – Sex Reassignment Surgery

WPATH – World Professional Association for Transgender Health

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Introduction



Figure 1: Annemarie à Berlin. Annemarie Schwartzbach, taken by Marianne Breslauer, 1931.

Breslauer who said of [Schwartzbach], “She was neither a man nor a woman, but an angel, an archangel”.

(Hotz, 2016, no pagination)

Because third-gender spaces exist in other cultures, many wonder whether U.S. culture is too rigid to allow for a third (or fourth) gender – forcing people to locate in one or the other of the two main genders – or whether people actually chose to identify with the main genders. The biggest difficulty with affirming a third-gender category is knowing what that means.

(Roughgarden, 2013, p. 393)

Voices from Beyond the Gender Binary

In 2002, Joan Nestle, Clare Howell, and Riki Wilchins edited a collection comprised of Wilchins' essays and short community pieces titled *Genderqueer: Voices from Beyond the Sexual Binary* (2002). This was remarkable at the time not only because of its bottom-up centralisation of marginalised voices, but because of the very explicit nature of its central premise: individuals, whose genders are neither male nor female, exist. Whilst the essays within Nestle's, Howell's, and Wilchins' collection certainly recognised the sexual, their focus was not in terms of sexuality, but rather, in terms of gender.

Such experiences of gender have been recognised both historically and cross-culturally (Herdt, 1993). However, identification outside of the gender binary has also been clearly articulated within modern, Western contexts (Feinberg, 1996). Whilst predating the conceptualisation of the identity category 'non-binary' in and of itself, the French artist Claude Cahun expressed both identity and presentation that went beyond the limitations of masculinity, femininity, maleness and femaleness – conveyed through photographic self-portraiture in the 1920s and 1930s.

The gender identities of such individuals cannot be subject to revisionism on the basis of new categories of identification and understanding now being available (as with sexuality, in historical contexts prior to conceptualisation of 'the homosexual', for example). There is contemporary political resonance to this history however, as transgression of gender norms has been centralised within 'genderqueer' identification. Further, the lack of cultural intelligibility of gender beyond or outside 'male' and 'female' renders historical examples at risk of erasure – as seen in anthropological contexts (Roscoe, 1993; Jacobs, 1968).

More recently, recognition of gender beyond male and female has occurred in far-reaching and widely discussed contexts. In 2014, the social networking website Facebook introduced dozens of additional options for individuals' gender identities aside from 'male' and 'female' (Williams, 2014). The following year in an interview with *TIME*, the performer Miley Cyrus shared that she identifies as genderfluid (Steinmetz, 2015). Such occurrences shape gendered discourses, as more people are exposed to broader models of the possibilities of gender.

It is important to note how there has been significant overlap and conflation between experiences of sexuality, and of gender identity. Early sexological scholarship

attempted to explain male homosexuality as ‘the female soul trapped within the male body’ (Ulrichs, 1994). This essentialising turn of phrase has henceforth been used in relation to gender identity, particularly transgender women – though also people assigned male at birth identifying outside of the gender binary (Chettiar, 2015; Siomopoulos, 1974).

The lack of research into non-binary identities meant that this research benefitted from considering factors of greatest relevance to the *collective* non-binary population. The questions central to this research project were as follows:

- How are non-binary identified individuals involved with and integrated into queer communities?
- How do non-binary identified individuals negotiate existing medical practices?
- What does the emergence of non-binary gender identities imply for queer community organisation and activism?
- What does the emergence of non-binary gender identities imply for trans/queer healthcare?

I argue that whilst many additional contexts – such as the workplace – have also not been considered in relation to non-binary gender identities, these particular domains of focus are justified through the centrality of their importance to experiences of being transgender. Community interactions are sites of identity exploration, central sources of affirmation, and grant access to resources in negotiating experiences of stigma (Singh et al., 2011). In addition, medical transitions may be critically important to processes of transgender identity negotiation (Levitt and Ippolito, 2014), and transition discourses have affected experiences of transgender communities even for those individuals who do not wish to medically transition (Kuper et al., 2012; Factor and Rothblum, 2008). Access to medical services in order to transition have been central in the study of transgender people since the establishment of the term ‘transsexual’ by clinicians, which has influenced the experiences even of those who do not wish for medical interventions regarding their gendered embodiment (Snelgrove et al., 2012). The intelligibility of these questions, and the analysis which will serve to answer them, are dependent upon consistent and clear use of terminology which I will now elucidate.

Definitions and Terms

Language related to gender identity can be extremely problematic, and difficult to use in a politically sensitive way – especially for those lacking experience with transgender

communities (GLAAD, 2016). Transgender people themselves may still use language that other in-group members consider problematic or offensive. It is also important to recognise that many identity labels are used by different individuals to mean (sometimes subtly) different things, which can complicate communication. These differences can be a result of changes over time in meanings (such as reclamation of slurs, such as 'queer'), different national or geographical contexts, or of differences in the political opinions, social backgrounds, and educational experiences word-users have in describing themselves or others. Reflection on naming the self is significant across oppressed groups because of the political implications and ramifications which language use may have, which is context dependent (Zola, 1993).

It is necessary to recognise that the subsequent unpacking of language is within the context of contemporary (British) English. Many languages use highly similar terms to those that have been constructed in English (particularly 'transsexual', 'transgender', and 'transvestite'). They may subtly differ however, or carry context-dependent undertones that are easy for non-native speakers who are not community members to miss, or over-simplify. Whilst this nomenclature-based reflection obviously does not have the scope for an exhaustive international discussion, examples include how 'transgénero' may be used in Spanish differently from 'transgender' in English, and the use of 'Travesti' or 'transformista' in various South American contexts differs markedly from common English understandings of 'Transvestite', due to culturally situated, differentiated discourses around both sex work and medical transitions (Ochoa, 2008). The following discussion is thus descriptive rather than prescriptive, and inevitably cannot reflect the feelings of all individuals who identify with the discussed terminology.

The adjective 'transgender' is understood by many to simply refer to any individuals who do not identify with their gender assignment at birth. However, 'transgender' has a multitude of potential interpretations. It can often be implicitly used to specifically refer to those individuals who have transitioned or wish to transition from 'one side' of the gender binary to the other – that is, 'binary identifying' transgender men and women (assigned female and male at birth, respectively). Such a transition may be exclusively social, such that typically gendered clothing choices, name, and formal documentation are changed to be congruent with the gender the individual identifies with. Transition may also involve medical intervention, whereby hormones may be prescribed (or otherwise accessed), and/or a range of gender affirming surgeries may be undertaken to bring the individuals' embodiment into better alignment with their sense of selfhood.

Over most of the 20th century, transgender people were required to transition socially *and* medically, and also to conform to socially dictated standards of hegemonic femininity and masculinity in order to receive any kind of formal legitimisation (Stryker, 2008a; Spade, 2006). This is illustrated in part by media responses to some of the first publically recognised transgender women - such as Christine Jorgensen, who in 1952 made front-page U.S. news with the now-famous headline 'Ex-GI becomes Blonde Beauty'. Whilst the term used to describe Christine at the time was *transsexual*, Virginia Prince was instrumental in introducing the term *transgender*, in an attempt to differentiate between those who accessed surgery – transsexuals – and those who did not, but still lived and identified with the 'other' (socially intelligible) gender, 'transgenderists' (Prince, 2005). I will use the term 'transsexual' only when discussing historical contexts, in which this was the term used by professionals and trans people alike.

Prince's model did not stand the test of time. Whilst some (usually older) individuals may identify as transsexual regardless of surgical history, many transgender people find this term to be offensive due to its clinical and pathologising overtones. Likewise, 'transgenderist' is even more rarely encountered. 'Transgender' is now often used as an umbrella term (Currah, 2006) including a wide range of identifications and presentations. The 'boundaries' of transgender may still be debated – for example, some may include those who engage with any cross-gender or transgressive gender presentation (such as cross-dressers, or drag queens and kings). Others, on the other hand, may resist acknowledging anyone as transgender except those who experience gender dysphoria – commonly characterised as a severe experience of distress or depression in relation to the disjunction between self-conceptualisation and the body, and/or social positionality (American Psychiatric Association, 2013).

For the purposes of this work, I use 'transgender' as an umbrella term in reference to individuals who do not identify with the gender they were assigned at birth. This therefore includes individuals who identify within the gender binary or outside of it (binary and non-binary transgender identifications), but not drag performers or cross-dressers. Whilst a drag artist or cross-dresser may also potentially identify as transgender, cultural acts of gender transgression do not in and of themselves position one under the transgender umbrella, as I use it. This is also reflective of the fact that whilst transgender discourses have often been positioned as inherently transgressive, homogenising transgender identities as such risks over-simplification and erasure.

Whilst 'transgressing' the commonly-held belief that physiological structures (penis and vagina) both universally and accurately predict gender identity, binary transgender people are quite capable of normative or even conservative views regarding gender presentation and roles. I maintain that 'transgender' can function as a sharper demarcating tool when employed in relation to identification, rather than presentation, or role transgression. There is also the vital advantage of such a usage of transgender being generally more respectful – drag queens and cross-dressers often do not identify as transgender, and many transgender people can resent the conflation that can be made between their genders, and others' gendered performances.

The term 'trans', whilst originating as an abbreviation of transgender, may often be used as a word in and of itself, with the same meaning as transgender. This also had roots in an attempt to bridge any sense of differentiation between those who identified as transgender or transsexual (as introduced by Prince). Due to the commonality of 'trans' being used specifically in relation to binary transgender men and women, 'trans*' (with an asterisk) has been used by some to indicate an explicit recognition of gender pluralities (Killermann, 2012). Others argue that this is not necessary as 'trans' already adequately signifies gender plurality, and that the asterisk needlessly risks reproducing a hierarchy of transness (Ory, 2014). In this thesis I will often use trans as synonymous with transgender, whilst avoiding 'trans*', as I agree that an umbrella understanding of trans renders the asterisk redundant.

When referring to individuals who *do* identify with the gender they were assigned at birth, I will frequently use the term 'cisgender', or 'cis'. The construction of this word was made in reference to the Latin etymology of 'trans', meaning 'across' or 'on the other side' – with cis correspondingly meaning 'on the same side'. The usefulness of cis is to decentralise 'not-trans' as being positioned as 'default'. This relates to the concept of 'cishnormativity' – which describes social practices which assume all individuals identify with the gender they were assigned at birth. This positions cisgender individuals as 'normal' – and thus binary and non-binary transgender articulations as 'abnormal' (Bauer et al., 2009) in a manner analogous to the erasure of minority sexualities under heteronormativity (Schilt and Westbrook, 2009; Ekins, 2005; Kitzinger, 2005). This is particularly salient in medical contexts, where it may be assumed erroneously that one can always accurately infer physiology from gendered appearance (Baril and Trevenen, 2014).

Recognising and challenging cishnormativity encourages a reflexive use of written language in relation to gender. Thus, if referring to an infant observed at birth to

possess a phallus, declaration that the infant was ‘born male’¹ can be problematized due to naturalising and essentialising gender to the penis. This can be avoided by describing the infant as ‘assigned male at birth’ – or ‘AMAB’. Likewise in the case of an infant lacking a penis, they would almost always be assigned female at birth, or ‘AFAB’. Gender ascription at birth only indicates the apparent genitals, which is then conflated with gender identity. Disentangling this also assists in avoiding erasure of non-binary people, as it is not possible under a Western paradigm to be ‘assigned non-binary at birth’ (in any way other than recognition of intersex² physiology). Some non-binary people may make the argument they were always non-binary because that is what they *are*, which language insisting that one is ‘born male/female’ erases. Whilst my use of the term non-binary does not include individuals on the basis of being intersex, there is the potentiality for intersex people to have non-binary gender identities. Membership of the category ‘non-binary’ rests with identification - rather than physiology or gender presentation.

Prior to the cultural rise of ‘non-binary’ as an identity category, individuals who did not identify as male or female might identify as *genderqueer*. The foundation for this identity category was laid by transgressive trans activists of the early 1990s (Feinberg, 2010; Bornstein, 1994), however the earliest usage of the word *genderqueer* itself was by Riki Wilchins in 1995:

The fight against gender oppression...[is] about all of us who are genderqueer: diesel dykes and stone butches, leatherqueens and radical fairies, nelly fags, crossdressers, intersexed, transsexuals [sic], transvestites, transgendered, transgressively gendered, and those of us whose gender expressions are so complex they haven't even been named yet. More than that, it's about the gender oppression which

¹ This challenges the idea that physiological structures such as the penis are inherently or naturally gendered, and recognises the inscription of gender onto infants as a cultural act. This also respects trans individuals who might argue that as with cis people, their gender was always what it is, but that they needed to grow up in order to be able to articulate it.

² Intersex individuals possess any one of many possible variations in biological characteristics (chromosomes, genital or gonadal structures, or hormone levels or sensitivity) that do not fit with typical notions of male or female bodies. The most obvious examples, which are detected at birth, involve genital ambiguity, but cases such as new-borns assigned female at birth, later found to have XY chromosomes are also well recognised. For more information see: Harper, C. 2007. *Intersex*. Oxford, New York: Berg.

affects everyone [...] But maybe we genderqueers feel it most keenly, because it hits us each time we walk out the front door openly and proudly.

(Wilchins, 1995, p. 4, underlines original)

Here, it is clear that genderqueer is being used as a broad term to highlight transgression of gender norms. Whilst some contemporary readings of genderqueer may intimate a more presentation-focused, transgression-oriented reading when compared to 'non-binary', these terms may be approximately used synonymously. The possibility of course exists for individuals to identify with one label and not the other, in which case such identification necessitates respect. Genderqueer identification however falls within this thesis' understanding and usage of non-binary as an umbrella term.

I use 'non-binary' to refer to individuals who do not identify as exclusively male or female. Non-binary identification necessitates dis-identification with assignation at birth, positioning non-binary identities as under the transgender umbrella. Non-binary, however, also functions as an umbrella term, encapsulating a wide range of both named identifications, and individualistic personal conceptualisations. Non-binary identification does not infer whether an individual experiences gender dysphoria or not, nor whether they wish to access hormones or surgeries. Non-binary individuals may identify as part of an explicit 'third gender' category that is static and stable, or they may identify as genderfluid, whereby gender identity can shift over time. Some may identify as bigender, where one identifies as male (or more male) some of the time and female (or more female) at other times. Yet others may identify as agender or neutrois, approximately synonymous terms which may be interpreted either as the absence of gender, or the presence of a neutral gender. Many more community-recognised identity labels exist in addition to these few. However, it is not possible to give an exhaustive account of the language coined in order to negotiate the multitude of personal experiences of gender, not least because of its continual growth and negotiation. Any attempt at formal codification would be dated as soon as produced. From this, one can see that non-binary gender identities are rich and complex, and can involve either a mixture or combination of maleness or femaleness, or stepping outside of this paradigm altogether (Yeadon-Lee, 2016).

There remains the potential difficulty of those who may identify as non-binary, without identifying as transgender. This reiterates how bounded categories are inevitably

permeable and imperfect, and that no simple model of nomenclature will ever be able to encapsulate all possible nuances of identification. It is however very common for non-binary people to identify under the transgender umbrella, rather than outside it. This is in large part due to the centrality of transgender identification relating to dis-identification with birth assignation, shared by binary and non-binary trans people alike.

'Queer', like genderqueer, is a term that has been associated with resistance and controversy. Whilst historically meaning 'strange' or 'unusual', the meaning behind this word has changed greatly over time, and no longer occupies a clear single sentiment. As the word's meaning came to be understood as a pejorative slur particularly in reference to passive male partners in anal sex throughout the 20th century (Robertson, 2002), by 1990 there were explicit efforts to reclaim the term such as through the foundation of the activist organisation 'Queer Nation' in New York (Fraser, 1996). 'Queer' is often used as yet another umbrella term for a wide range of highly differentiated sexualities and gender identities (Jagose, 1996). The rejection of heteronormative perspectives may be arguably a universal feature of queerness, however use of queer as an identity label does not indicate whether an individual identifies within the gender binary or not, or whether they are cis or trans. In addition to appreciating the language related to non-binary trans identities, the structure of UK medical services must also be introduced, to contextualise participant healthcare interactions.

Non-Binary Medical Encounters

In discussing medical contexts within this thesis, it is important to clarify some terms that relate to this. Firstly are the different systems of care available. The majority of medical ailments are addressed by an individual's GP³ – such a first port-of-call is termed primary care. Secondary care refers to more specialised physicians (such as dermatologists or psychiatrists) to whom one may be referred by a GP in order to address specialised healthcare needs. Tertiary care is also specialised care, and is also associated with referral from primary (or secondary) care physicians. It is consultative, and possesses specialised facilities, such as for cancer, or surgical management. Gender Identity Clinics (GICs) fall under tertiary care – these are the medical centres where individuals are referred to receive a formal diagnosis of gender dysphoria, and to be given recommendations that allow access to hormones and surgeries to adjust gendered embodiment.

³ General Practitioner.

In relation to non-binary health needs, medical practice can be divided into two main areas – medical services related to gender transition (or gender affirming medical services), and all other health needs. For those who wish to access gender affirming medicine, a referral is needed from primary care to a GIC if utilising the NHS⁴. In contrast, private healthcare practitioners may be approached through self-referral. This has the advantage of avoiding extremely long waiting times (UK Trans Info, 2016), but is also expensive. Some individuals may access private care whilst remaining on an NHS waiting list. This is because, for example, private assessment and hormone prescriptions may be affordable, whilst private surgery may not be.

Non-binary gender identification may impact access to, and experiences of medical services beyond those services directly related to gender transition. On the one hand, there are areas of medicine that are significantly cisnormatively gendered, such as sexual health, or obstetrics. On the other hand, there is also the potentiality for gendered assumptions to impact the doctor-patient interaction in any context, no matter how mundane or unrelated to gendered medicine itself (e.g. a broken arm).

Due to the lack of intelligibility (Butler, 1993a) of non-binary gender identities, non-binary people often experience erroneous gender attributions. Gendered interactions may be made confidently (yet wrongly) when an individual is read in binary terms, or be navigated awkwardly or insensitively if an individual has an androgynous presentation. Such experiences are examples of ‘misgendering’. In the context of primary care, a lack of non-binary cultural intelligibility and cultural competence (Betancourt and Green, 2007) among practitioners may produce problematic experiences even when attempting to access services that are not fundamentally gendered. Accessing gendered medical services can necessitate a process of ‘outing’ oneself, in order to navigate symbolically ascribed disjunctions made by the physician between a patient’s appearance and their medical needs.

Primary and secondary healthcare may still deal with heavily gendered areas of medicine related to physiology that is socially positioned as ‘male’ or ‘female’ – such as sexual health screening, smear tests, or prostate examinations. In navigating the social world, attributions of gender are made constantly – with external appearance taken to be indicative of a person’s physiology; this has been termed ‘the cultural genitals’ (Kessler and McKenna, 1978). The ubiquity of gendered social interactions means that

⁴ National Health Service.

possession of a non-binary gender identity changes how such interactions are experienced, which this thesis explores.

It is important to note that experiences of primary, secondary, and tertiary care do not necessarily neatly demarcate. The maintenance of particular aspects of GIC-associated, gender affirming medicine (such as blood tests and hormone prescriptions) are transferred back to primary care after assessment and diagnosis – a practice termed ‘shared care’. Medical records and administration, such as notes on medical files, and name or title changes, are theoretically shared between all sites of medical care (such as the GP and the GIC) via a Summary Care Record, or SCR (Greenhalgh et al., 2010). This holds a patient’s details in a central database, allowing their data to be accessed by any NHS site where consultation or treatment may be provided. Access to SCRs by doctors is not necessarily guaranteed, and concerns with patient confidentiality have been raised by medical practitioners (Devlin, 2010).

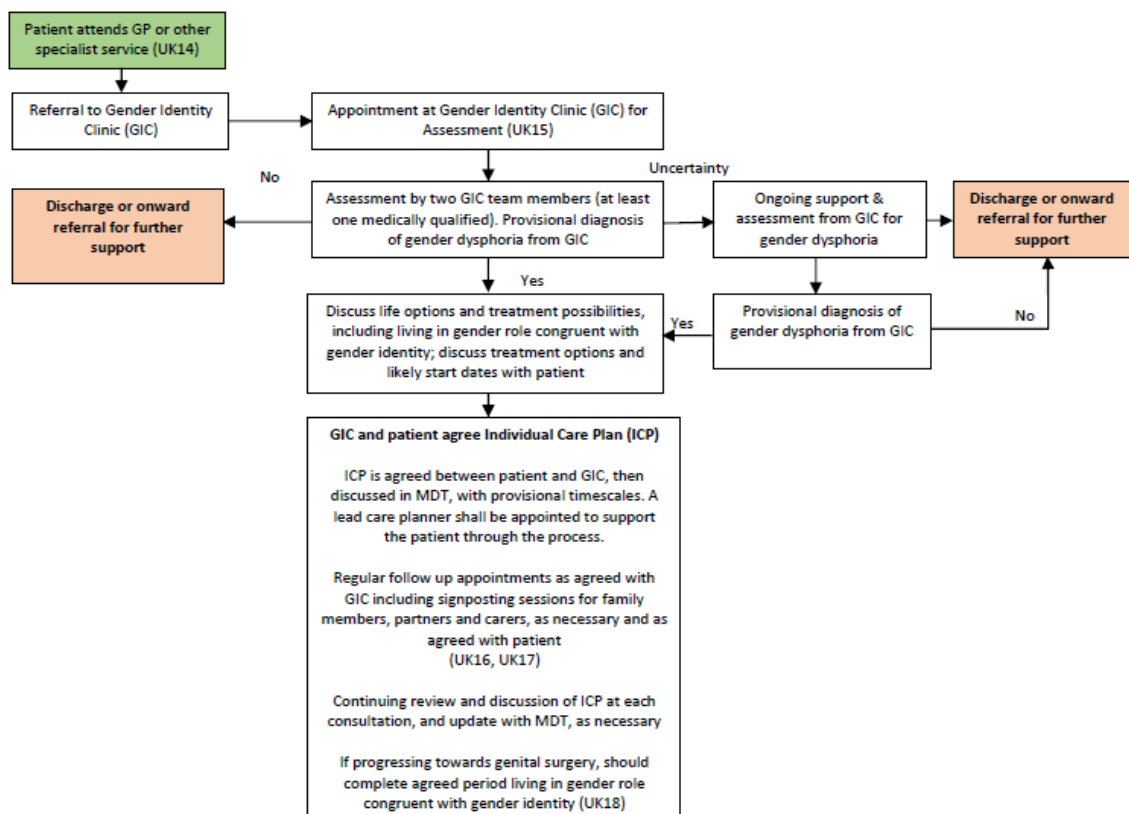


Figure 2: Simplified GIC protocol chart.

(NHS England, 2013, p. 4)

The above figure is a simplified version of the chart given in current NHS England practice guidelines, illustrating the progression of clinical interaction following referral to

a GIC. The full chart differentiates in terms of the treatment of trans men and trans women, and gives more specific details on the protocol for accessing GRS⁵ as part of the ICP⁶ if desired. Such a binarised construction of the GIC protocols can be problematized by non-binary individuals, who may seek to access GRS, without being positioned as men or women.

Further, the views that non-binary people have of medical practice may not be clearly differentiated along the lines of primary, secondary, and tertiary care. This is particularly the case for any participant who does not have first-hand experience of accessing referral to a GIC, as lack of direct contact with specialists may mean their view of doctors is homogenous. However, the expectations held of primary, secondary, or tertiary care doctors (to be both knowledgeable of medical policy and to be respectful of an individual's identity), and the services they offer, can be meaningfully demarcated. Thus, so can perceptions of primary, secondary, and tertiary care.

Many non-binary people have no personal experience of seeking gender affirming medical interventions, either through feeling no need or desire for medical transition, or due to a wide range of possible barriers. As there has been a lack of focus on (binary or non-binary) transgender experiences of medicine outside of the context of transition more generally, I ensured a theoretical framework and selection of research methods that enabled analysis of all experiential aspects of non-binary people's healthcare.

Chapter Outlines

Each of the forthcoming chapters will each contribute particular key theoretical, methodological, or analytical themes. Chapter one begins the contextualisation of transgender identities, with a particular focus on how transgender history of the past 150 years has been intimately entwined with medical practitioners/researchers. This chapter also engages with literature from the sociology of health and illness. Whilst doing so, I reject the position that transgender identification is a pathological condition in and of itself, which is an increasingly mainstream position among practitioners specialising in transgender health (Richards et al., 2015). Health and illness literature is still relevant however, due to how gender dysphoria is addressed within clinical contexts, and the parallels that can be drawn between hormonal and surgical interventions, and the treatment of chronic health conditions.

⁵ Genital Reassignment Surgery.

⁶ Individual Care Plan.

Chapter two continues the examination of relevant literature, though now moving to the sociology of (trans)gender, specifically. This allows for conceptualisation of transgender identities beyond the gender binary to be explored in greater detail, and acknowledgement of the small amount of work that has recognised non-binary identities explicitly. Chapter three goes into detail on methodological considerations. I examine the epistemological position of my theoretical framework of symbolic interactionism (SI), and how this fits with the consideration of gender identities. I justify the choice of methods used (diaries followed by semi-structured interviews) to answer the research questions. I follow with reflexive analysis where my position as an insider researcher is explicitly acknowledged, and discuss the interplay this had with the project. Research involving a stigmatised minority group, such as trans people, particularly necessitates rigorous ethical considerations, which are also fully explicated within this chapter.

Chapters four to seven are structured in relation to themes within the data, rather than in relation to the research questions themselves – such that analysis within a given theme may contribute to an understanding that cuts across the research questions. Chapter four considers the theme of instability and insecurity around a non-binary gender identity, with particular reference to notions of ‘not feeling trans enough to be trans’. Chapter five builds on this, focusing on aspects of non-binary experiences that impact over time. This includes consideration of specific community interactions and dynamics.

Chapters six and seven function as a relatively tight pairing, with attention focused on participant accounts of medical practice. Chapter six scrutinises accounts of non-transition oriented medical care, mostly primary care with some experiences of secondary care services. However the process of referral to a GIC, which is primary care based, and cross-care experiences of administration are also addressed here. Chapter seven looks into gender affirming medical interventions, the vast majority of which occurred in the context of the NHS GICs (although some private practice and non-UK examples are also present). The thesis concludes by considering what systemic improvements may be made to queer communities and medical provisions, to allow the heterogeneity of non-binary identifying people to feel legitimised in their identities, and have equal access and experience of services. In order to optimise such recommendations, the limitations of this study and future necessary directions of enquiry will be considered. Finally, the appendices contain some auxiliary information

that particularly relates to the methodology – such as consent forms, recruitment material, and an interview protocol.

As transgender lives become increasingly visible, so too has academic interest increased. I believe it essential for researchers to be highly committed to their work having demonstrable value to the lives of their research populations. This also informed my theoretical framework choice – as this conviction is validated by a pragmatist philosophy, which underpins SI. The ability to efficaciously contribute to both scholarship and lived experiences requires appreciation of a ‘big picture’, thus my conclusion will also consider the limitations of this work. Recognition of the need to situate research within both the social, and academic contexts that have come before, leads directly to the review of literature relating medical practice, health, and transgender discourses.

Chapter 1 – Transgender and Medicine

Medical practitioners and institutions have the social power to determine what is considered sick or healthy, normal or pathological, sane or insane – and thus, often, to transform potentially neutral forms of human difference into unjust and oppressive social hierarchies.

(Stryker, 2008a, p. 36)

Introduction

The sociology of health and illness can be situated as important to this thesis for two central reasons. Firstly, hegemonic Western transgender narratives were originally constructed within the medical establishment, with a particular root in early 20th century sexology. Secondly, in considering how non-binary people negotiate existing medical practices, it is necessary to consider how such practices have been sociologically examined, and how medical practice has shifted over time. The sociology of medicine illustrates how the production of (supposedly objective, scientific) knowledge was, and is, socially produced and constrained.

It has been argued by Timmermans and Haas (2008) that over time, the original field of ‘medical sociology’ has fundamentally changed into the sociology of health and illness. The difference, they claim, is that the sociology of medicine “implied a discipline focused on the medical profession, hospitals, and the broader health service industry. Even more, it may have implied a discipline that uncritically worked within the value parameters and priorities set by clinicians. To rename medical sociology as the sociology of health and illness thus manifested a recognition that illness experiences spilt over into family, work, school, and other areas of life” (Timmermans and Haas, 2008, p. 661). Recognition of the intersections between non-binary identities as negotiated in clinical contexts, and in other areas of life, thus benefit from this sociological shift.

The first section of this chapter discusses how medical sociology nucleated into a discrete discipline, and important early contributions that came from this then-new area of interest. I follow this by outlining the shift of the doctor’s responsibility from ‘preventing disease’ to ‘maintaining health’ (Donovan, 1977) and the implications this had for the social roles of medical practitioners. An important aspect of how the doctor’s role has been renegotiated has been the management of chronic conditions and disabilities in collaboration with healthcare systems, and increased recognition of

this. Due to the highly specific, detailed, and complex needs that individuals with chronic conditions can negotiate within their lives, the rise of 'expert patients' (Taylor and Bury, 2007; Fox et al., 2005; Donaldson, 2003; Prior, 2003) has had important ramifications for the power and agency of health service users, which will be discussed. It bears repeating that I do not conceptualise transgender or non-binary identities as 'chronic conditions', as this implies an understanding rooted in pathologisation, which is deeply problematic. Parallels do exist however, due to chronic conditions and being trans both being long term/lifelong, and requiring specialised knowledge in some medical contexts.

Despite originating as a topic of medical research, the relative obscurity of transgender discourses meant no work was produced by early medical sociologists on transgender identities or experiences. Further, early researchers were near-exclusively practitioners of medicine, rather than sociologists in their own right. The epistemological dominance of essentialism and positivism within the natural sciences during most of the 19th and 20th centuries had an enormous impact on how gender variance was conceived when first receiving academic attention.

The second section of this chapter will consider this early history, where labels of gender identity and sexuality (initially highly intertwined) were conceived to explain social deviance and 'mental disorder'. Thus, gender variance moved into the domain of psychiatry. Further, the evolution of the medical consideration of transgender is also highlighted through the different (and ultimately highly critiqued and problematic) theories that were conceived to make a taxonomy of transgender in scientific terms – such as 'primary' and 'secondary' transsexualism, and 'autogynephilia'.

The vast majority of literature considering transgender people's interaction with medical services focuses on gender transition, rather than more general experiences of clinical practice. Following from the clinical, transition-related literature, I examine research that considered other transgender healthcare experiences. Whilst general consideration of primary care is particularly under-researched, work on transgender experiences of alcoholism and addiction, sexual health, and mental health has been conducted, and is discussed.

In the third section, I consider how medical practitioners and systems have intersected with transgender narratives and experiences, and how this has been sociologically examined. Rather than the medical sociological work performed by clinicians of the previous section, the work considered here emphasises research in the sociology of

health and illness, in relation to transgender. This includes topics such as doctor-patient interactions, and transgender erasure within healthcare.

This chapter closes by summarising the production of, and interactions with medical guidelines for the treatment of transgender people. Such documentation offers instruction to physicians on how to proceed with specific medical circumstances that may be outside of their day-to-day practice duties, such as hormone prescription, and surgical referral requirements. In relation to transgender transition needs, such guidelines and protocols may be praised for playing a part in assisting access to medical intervention, particularly if transition has been delayed by an excessively cautious or prejudiced general practitioner. However, such documents may also be critiqued for operating from a cisnormative position, and only in recent years have their contents shifted away from explicit pathologisation of transgender identification.

From Medical Sociology to the Sociology of Health and Illness

The importance of the social world within medicine was recognised concurrently with the ascent of biomedicine to the dominant practice within Euro-American contexts. Rudolph Virchow, credited as the father of modern pathology, is quoted as declaring medical practice to be a social science as early as the 1840s (Bloom, 2002). Whilst the ‘social aspect’ of medicine was academically recognised as early as 1915, through the production of a journal titled ‘Sociologic Medicine’ (Freeman and Reeder, 1957), such work was performed exclusively by medical practitioners.

Medical sociology underwent great development between the 1940s and 1960s (Annandale, 1998), with the first conference on medical sociology in Britain held in 1964 (Thomas, 2007). Whilst the shift in knowledge production from physicians to sociologists was significant, Straus (1957) highlighted how it was important to recognise that by engaging in dialogues with practitioners, sociologists may experience pressures to construct their work in terms *favoured* by physicians. This can begin with technical language co-option, but end with limiting the scope with which sociological data is interpreted. Straus argued that ‘thinking like physicians’ risked limiting the possibilities of medical sociology, and could prevent *critical* engagement with (and thus improvement of) established medical practices (Straus, 1957).

Indeed, sociological consideration of biomedicine has highlighted limitations with the biomedical model, which underpinned medical practice during the 20th century, and through to the present day (Annandale, 1998). These include reliance upon a reductivist and essentialist philosophy, whereby ‘disease’ invariably “is a problem of the

individual body, rather than a result of the interaction of the individual and the social world” (Annandale, 1998, p. 4). Further, in emphasising a preventative medicine, biomedical practice often attempted to recognise specific causes of a disease – its aetiology, which rarely provided a complete account beyond the most classical of pathogen-related conditions. Biomedical research has also positioned itself as fundamentally objective in nature. This has been heavily critiqued by feminist researchers (Haraway, 1988; 1989; Harding, 1986; Oakley and Roberts, 1981) who have argued that the dominance of the natural sciences by men within a patriarchal context resulted in the masculinisation of the discipline, and under-recognition of how misogyny (among other socialised biases) can impact scientific interpretation.

Such critiques of a supposedly ‘objective’ epistemology have informed sociological work on experiences of health and illness, such that access to vulnerable and minority groups by researchers have become more effective and sensitive (Bolitho and Huntington, 2006; Sheriff and Chenoweth, 2003). In addition, recognition of subjectivity in medicine allowed for consideration of how social values may affect how medicine is practiced directly (Nurok and Henckes, 2009; Keating et al., 2007). A particularly revealing example by Hughes and Griffiths scrutinised arguments for the denial of surgery to patients with particular adverse risk factors. Whilst doctors claimed such decision making was ‘objectively’ informed, it was found that “age, lifestyle, and wider social structural factors figure centrally in discussions and appear to influence outcomes” (Hughes and Griffiths, 1996, p. 172). Thus sociological research can draw important attention to aspects of medical practice which may negatively impact patients through the limitations of the biomedical model. This is pertinent to the medical treatment of binary and non-binary people alike.

The critiques of how biomedical practice can harm patients can be quite varied, including emphasising how social, psychological, or behavioural factors can be neglected, or using iatrogenesis⁷ as grounds for dismantling the current system (Lyman, 1989; Engel, 1977; Illich, 1976). Lack of recognition of the importance of social factors in medicine allows for moralistic and biased practice to be erased, and remain unchallenged. This is particularly clear with health factors such as weight (Throsby, 2009; Jutel, 2005; Saguy and Riley, 2005) and addiction (Hill, 2010; Berridge, 1979), yet also in relation to being transgender (Harbin et al., 2012; Spade, 2003).

⁷ Iatrogenesis refers to inadvertent and undesirable health outcomes resulting from actions of healthcare and practitioners. This might include medication side effects, as well as misdiagnoses, refusal of treatment, and surgical and prescription errors.

Whilst there has been extensive development of a wide range of health subtopics since the 1960s, the impact of many theoretical (Rosenhan, 1973; Parsons, 1951) and methodological Glaser and Strauss (2009); (1966) ideas remain relevant today. One of the most important early theorists, Talcott Parsons, undertook influential work considering the interactions between patients and doctors. Parsons conceived the notion of the 'sick role', which ascribes both rights and obligations to individuals who occupy the social category of 'sick' (Parsons, 1951). Under this model, the sick individual is positioned as not responsible or blameable for their condition, and is correspondingly exempted from typical social obligations (such as work or self-sufficiency) for as long as they remain sick. However, the individual must also be committed to exiting the sick role, and is expected to cooperate with recognised medical professionals in order to do so. Failure to perform these obligations may be used to justify no longer considering the individual as within the sick role, and thus unable to benefit from the associated exemptions. Such a framework provides historical context to see how a diagnosis of 'transsexualism' legitimised transgender realities, and attempted to mitigate stigma by redefining gender variance as pathology, rather than moral failure or perversion.

Stryker illustrates how such early medicalising practices could protect the transgender population in the context of the 1960s. When a clinic was created at Stanford University Medical School which offered gender affirming surgical interventions, patients were provided with a laminated card which explained they were:

Under treatment for transsexualism at the Center for Special Problems. Whilst the ID card did 'out' those carrying it as transsexual, it nevertheless allowed people to open bank accounts and do other things that required identification. Without that card, transsexuals living in a social gender other than the one assigned to them at birth were essentially 'undocumented workers' who had great difficulty finding legal employment.

(Stryker, 2008a, p. 76)

This historical case illustrates how the social interventions of the gender clinic could assist in rendering transsexuality recognisable (albeit as a pathology). The appreciation of barriers associated with transgender life, such as difficulty finding work, resonates with Timmermans and Haas' (2008) earlier reminder of the importance of recognising social intersections with the provision of healthcare. These were the first steps in

allowing for cross-gender identification and articulation to be publicly expressed, with an official sanction so as to not be punished under the law. Such practices would now be deeply problematized due to the pathologisation of gender identity, and forced 'outing' to any number of law enforcers or administrators – which may be embarrassing, distressing, or put an individual at serious risk of harm.

Parsons' model can also be read positively in that he recognised that understanding sickness as purely biological was problematic. However, the model has been criticised, and updated of its inability to address chronic health conditions whereby an individual's condition is not something that can be 'cured', but managed (Turner, 1986; Bury, 1982; Levine and Kozloff, 1978). Parsons also made no provision for conditions which may have medical relevance but which are not constructed through a pathologising lens, such as pregnancy – as well as gender identity (Richards et al., 2015).

Whilst it is now generally understood among specialists that transgender identification is not a mental illness (Robles et al., 2016; Richards et al., 2015; Meyer-Bahlburg, 2010; Sennott, 2010), there remains debate around diagnosis being necessary in order to access services, and how this may be wielded as a form of social control of perceived deviance. In relation to this, Crossley (1998) has argued that assuming medical decisions are exclusively made in terms of humanitarian principles⁸ fails to take into account social and administrative constraints within which the NHS must operate. Whilst Crossley studied this in the context of how those with a long-term HIV positive status may be disempowered by being positioned as 'sick', despite being asymptomatic and active, particular parallels with the trans population can be made. Being positioned as 'sick' allowed for medical practitioners to attempt to exert power over how HIV positive individuals live, which could foster feelings of resentment or resistance (Crossley, 1998). Such responses to doctors can be found among the transgender community (Washington, 2016). The sick role fails to accommodate the possibility of patients having a more nuanced sense of their holistic and individualised needs than a healthcare provider, or that patients are not simple, passive recipients of medical instruction.

⁸ Subsection F of principle 18 of the Yogyakarta principles, which apply international human rights law to sexual orientation and gender identity, states that "medical or psychological treatment or counselling [must] not, explicitly or implicitly, treat sexual orientation and gender identity as medical conditions to be treated, cured or suppressed". See The Yogyakarta Principles. 2007. *The Yogyakarta Principles*. [Online]. [Accessed 30/09/2016]. Available from: http://www.yogyakartaprinciples.org/principles_en.pdf.

The shift from what was initially termed 'medical sociology', to 'sociology of medicine', to 'sociology of health' or 'sociology of health and illness' highlights what Straus termed the difference between 'sociology *in* medicine' and 'sociology *of* medicine' (Straus, 1957, italics added). Straus's differentiation was based on whether the sociologist was concerned with "such factors as the organisational structure, role relationships, value systems, rituals, and functions of medicine as a system of behaviour" (Straus, 1957, p. 203). This for Straus is the sociology *of* medicine – he argued that to analyse such factors one would need to be situated outside of the medical establishment, or risk untenable bias. Sociology *in* medicine by contrast was positioned as collaborative research with medics and/or integrated teaching efforts – making study of medical practitioners themselves difficult due to the potential of jeopardising one's working relationships.

Sociological research became decoupled from medical practice as the field developed and expanded within the academy. Increasing attention was given to how experiences of health and illness might intersect with lived experiences and identity. Bury (1982) considered how experiences of chronic illness could function as 'disruptive events' which could critically change an individual's conception of themselves, and argued that onset of chronic illness (specifically using the example of rheumatoid arthritis) functioned to cause biographical disruption. Diagnosis may result in new constraints and responsibilities, which can dramatically affect routine life as well as prevent engagement in activities previously connected to an individual's identity.

Bury highlights how disruption "throws into relief the cognitive and material resources available to individuals" (1982, p. 178), illustrating how experiences of illness can lead to changes in the self. This is not only because of renegotiating interactions with the geographical, the material, or other social actors, but also due to changes in how an individual looks at their own life. Comparisons may be made to queer coming-out processes, whereby an individual renegotiates their relationship with themselves as well as other social actors in their lives. In the context of a social gender transition, difference in treatment, and/or fear and experiences of stigma and discrimination may likewise change routine life and activities.

The relationship between biographical disruption and transgender identification is not a smooth parallel. This is chiefly because gender variant individuals inevitably experience gendered introspection and negotiations prior to any clinical interactions, if any. Medical professionals must then be approached in order to access any gender affirming treatments, rather than awareness of gender variance being identified by a

clinician⁹. This contrasts with a patient presenting symptoms and then being given a clinician's diagnosis on the basis of interpreting those symptoms, as with the majority of actual chronic illnesses. Additionally, gender identity negotiation does not occur at a fixed point (as with the event of receiving a formal diagnosis) but over time, through processes of introspection and interaction¹⁰. Whilst experiencing chronic illness may involve a process of identity change (Carel et al., 2016), the critical event of the diagnosis does not have an analogue in the context of transgender/non-binary identity. However, experiences of minority stress (Meyer, 1995) may cause gender-variant individuals to be particularly aware of, and to value cognitive and material resources (community support, or finances to access healthcare, for example) in the same way as the chronically ill.

Bury (1982) also highlights how patients may direct sharp criticism at the medical establishment, as they come to be more frequently and intimately involved with doctor-patient interactions, and find that expectations are not necessarily met. This has been particularly considered in the context of the crisis of HIV in communities of gay men in the 1980s. Here, the traditional top-down power dynamic between doctors and patients was challenged through activists refusing to accept the initial apathy expressed by the political and medical establishments to the plight of socially undesirable demographics – namely gay men and injecting drug users (Epstein, 1996; Treichler, 1987). Individuals with chronic conditions frequently accrue lay and medical knowledge such that their expertise outstrips that of their doctors.

The earliest occurrence of the term 'lay expert' (to refer to individuals who do not practice medicine but possess expert knowledge on a condition) has been claimed as 1994 (Prior, 2003). Whilst any individual with a given chronic health condition is likely to

⁹ It may be the case that an individual presents to a psychotherapist or psychiatrist with feelings they do not understand that are negotiated within a clinical context, however a diagnosis of gender dysphoria would not be made without the patient's agreement. This fundamentally differs from any medical context where a patient relies on a doctor to ascertain *what* a patient has, even if the patient gave information necessary for that diagnosis to be made.

¹⁰ That said, *attaining* a diagnosis may take a long time if chronically ill, as GPs may lack specialist knowledge to diagnose rarer conditions, or to identify chronic problems with common symptoms only (such as pain). Trans people and chronically ill people may therefore share the difficulty of accessing specialist care, though for significantly different reasons. While the chronically ill require diagnosis to access treatment and legitimise the sick role, trans people self-identify, and may seek 'diagnosis' as a tool to access resources, even if potentially problematizing the process of requiring diagnosis.

have some specialist knowledge of their condition for management purposes, the motivation for lay experts can be broadly positioned as in order to challenge medical hegemony (Prior, 2003). In fully understanding one's condition, an individual can reclaim power by challenging professional decision-making, actions, or inaction that they have evidence to believe is not in their best interests. An important example of expert patienthood was seen in the responses of the gay community to the onset of the HIV epidemic in the 1980s. Little information was available, and it took significant resistance from individuals to access the most up-to-date treatments from unspecialised physicians. On a more macro scale, community activism (containing many expert patients) worked through activist organisations such as ACTUP (the AIDS Coalition to Unleash Power) in order to challenge lack of medical funding and silence from the Reagan administration (Epstein, 1996). Transgender activists have challenged the pathologisation of transgender identities, whilst stressing the necessity of maintaining access to transition-facilitating treatments – particularly in countries with insurance-based healthcare such as the United States.

Whilst Prior (2003) argues that for the most part, lay experts are not 'true' experts due to a lack of knowledge about 'medical fact gathering' and diagnostic practices, even in accordance with such an understanding, being transgender may be an exception. This depends upon the paradigm shift in the conception of 'transgender' - to an identity-based model, rather than a disease-based model (Bockting, 2009). The difference is summarised as:

The disease-based model assumes that normative gender identity development has been compromised and that the associated distress can be alleviated by establishing congruence between sex, gender identity and gender role, if necessary through hormonal and surgical sex reassignment. The identity based model assumes that gender variance is merely an example of human diversity and that the distress transgender individuals might experience results from social stigma attached to gender variance.

(Bockting, 2009, p. 103)

Bockting's summary may still be critiqued as being over-simplistic, as this account of the identity based model does not provide space for distress in relation to embodiment rather than social stigma. As a biologically focused approach depends upon reproducibility to establish medical fact (Epstein, 1996), the identity based model does

not resonate with the medical establishment's historical approach to gender transitions. This has however been informed by iterative feedback from transgender service users over the years, which partially explains the slow de-pathologisation of trans identification even in clinical contexts (Richards et al., 2015). Recent medically oriented fieldwork has shown increased recognition of social rejection and violence rather than situating distress solely with embodied dysphoria (Robles et al., 2016). This does not however undermine the importance of continued provision of transition-related medical services.

The history of pathologising medical research also highlights tensions that have existed between clinical and sociological approaches to transgender realities. Richards et al. critique members of the academy who risk simplifying circumstances to that of "trans people vs. medical professionals" (Richards et al., 2014, p. 255), and condemn the academic criticism of practitioners who must operate within current systems - though as Taylor and Bury highlight:

For most lay people such interdisciplinary disputes are merely 'academic'...Their main interests lie in having affordable access to timely and effective treatments and support services, based on the best possible appreciation of the options available to them as individuals in society.

(Taylor and Bury, 2007, p. 42)

Epstein argues that "the cultures of experts significantly encroach upon and transform those of the laypeople who would engage with them" (1996, p. 4). This raises the question of how cultures of 'experts' are transformative of service users, and how being situated as a 'lay expert' modifies this encroachment and transformation. These ideas relate to my own research questions, in particular "how do non-binary identified individuals negotiate existing medical practices".

Another key similarity between the AIDS activist narratives which Epstein details and the interplay between some transgender activists and the medical establishment is the championing of identity politics:

Because identity politics stand in opposition to what Foucault calls "normalization," these defenders of identity are highly sensitive to the imposition of norms, categories, and labels by outside authorities.

(Epstein, 1996, p. 22)

By this, Epstein implies that the gay community (and correspondingly the transgender community) have resisted and rejected medical explanations of their lived experiences which are constraining, un-relatable, and positioning of the subject as deviant, or indeed sick *because* of being gay, or being trans. Such notions strongly underpin the history of how gender variance was constructed and viewed within medical research and practice, which will now be contextualised.

The Construction of the Transsexual, through to Non-Disordered Gender Complexity

During the late 19th and early 20th century, consideration of sex and sexuality increased as a subject of interest for doctors and scientists (Jordanova, 1993). This became possible as the monopoly held by Christianity over the legitimisation of knowledge lessened. A cultural shift occurred such that understandings of sex (both sexed anatomy and sexual intercourse) were to become the realm of medical researchers, rather than the church (Chauncey, 1982). Foucault (1978) articulated how there was a shift from the 'moral' authority of Christianity to the 'rational' authority of science, and challenged the notion that Victorian society was 'repressed' with regards to sex. Foucault illustrated an abundance of sexual discourses, and shifts in focus on what constituted 'authoritative' knowledge on and of sex.

Historically, the articulation of sexuality was as essentialised to the 'truth' of an individual's gender as their genitals (Trumbach, 1993; Kessler and McKenna, 1978). That is, attraction to men was seen as so essentialised to the category 'woman' that anyone attracted to men must therefore *be* a woman. Culturally constructed notions of masculinity and femininity also demanded that men performed their gender as active, thus acting as sexual penetrators, whilst women were passive and were penetrated. Sodomy in and of itself did not pose a challenge to a man's status as male, so long as the man in question was not penetrated. Thus men (rather than boys) who *were* penetrated, and women who penetrated women "violated the patriarchal code... such persons were likely to be classified as hermaphrodites and, thus, as biologically deviant. In men, this classification was sometimes understood to be symbolic, but in the case of women, they were likely to be examined by doctors for signs of actual clitoral enlargement" (Trumbach, 1993, p. 113). This illustrates how early discourses of what we now understand as sexuality related to the nucleation of non-binary identification – individuals who conformed to some ideas of gender but transgressed others could be relegated to suspicious or stigmatised gender-ambiguity.

Such a backdrop was to influence how homosexuality was to be conceived by late 19th and early 20th century scientific research on sexuality and gender. Foucault articulates that “homosexuality appeared as one of the forms of sexuality when it was transposed from the practice of sodomy onto a kind of interior androgyny, a hermaphroditism of the soul. The sodomite had been a temporary aberration; the homosexual was now a species” (1978, p. 43). As this quotation implies, ideas about sexuality and gender identity were strongly intertwined. Sexuality and gender were to be both defined and disciplined through medical scientific authority.

Homosexuality was understood within a strongly heteronormative social framework, whereby it was repositioned and naturalised in heterosexual terms through claims of the ‘internal female truth’ of the homosexual man. That is, due to the essentialised notion of ‘attraction to women’ as necessary in order to ‘really’ be male, homosexual men blurred understandings of gender as the essential qualities of ‘phallus’ and ‘attraction to men’ directly contradicted. Karl Heinrich Ulrichs was the first to articulate this idea as ‘a female soul trapped in a male body’ (Ulrichs, 1994). This phrase still has cultural salience today, though is now often used in order to provide a simple (but limited) explanation of binary transgender women.

Work by early sexologists such as Richard von Krafft-Ebing further developed the view of same-gender desire as a pathological problem. He drew from Ulrichs in articulating women attracted to women as having ‘a masculine soul, heaving within a female bosom’ (Krafft-Ebing, 1886). As terminology was still being negotiated, there was a lack of consistency over how phenomena of sexual orientation and gender variance were described (Ellis, 1927a; 1927b; Moll, 1919; Marcuse, 1916; Hirschfeld, 1910; Krafft-Ebing, 1886).

Magnus Hirschfeld (1910) coined the term ‘transvestite’ in reference to men wearing women’s clothing. However, a clear distinction between men who found pleasure in wearing women’s clothing but still identified as men, and individuals who dis-identified with the gender they were assigned at birth was only to come in the 1940s and 1950s (Ball, 1967). Further, little attention was paid to those individuals assigned female at birth who presented themselves as male, despite notable historical examples of women who cross-dressed and served in the military (Stryker, 2008a; Cromwell, 1999a).

Whilst Hirschfeld was the first to use the term ‘psychic transsexuality’ (1923), Cauldwell was the first to use the term ‘transsexual’ to specifically describe desires for physiological/anatomical change, accompanying cross-gender presentation

(Meyerowitz, 2002; Bullough, 1987; Cauldwell, 1949). The medical construction of transsexuality allowed for the introduction and legitimisation of hormonal and surgical ‘treatment’ for individuals diagnosed with transsexualism – due in great part to the work of Harry Benjamin, who advocated for such access (Benjamin and Ihlenfeld, 1973; 1967; 1966; 1954). Whilst the earliest transsexual surgical procedures were carried out under the supervision of Hirschfeld in Germany – such as Dora Richter in 1930, and Lili Elbe in 1931 (Stryker, 2008a), these were experimental and not yet more broadly known or accessible. Predating this however was the surgical masculinisation of the genitalia of Herman Karl in 1882. This ‘change of sex’ was officially recognised by the Prussian state (Bullough and Bullough, 1993).

Access to surgical intervention remained extremely limited for many years. This is well illustrated by the experiences of two early pioneers of gender affirmation surgeries – Roberta Cowell, and April Ashley. Roberta Cowell was the first transsexual woman to receive surgery in the UK in 1951; however this was only possible due to a manipulation of the contemporary medical system. Cowell had developed a friendship with Michael Dillon, who was the first trans man to undergo phalloplasty in the UK (Beemyn, 2013). Dillon was a medical student, and agreed to conduct an illegal, secret orchiectomy (removal of the testes) on Cowell – as detailed in a biography by Kennedy (2008). This allowed Cowell to convince a Harley Street doctor that she was intersex, allowing access to the first UK vaginoplasty and a change of birth certificate. This significantly illustrates how the medical establishment at this time, despite interest in ‘transsexualism’ as a medical disorder, failed to provide recognition unless intersex arguments could be levied to make claims of the ‘truth’ of a person’s physiology. Transsexuality was positioned as a mental disorder, with the view of the genitals at birth still being positioned as the ultimate indicator as to the individual’s ‘real’ sex/gender.

Hines has argued that class position was a significant factor in Cowell being able to access surgery in the UK. April Ashley – who was working class – needed to travel abroad to Morocco in 1960 to access surgery, due to lack of relevant social capital (Hines, 2007a). Whilst the availability of social connections and mobility undoubtedly had a crucial role¹¹, it is important to recognise the extent of the resistance to provision of surgical procedures for transsexual people – as distinct from intersex people – at this time. Dillon’s access to medical education uniquely positioned him as the first

¹¹ Dillon was also part of a family with an inherited Baronetcy, indicative of his relative wealth, status, and social mobility.

transgender person able to write on the subject within the academy – as early as 1946, arguing against a model of mental disturbance (Dillon, 1946).

Dillon's medical contemporaries commonly approached transsexualism as a mental condition, produced through social factors and trauma, which they believed was best approached via psychiatry. These assumptions percolated throughout decades of research, typified in how Pauly stated "parents ought to be made more aware of the need to positively reinforce all infants for those gender characteristics which are consistent with their biological sex" (Pauly, 1974, p. 509). The ways in which gendered behaviours are socially constructed were long from being recognised, with medical decision-making structured around the curing of sickness, production of 'normality', and the disciplining of deviance (Foucault, 1973).

Medical narratives of transgender were not only stigmatising and constraining through the positioning of transgender identification as a mental illness, but were also highly normative - enforcing the gender binary and gender roles. This is illustrated by the infamous case of John/Joan (Money and Ehrhardt, 1972). In this case, a child unambiguously assigned male at birth had his penis destroyed in a circumcision accident. Under the advice and supervision of John Money, the infant – anonymised as John/Joan in Money's writing and later literature (Sloop, 2000) was surgically reassigned as female through vaginoplasty. The parents were instructed to raise their child as a girl, whilst concealing his original assignation and physiology. It was believed by Money that gender identity was entirely dependent upon socialisation, provided a consistent role was set in early childhood. As Rosario points out, the case was "cited not just in the psychological literature but in feminist circles as well as the most dramatic proof of gender plasticity" (Rosario, 2006, p. 3).

It was later revealed however that John/Joan (later coming forward publicly as David Reimer) had an unhappy childhood and adolescence, eventually rejecting his female re-assignation and upbringing (Diamond and Sigmundson, 1997). David received a phalloplasty procedure and was able to assert his attraction to women as heterosexuality, however the impact of David's earlier experiences have been strongly intimated as relevant to his suicide in 2004 (Colapinto, 2004). Money reported Reimer's case as 'successful', which resulted in "the basis of surgical standard of care for intersex infants for the next three decades" (Beh and Diamond, 2005, p. 7). This illustrates the potential consequences in under-recognising how medical research operates within a social context, and is unavoidably influenced by social norms and interactions. It also demonstrates how the positioning of biomedical research as the

authoritative source of academic knowledge can fail to incorporate vital dimensions (such as David's lived experience and identity). This can purport harmful and erroneous information whilst maintaining a position as 'unproblematically factual', as a strategy of being beyond rational reproach. Benatar has highlighted that it is a "violation of autonomy" for parents to be allowed to decide how an infant's genitals are to be constructed, in cases where there is no pathological risk or loss of function (Benatar, 2006, p. 88).

The medical category of transsexualism became more widely recognised, with first mainstream visibility occurring in 1952 through the media coverage of the transition of Christine Jorgensen (Meyerowitz, 1998). Consequently, awareness of the possibility of medical gender transition began to spread. However, the creation of diagnostic categories and criteria were applied such that only the most normative expressions of cross-gender identification were legitimised. For example, when medical research attempted to construct an aetiology of transsexuality, a hierarchical narrative was built such that transsexual people were subcategorised as 'primary' or 'secondary' (Doorn et al., 1994; Person and Ovesey, 1974a; 1974b). This may be related to the use of 'primary and secondary' conditions in medicine more generally, where a primary condition is defined as an underlying cause, whilst secondary conditions may constitute treatable symptoms, that are only cured through addressing a primary condition (Kinne et al., 2004).

Primary transsexuality was characterised by very early onset (before puberty) and highly stereotyped behaviour, and identity patterns conforming to gender norms – as were then particularly acute, such as (in patients assigned male at birth) passivity, femininity (in physical build, mannerisms, and presentation), activity choices considered feminine, and sexual attraction towards men. Secondary transsexuals were positioned as "effeminate homosexuals and transvestites, who develop transsexualism as a regressive phenomenon under conditions of stress" (Person and Ovesey, 1974b, p. 174) and could thus be positioned as 'inauthentic'. This reiterates the un-evidenced assumption within such early research that transsexuality could be a response to trauma – in this case, the stress of being homosexual. The model did not offer space for transgender women attracted to women.

Under the 'disease model' then implicit in practice, stereotypical gendered behaviours associated with the 'opposite' gender to that assigned to the individual at birth functioned as a 'symptoms', or diagnostic criteria. The medical establishment thus disciplined gender variant individuals to be socially produced as normative and

heterosexual after having accessed medical services. This contributed to the circumstances whereby the transgender community would learn that presenting themselves to fit with the narrative of the primary transsexual would be far more effective in procuring medical legitimisation. Further, it was common practice for transsexual people who transitioned to be expected to reinvent their lives, tell no-one of their transition, and not to have contact with other transsexual people (Beemyn and Rankin, 2011).

A further influential piece of theorisation which impacted interactions between medical practitioners and trans service users was Blanchard's theory of autogynephilia (Blanchard, 1993; 1989a; 1989b). The term was created to refer to the idea of individuals assigned male at birth experiencing erotic arousal at thoughts or images of themselves as women. The theory sought to expand the limited parameters that defined the classical image of the medically legitimised transsexual, as medical gatekeepers were forced to recognise that many individuals assigned male at birth who sought to be recognised as women still experienced attraction to women.

Trans AMAB patients also did not always exhibit femininity, and may also have previously identified with or practiced 'transvestitism' (Serano, 2010; Blanchard, 1989a). Blanchard proposed that transsexual people assigned male at birth ('MtF' or 'male to female' transsexuals) could be usefully categorised based on whether an individual was exclusively attracted to men or not, and that this factor could be used to determine separate aetiologies. This depended upon the presence or absence of a heteronormatively conceived 'erotic target location error' (Serano, 2010; Freund and Blanchard, 1993). Blanchard claimed that lesbian transgender women were in fact eroticising the self, whilst being in denial about this (Baril and Trevenen, 2014).

Baril and Trevenen consider how the manner in which the claim to a transgender identity is articulated impacts on whether the individual's identity is granted legitimacy by medical practitioners, and correspondingly whether that individual is then able to access gender affirming hormones and/or surgeries. They argue that a hierarchy is created between "identity troubles and paraphilias" (2014, p. 390), such that claims rooted in 'decreased distress' are given greater legitimacy than 'increased happiness/pleasure'. It is also recognised how such gatekeeping is part of a larger narrative of attempts by medical researchers to create a diagnostic hierarchy of 'realness', such as with the classification of 'primary' and 'secondary' transsexualism (Person and Ovesey, 1974b). More specifically, Baril and Trevenen argue that the legitimisation of transgender articulations is based on identity politics, whilst any

intersection between gendered self-conception and eroticism is positioned as an illegitimate pathology is inherently “ableist, sex-negative and cisnormative” (Baril and Trevenen, 2014, p. 408).

Blanchard’s model has received significant criticism for being dramatically overstated and centred around a flawed methodology, including lack of replication of results, a non-representative sample, no control groups, and presumptive or leading recruitment criteria (Serano, 2010; Wyndzen, 2003). The model also makes no mention of aetiology for experiences of individuals assigned female at birth (cisgender women or transgender men). Work on autogynephilia fails to recognise the now widely accepted notion that sexual orientation and gender identity operate socially as separate traits, albeit with an entangled history.

It has also been noted that the majority of transgender women who judge Blanchard’s theory believe that it is unrepresentative of their identities or experiences (Veale et al., 2012). In further highlighting the cisnormative basis of the theory, Moser performed work that suggested up to 93% of cisgender women fulfilled the clinical criteria of autogynephilia (Moser, 2009) – yet the policing of sexuality so as to demarcate some individuals as ‘autogynephilic men’ served to specifically police and delegitimise trans claims of womanhood. Blanchard and other clinical researchers fail to appreciate how their work may be used to justify a medical system which erases and disenfranchises particular expressions of gender variance, through an authoritative positioning of heterosexuality and cisgender as ‘normal’ (Ansara and Hegarty, 2014; 2012; Baril and Trevenen, 2014).

Much has changed in the protocols that govern the provision of treatment to gender variant individuals (Israel and Tarver II, 1997). Clinics now state that they no longer judge a trans person’s treatment eligibility on their appearance or sexual orientation (NHS, 2014), nor are arbitrary and unnecessary procedures such as microscopic inspection of chromosomes, or EEGs¹² routinely performed (Bolin, 1987). This reflects changes in how medical power is supposed to be exerted in practice. However, it is important to also recognise that the existence of explicit guidelines and protocols does not guarantee their application. Guidelines may be rejected by individual practitioners as “cookbook medicine that threatens the art and autonomy of medical practice” (Berwick et al., 1992, p. 305). Further, factors such as gendered presentation and

¹² Electroencephalograms, a method of measuring brain neuron voltage used to identify a range of focal brain disorders.

'passing' as one's identified gender¹³ in clinical appointments may well potentially influence who a doctor considers a 'straightforward case' or not, beyond their conscious decision-making. Improvement of protocols does not automatically result in a paradigm shift in how socially constructed gender norms influence clinical practice (Bird and Rieker, 1999)

Foucault outlines how the medical gaze was able to function as "no longer the gaze of any observer, but that of a doctor supported and justified by an institution, that of a doctor endowed with the power of decision and intervention" (Foucault, 1973, p. 109). What is seen and correspondingly judged by that medical gaze is difficult to challenge because of the weight of institutional authority behind it. As medicine has increasingly recognised the role of the patient in negotiating (and resisting) healthcare practices, Singer (2006) highlights particular factors in evidencing a healthcare paradigm shift:

| Pathology Model | Trans-health Model |
|--|---|
| Normative bodies and genders | Nonstandard bodies and genders |
| M/F – only two types | Spectrum of body types and genders |
| Institutional regulation | Harm reduction and advocacy |
| Gate-keeping (meeting standard criteria) | Informed consent |
| Experts and providers in control | Peer expertise and community partnering |
| Pathologization | Self-determination |
| Gender Identity Disorder | Non-disordered gender complexity |

Table 1: A pathology model versus a trans-health model approach to gender identity.

(Singer, 2006, p. 615)

Whilst the division of these healthcare models into diametrically opposing factors is inevitably a simplification of real-life complexities, these factors can act as signposts for the political positioning of practitioners relative to their trans patients under current criteria. Building on her work looking at trans patient behaviour supporting and challenging medical knowledge, Dewey has investigated the challenges of implementing collaborative models of decision making with trans patients (Dewey,

¹³ Impossible for a non-binary patient, as there are no presentations that are culturally codified as specifically 'neither male nor female'. At best, one can mix 'male and female presentation', which may be potentially interpreted as 'incomplete' or 'confused'.

2013). Whilst this US-based study showed medical practitioners often desirous of collaboration with patients, lack of formal education on gender, together with absence of institutional support and inconsistency in applying diagnostic guidelines created barriers. Also, whilst the importance of trust in the client-practitioner relationship was emphasised, this was upset when transgender service users felt obliged to present in particular ways as a result of how diagnostic manuals were sometimes applied (Dewey, 2013).

There is a lack of academic discussion over whether a person's transgender identity may impact access to healthcare unrelated to transition. It is important to recognise that amongst the literature considering LGBTQ¹⁴ interactions with healthcare, some will fail to adequately engage with the range of gender and sexuality minorities they claim to. For example, when considering Quinn et al.'s recent (2015) work looking at 'LGBTQ perceptions and healthcare experiences', the data shows that of 632 participants only 13 listed themselves as transgender or 'other' (than male or female). These categories were then "not included in subsequent analyses" (Quinn et al., 2015, p. 251), with discussion exclusively centred around LGB – rendering the title of the article misleading, and claims in the discussion under-substantiated for these unreachable populations.

When it is discussed explicitly within healthcare literature, 'transgender health' almost always centres on gender affirming transition related services. Little attention has been given to transgender experiences of medical services that relate to other healthcare needs. Despite this, it has been recognised that transgender identification does place an individual at higher risk of suicide, HIV contraction, and drug/alcohol addiction. This is usually in research contexts looking at LGBTQ collectively, to the neglect of trans specificity (Quinn et al., 2015; Hughes and Eliason, 2002) although some specific work on trans communities has been performed, which will now be considered.

The 2014 National Transgender Discrimination Survey in the United States found that 44% of those trans people assigned female at birth and 38% of those assigned male at birth made at least one suicide attempt across the life course (Haas et al., 2014). These figures rose to between 51-60% when adjusted for those who have had negative experiences of medical care. This indicates correlation, and due to the intense

¹⁴ Lesbian, Gay, Bisexual, Transgender, Queer.

importance of medical care within many trans narrative, may be directly or partially responsible¹⁵.

These figures are broadly supported by smaller scale investigations, with a study containing 515 transgender individuals¹⁶ finding an overall attempted suicide rate of 32% (Clements-Nolle et al., 2006). In relation to this, “28% had been in alcohol or drug treatment, 59% had been physically forced to have sex or raped, 62% experienced gender discrimination, 83% experienced verbal gender victimization, and 36% reported physical gender victimization” (Clements-Nolle et al., 2006, p. 59). The link between experiencing gender based victimisation as a transgender person and attempted suicide has been explored specifically, finding those who experienced such victimisation were more than four times more likely to attempt suicide (Goldblum et al., 2012).

The discussion of sexual health among transgender people has been polarised towards binary transgender women (Melendez et al., 2006). Herbst et al.’s (2008) literature review found 29 studies considering HIV in trans people, with 22 of these focused on trans women. Melendez et al. found that whilst there were not substantial differences in the health statuses of HIV positive trans women and HIV positive cis people, trans women were less likely to take highly active antiretroviral therapy. This would support a hypothesis that trans women are more likely to experience barriers to sexual healthcare. Trans people (particularly trans women) are among the highest at risk of HIV infection (Operario and Nemoto, 2010). Infection is linked to societal rejection, high rates of sexual abuse, and the utilisation of sex work in order to fund transition, or more broadly to survive (Kosenko, 2011; Bockting et al., 1998).

The relationship between increased sexual risk (among trans women) and alcohol or drug use as a response to stress has been considered (Santos et al., 2014; Hotton et al., 2013). This found a significant relationship, emphasising how responses to stigma and social exclusion are interconnected. Linkage has also been made to transgender experiences of mental health conditions, with stigma concerns and anxieties around

¹⁵ Whilst correlation does not imply causation in and of itself, the highest percentage of 60% attempted suicide for those with negative experience(s) of medical practice were those who said “[a] doctor or other provider refused to treat me because I am transgender/ gender nonconforming” (Haas et al., 2014, p. 12). Thus it can be inferred that the more extreme the negative experience of healthcare, the higher the chance of a suicide attempt.

¹⁶ 392 participants were labelled MTF, whilst 123 were labelled FTM. This study made no mention of non-binary identities.

potential interplay with transgender status. This included concern that having a mental health condition would impact the ability of an individual to access transition related services – the fear of being deemed mentally unstable rather than transgender, as an explanation of the desire to transition. Others were concerned that transgender status may be inappropriately fixated upon in accessing treatment or therapy for anxiety or depression (Shipherd et al., 2010).

None of this research made specific reference to how the nuances of identification outside of the gender binary may relate, though analysis of The National Transgender Discrimination Survey suggests that non-binary experiences of stigma and concordant risks to health are equal to or worse than the overall trans population (Harrison et al., 2012) . Further, research on medical outcomes for trans people generally, that is, not oriented around transition, near-exclusively consider sexual health, drug and alcohol addiction, or mental health. Therefore this project begins to provide a long-overdue contribution to trans experiences of general healthcare, though specifically for non-binary people.

Investigation into how practitioners conceive of their roles, the role(s) of the medical institution, the responsibilities and rights of patients, and their conceptualisations of gender are highly relevant areas of consideration that relate to my research questions. The following section recognises that as the sociology of health came to be studied by academics outside of the medical profession, critical new perspectives came to be articulated. I now consider the research which has sociologically considered transgender healthcare but was not produced by medical doctors – sociology *of* medicine, in contrast to the earlier sociology *in* medicine (Straus, 1957).

Sociological Consideration of Transgender and Medicine

Whilst a slow dissemination of information on transsexualism occurred in the academic medical community from the 1950s onwards (Barlow et al., 1973; Randell, 1971; Ball, 1967; Benjamin, 1966; Money et al., 1957), the ways in which practitioners' views of gender were culturally ingrained resulted in large restrictions in how individuals could express themselves and be found eligible for treatment. This has been considered by Spade (2006; 2003), who emphasises that problematic rigidity in accessing gender affirmation services is not yet a historical relic. Spade argues that there is a continued over-reliance on medical evaluation and 'expertise' (considering the limited and problematic results this has historically generated), which creates legal difficulties in lobbying work for transgender equality. In many parts of the world, access to medical

care is dependent upon one's financial resources, and within a North American context for example, ensuring gender affirmation procedures are covered under insurance policies is often difficult. This means that accessing medical procedures (which are frequently viewed as evidence for legal recognition) are highly constrained by class, which at the level of populations, intersects sharply with race. Health inequality intersections with class and race are apparent transnationally, with differential complex manifestations dependent on national context, healthcare system, and many other nuances.

Transgender activism has undertaken the difficult position of challenging medical authority, whilst still negotiating the use of medical services. Spade considers the relationship between gender variant individuals seeking gender affirming services and "the medical establishments with which they must contend" (Spade, 2006, p. 316). He makes the argument that whilst "the creation of the subject position "transsexual" by the medical establishment restricts individuals seeking body alteration and promotes the creation of norm-abiding gendered subjects" (p. 316), trans consumers are also themselves *shaped* by navigating a system which is rooted in gender norms. Spade argues (and demonstrates through personal narratives) that the medical approach to gender variance places restrictions upon attempts to transition into a non-normative gender role. He also however recognises that "courts examining the question of what qualifies a transsexual to have legal membership in the new gender category have relied heavily on the medical model of transsexuality when they have decided favourably for transsexuals" (p. 328).

Spade's nod towards such historical progress can be related to Spivak's concept of strategic essentialism (1985). Whilst conceived in the context of postcolonial theory, this posits that a group may benefit from the (temporary) simplification of group identity in order to achieve particular political goals. Biomedical research has been used by transgender activists to demonstrate that transgender identities are 'real' and embodied – such as similarities between the structures of the hypothalamus in cis and trans people of the same gender (Kruijver, 2004). This simultaneously occurs with critiques that problematize reliance on an essentialist and reductionist biomedical system of knowledge production (Heyes, 2007).

In addition to such macrosociological medico-legal discussions, sociologists of health have considered the negotiation of transgender healthcare in practice. Dewey has performed sociological health research looking at the interactions between transgender patients and their doctors (Dewey, 2008). A complex interplay is described, where

transgender patients may simultaneously accept (or tolerate) and resist existing medical knowledge and practice from their physicians. Dewey utilises Hirschorn's model of 'knowledge legitimacy' (Hirschorn, 2006) which considers how doctors employ different forms of knowledge. The model conceives of 'technical knowledge', which is legitimised through an appeal to the authority of biomedical research, and 'indeterminate knowledge', which is produced through the practitioner's experiences within the clinic and is socially legitimised by their position of power and expert status (Jamous and Peloille, 1970). Such knowledges may be transformed into common or everyday knowledge, or conversely positioned as exclusively available to professionals (Dewey, 2008; Hirschorn, 2006). However, with the increasing ubiquity of digital networking and the ease of knowledge access through the internet (Lupton, 2013; Morris et al., 2011; Agarwal et al., 2010; Sethuram and Weerakkody, 2010), less and less information is positioned as inaccessible, particularly when considering the earlier discussion of expert patients (Taylor and Bury, 2007; Fox et al., 2005; Donaldson, 2003; Prior, 2003).

Acceptance by transgender service users of medically articulated knowledge was notably apparent in contexts where stigma could be avoided through such acceptance, to further their access to desired treatments and care. Yet resistance could be articulated, through such means as the termination and replacement of medical relationships (which is possible even in the relatively restricted UK context of a GIC). In the context of primary care, it was evidenced that 'coming out' as transgender to a medical practitioner could result in unequal treatment and potentially constrained access to services. An example illustrating this involved a patient sharing:

That by concealing her trans-identity she had more flexibility to make an appointment whenever she desired instead of the designated day reserved for trans-patients. She revealed that her medical practitioner scheduled all trans-patients on the same day so that regular patients were not offended.

(Dewey, 2008, p. 1351)

This particular example relates back to potential specific concerns that transgender people may encounter at the primary or secondary care level, rather than in specialised gender clinics.

Whilst medical access for binary transgender people has undoubtedly improved, no longer needing to utilise intersex narratives to gain access to the services which now

specifically exist to facilitate medical transitions (Bockting et al., 2004), it remains unknown how non-binary people negotiate medical services. The question of whether non-binary people feel their identities and needs are treated with as much validity as established binary narratives also remains under-researched. Dewey raises the important question of whether “new forms of medical knowledge can be introduced, legitimated, and sustained” as a result of trans patients introducing fresh perspectives on trans people to doctors (Dewey, 2008, p. 9).

The medical establishment have long recognised the fallibility of a rigid gatekeeping system, with Stoller saying in 1975:

Those of us faced with the task of diagnosing transsexualism have an additional burden these days, for most patients requesting ‘sex change’ are in complete command of the literature and know the answers before the questions are asked.

(Stoller, in Cromwell, 2006, p. 248)

One can note a possible tone of resentment here, in that the medical professional’s position of power is partially undermined by transgender service users ‘gaming the system’ (Spade, 2003). This illustrates a problematic perspective that has been highlighted amongst some medical practitioners, as viewing transgender people as manipulative or deceptive, with doctors needing to be a ‘step ahead’ - rather than engaging in a collaborative medical enterprise. Hagen and Galupo recognise this when they discuss an article written by the psychologist Michael Bailey, titled ‘What many Transgender Activists Don’t Want You to Know: and why you should know it anyway’ (Hagen and Galupo, 2014; Bailey and Triea, 2007). Hagen and Galupo discuss how Bailey’s writing “showcases the distrust of the medical community of trans* patients” (2014, p. 18), and positions doctors and patients as operating oppositionally. Claudine Griggs illustrates her personal frustration with such a system in saying:

[Psychiatrists and therapists]... use you, suck you dry, and tell you their pitiful opinions, and my response is: What right do you have to determine whether I live or die? Ultimately the person you have to answer to is yourself and I think I’m too important to leave my fate up to anyone else. I’ll lie my ass off to get what I have to.

(Griggs, 1998, p. 32)

The implicit claim made by Griggs is that medical practitioners are ultimately a hindrance for trans people attempting to access medical transition, but that this is currently unavoidable (although can be ameliorated if one can afford to pay for private healthcare). The purported purpose of medical gatekeeping regarding access to hormones and surgeries is to support those who are uncertain of their gender identities, and also to prevent individuals with delusional cross-gender identification (such as particular manifestations of schizophrenia) from inappropriate service access. However, this illustrates the cisnormative lens through which the medical establishment has approached gender variance. Gatekeeping is disproportionately concerned with a very small number of, or hypothetical cases of inappropriate attempted access, rather than with the majority who are constrained and impacted by far greater waiting times, and the associated difficulties and risks, including suicide as already highlighted (Jeavons, 2015).

Califia supports the point that transgender people resist medical gatekeeping, in saying “the gender community has at this point accumulated a lot of folk wisdom about what you need to tell the doctors to get admitted to a gender-reassignment program” (Califia, 2012, p. 224). How such negotiations ‘play out’ will change and shift over time, not only due to changes in medical policy and the landscape of transgender identities, but also how society changes over time in response to newly-possible articulations of gender variance. It also remains unknown how frequently and to what extent non-binary people wish to access medical services in relation to their gender identities. Hines has discussed how the oft-repeated narrative of ‘a man trapped in a woman’s body’ or vice versa has been “repeated to gain surgical reconstruction” (Hines, 2007a, p. 65), but recognises that as the rigidity of the gender binary lessens, a wider range of medical narratives becomes possible (such as hormones without surgeries, surgeries without hormones, etc.).

Contemporary concerns that transgender people have regarding medical care are complex and variable. There remain concerns with a lack of inclusion of LGBTQ specific training within medical degrees (Obedin-Maliver et al., 2011), as well as fears of healthcare inequalities (Bradshaw and Ryan, 2012). Erasure of transgender people within healthcare is an area that has been examined sociologically (particularly from an activist position). This is discussed in Namaste’s work ‘Invisible Lives’ (2000), where erasure is defined as “how transsexuality is managed in culture and institutions, a condition that ultimately inscribes transsexuality as impossible” (Namaste, 2000, pp. 4-5). This extremity, whilst impossible in the tertiary care context of a Gender Identity

Clinic, may be identifiable at the level of primary care, especially in relation to non-binary gender identities which lack cultural intelligibility (Butler, 1993a).

Bauer et al. (2009) identified two key sites of erasure in relation to transgender healthcare – informational, and institutional. Informational erasure is defined as “both the lack of knowledge regarding trans people and trans issues and the assumption that such knowledge does not exist even when it may. It is manifest in research studies, curricula, and textbooks and in the information learned by or readily accessible to health care providers and policy makers” (Bauer et al., 2009, p. 352). Institutional erasure in contrast is “a lack of policies that accommodate trans identities or trans bodies” (2009, p. 354). The literature examining the (relatively short) history of state approved and regulated transition has almost exclusively examined transgender narratives that have been articulated as ‘crossing’ from one side of the gender binary to the other, with little to no challenge posed to how gender can be conceived of more broadly (Garfinkel, 1967).

Hines (2006) also argues that “a lack of emphasis on particularity¹⁷ within poststructuralist and postmodern theory has led to a homogenous theorisation of transgender” (2006, p. 49). Transgender interview subjects in Hines’ study rejected an “essential categorisation” of transsexuality, which supports the movement from an essentialist disease-based model to the sociologically supported identity-based model in clinical practice. However, the positions of medical professionals in the UK on their conceptualisations of transgender have yet to be sociologically examined, particularly with regards to gender articulations beyond the binary. In demonstrating the importance of particularity, Hines puts forward that a queer sociological framework is key to overcoming limitations within queer approaches to transgender, as this would situate analysis within “the material and embodied contours of transgender lives” (2006, p. 64).

When practitioners and transgender service users enter into a dialogue within the clinical space in the context of a medical appointment, a relationship is generated that can be considered through a Foucauldian lens of power dynamics impacting upon each other. Work in sociolinguistics (with a medical focus) has examined power dynamics that exist between patients and doctors through ethnographic studies. This has included investigation into how gender affects questioning and topic control in medical

¹⁷ ‘Particularity’ is defined as the quality of being individual, and thus a clinician’s ability to respond to particularity will inform how transgender identities are articulated within clinical dialogues.

encounters, and how diagnoses can be co-constructed through storytelling (Ainsworth-Vaughn, 1998).

The emergence of non-binary identities troubles pathology model-oriented practice, as normative and traditional understandings of gender are challenged. Non-binary identities are less likely to be well understood by doctors, or represented in diagnostic manuals. The final section of this chapter considers the construction of manuals and guidelines, and how they pertain to non-binary healthcare.

The Roles of Manuals and Guidelines in Medical Practice

Provision of treatment has historically rested upon the characterisation of gender dysphoria as a mental disorder (Cohen-Kettenis and Gooren, 1999). The DSM¹⁸, currently in its fifth edition, is a catalogue of diagnosable conditions, and may be used by clinicians for reference when making their diagnoses. The DSM is published by the American Psychiatric Association (APA) but sees application worldwide. The first edition of the DSM was released in 1952, and characterised homosexuality as a disorder until the seventh printing of the second edition (DSM-II) in 1974. In 1980, gender identity entered the DSM-III in two forms – ‘transsexualism’, and ‘gender identity disorder of childhood’. This illustrates how prior to this, for more than thirty years, there existed an uncomfortable tension between transgender service users being treated by the medical establishment, yet lacking any formal recognition within healthcare manuals.

When the DSM was revised in 1987, a third category – ‘gender identity disorder of adolescence and adulthood, non-transsexual type’ – was added, but then removed in 1994 with the advent of the DSM-IV and the synthesis into the single condition of ‘gender identity disorder’. It has been claimed that the addition of gender identity to the DSM may have had political motivations connected to the de-pathologisation of homosexuality (Zucker and Spitzer, 2005). Such thought is potentially significant due to how community discussion of this idea may have influenced transgender service users, who may remain distrustful of the levels of sensitivity and competence of the medical establishment in facilitating transitions in a manner that does not cause distress.

In the most recent edition published in 2013, Gender Identity Disorder (GID) was renamed ‘Gender Dysphoria’ to reflect “a change in conceptualization of the disorder’s defining features by emphasizing the phenomenon of ‘gender incongruence’ rather

¹⁸ Diagnostic and Statistical Manual of Mental Disorders.

than cross gender identification per se” (American Psychiatric Association, 2013). The propositions of gender dysphoria and the creation of separate criteria for children, and adolescents or adults were both accepted. ‘Subtyping’ on the basis of sexual orientation was also removed in this edition. The decision of whether to keep GID within the DSM was a subject that received much attention and debate, with the work group of the World Professional Association for Transgender Health (WPATH) charged with establishing whether distress is an inherent factor in being transgender, socially produced through stigma, or a combination of both. The specific forms of harassment, risk of violence, potential difficulty with mainstream social integration, employment, and family life that transgender people can face has been developed from the concept of minority stress with regards to sexuality in particular (Meyer, 2003; 1995) to that of marginalisation stress (Bouman et al., 2010).

Medical specialists in the area of transgender transitions have demonstrated recognition of the tension that exists between the need for service access by transgender people, but the problematic stigmatisation with identity itself still being pathologised (Richards et al., 2015; Bouman et al., 2010). The renaming of GID was articulated as an attempted compromise, due to the fact that “the healthcare funding systems in many countries are set up in such a way as to make it effectively impossible to assist trans people with hormones and surgeries if they do not have a diagnosis which relates to those interventions” (Richards et al., 2015, p. 310). There are therefore strong pragmatic reasons for trans to be medically positioned so as to allow individuals to make insurance claims to fund transition.

A similar redefinition is viewed as likely for the next edition of the ICD¹⁹, which is maintained by the World Health Organisation (WHO). Currently in its 10th edition, ICD 11 is projected to be released by 2018 (World Health Organisation, 2015). Drescher et al. (2012) neatly illustrate and summarise the evolution and re-evaluation of the medical construction of gender variance over time, within both the DSM and ICD:

¹⁹ International Statistical Classification of Diseases and Related Health Problems.

| Edition | Parent category | Diagnosis name | Code |
|-----------------------------|---------------------------|---|---|
| ICD-6 (1948) | N/A | N/A | N/A |
| ICD-7 (1955) | N/A | N/A | N/A |
| ICD-8 (1965) | Sexual deviations | Transvestitism | 302.3 |
| ICD-9 (1975) | Sexual deviations | Transvestism Transsexualism | 302.3 302.5 |
| ICD-10 (1990) | Gender identity disorders | Transsexualism Dual-role transvestism Gender identity disorder of childhood Other gender identity disorders Gender identity disorder, unspecified | F64.0 F64.1 F64.2 F64.3 F64.4 |
| ICD-11 (2015) ²⁰ | ? | Gender incongruence of adolescents and adults Gender incongruence of children (proposed) | ? ? |

Table 2: Gender identity-related conditions in different editions of the ICD.

(Drescher et al., 2012, p. 570)

²⁰ Since publication of this table, the ICD-11 release date has been pushed back to 2018.

| Edition | Parent Category | Diagnosis Name |
|-----------------|--------------------------------------|---|
| DSM-I (1952) | N/A | N/A |
| DSM-II (1968) | Sexual deviations | Transvestitism |
| DSM-III (1980) | Psychosexual Disorders | Transsexualism Gender identity disorder of childhood |
| DSM-IV (1994) | Sexual and gender identity disorders | Gender identity disorder in adolescents or adults Gender identity disorder in children |
| DSM-IV-R (2000) | Sexual and gender identity disorders | Gender identity disorder in adolescents or adults Gender identity disorder in children |
| DSM-5 (2013) | Gender dysphoria (proposed) | Gender dysphoria in adolescents or adults Gender dysphoria in children (proposed) |

Table 3: Gender identity-related conditions in different editions of the DSM.

(Drescher et al., 2012, p. 572)

In addition to the manuals that describe diagnostic criteria, WPATH has also produced standards of care to be followed by doctors providing for transgender patients (Coleman et al., 2012). These 2012 guidelines specifically highlight 'gender-nonconforming' individuals separately from transsexual and transgender people. There is also recognition of individuals who wish to socially transition and/or be recognised as a gender they were not assigned at birth, but do not wish for any medical intervention. However in practice "the history of pathologising trans* bodies and identities remains prominent" (Hagen and Galupo, 2014, p. 19). Normative and normalising gatekeeping practices can still be found within NHS governed transgender care, such as requirements for psychotherapy before accessing surgical services, and the 'Real Life Experience' (RLE), whereby an individual must live 'full time', articulating their identified

gender before particular gender affirming procedures can be accessed (Bockting, 2008). The RLE has been critiqued (Levine, 2009) due to the essentialist approach to gender that underpins any idea of what it means to 'live as a gender'. Further, it is standard practice for surgeons to request evidence of the RLE in an uncodified manner, with the potential to refuse to operate if they are not satisfied. This is a cisnormative and moralistic process, functioning to discipline candidates for surgery in terms of their surgeon's gendered expectations.

This poses particular problems for non-binary individuals due to the lack of a culturally intelligible (Butler, 1993a) non-binary 'role'. Further, this may force individuals into administrative or social changes they otherwise might not want – such as name or title change (potentially also true in a binary transgender context with unisex names – a name change is still often expected) in order to be found 'valid' for surgery. Expressing one's gender identity through gendered presentation and name change may provide significant risks of ridicule, violence, or stigmatisation should an individual struggle to 'pass' (Speer and Green, 2007; Kando, 1972). This evidences how the RLE was conceived exclusively with normative, binary identified transgender articulations in mind, from a cisnormative perspective that also assumes all individuals *want* to pass as cis.

It is also important to recognise that information presented in diagnostic and best practice guidelines are nearly exclusively considered by (particular secondary and tertiary) practitioners specialising in transition services, as assessments for transition-related care access are not made in primary healthcare²¹. The vast majority of the literature considering transgender healthcare discusses gender affirming medical services, rather than the healthcare experiences of the transgender population more generally. Correspondingly, the needs and experiences of transgender people wishing to access primary care for health concerns unrelated to their gender is under-researched, despite an individual's gender being an important recognised element within social interaction (Butler, 1990; Goffman, 1959). It has been observed that due to the relative ignorance of primary care medical professionals on gender variance, that many transgender people find themselves required to undertake the unofficial and unrecognised (and potentially uncomfortable and contentious) task of educating their practitioners (Hagen and Galupo, 2014; Grant et al., 2011).

²¹ Primary care practitioners are responsible for referrals and often have care duties transferred to them from GICs. Despite this, as well as the recommendation to provide bridging prescriptions due to lengthy waiting times, very few primary care practitioners have detailed familiarity with transgender healthcare.

Conclusion

This chapter has reviewed literature from both 'sociology *in* medicine' and 'sociology of medicine' (Straus, 1957). I have considered how this has shaped the sociology of health and illness, medical approaches to transgender people and theorisations, and the oftentimes blurred intersection between these interests. There has been a clear shift in the sociological paradigm from research occurring within the medical establishment, to within the social scientific academy. This has allowed the relationship between transgender and medicine to be considered in ways which were not possible when medical researchers were first constructing the language and practices which have informed how transgender discourses have been understood. As the conversations around transgender medical access and equality have broadened, it would be an artificial and limited enterprise to purport that only self-identified sociologists of health and illness have considered the interplay between transgender and healthcare. Indeed, a great deal of debate and scrutiny has come from transgender writers themselves, which reiterates the importance of expert patient/lay expert concepts in relation to this thesis. There has however been no prior work specifically considering how a lack of non-binary medical precedence may impact non-binary transgender people's access to gender affirming medical services.

The review I have presented also suggests a gap between the level of recognition of non-binary presentation and identification, or otherwise deviation from classical transgender narratives within guidelines, and the awareness and sensitivity of medical practitioners overall. One might argue that earlier practice guides have had limited impact due to the rigidity of gender discourses that most doctors are socialised with, and how being positioned as 'clinical expert' allows for the enforcing of their views in relation to patient care. Community voices emphasise this as the case far more than examples of a nuanced and holistic service provision, though this may well be changing (Webberley, 2016). In the next chapter I turn attention to formulations of gender-variant communities and history outside of the context of medicine, which have had important historical and contemporary interplay with biomedical institutions and other social structures, such as the government, workplaces, and the academy.

Chapter 2 – Moving Beyond the Binary in Transgender Studies

Perhaps the task of twenty-first-century scholars will be to deconstruct the social history of a transgender paradigm whose awakenings began in the 1990s.

(Bolin, in Herdt, 1993, p. 485)

Introduction

This chapter situates non-binary gender identities within existing research on transgender. Transgender Studies is interdisciplinary by nature, with important contributions from scholars within anthropology, medicine, the humanities, law, and sociology, amongst others. Attempting to demarcate transgender scholarship by different disciplines is no simple task however, with feminist discourses, gender theory, and activist scholarship coming from a wide cross-section of overlapping backgrounds. Despite this, I aim to discuss how the academic consideration of gender diversity has produced a varied and ever-expanding range of literature that vitally informs the specific consideration of non-binary identities.

As addressed in the previous chapter, academic enquiries into sex and gender were, historically, closely related to the study of sexual orientation (Bullough et al., 1983; Garfinkel, 1967; Krafft-Ebing, 1886), and the earliest history of transgender scholarship was exclusively the domain of medical research (Benjamin, 1966; 1954; Stoller, 1964; Money et al., 1957). However, this chapter's discussion will begin with some of the earliest *non*-medical discussions, which started to recognise the importance of social factors in relation to gender. Such contributions were to initially come from ethnomethodology (Kessler and McKenna, 1978; Garfinkel, 1967), which also highlighted limitations within the epistemological basis of earlier natural scientific enquiry (Martin, 1991; Harding, 1989).

The discussion will then move to feminism and transgender. Feminist scholarship initially exhibited particular hostility to transgender women (Raymond, 1979), however underwent shifts such that feminist work helped develop queer theory (Stone, 2006; Wilchins, 2004; Butler, 1993a; 1990; Sedgwick, 1991), and transfeminism (Salamon, 2008; Koyama, 2003). Subsequently I will illustrate the range of sociological transgender scholarship that was to follow (Davy, 2011; Hines, 2007a; Monro, 2007; 2003; Cromwell, 1999b; Gagné et al., 1997; Devor, 1989; 1987). Further, struggles for equal rights and recognition have resulted in important discourses on transgender

experiences in relation to the law (Spade, 2006; Whittle, 2002), and also from transgender activists who work within the academy (Califia, 2012; Serano, 2010; 2007).

The majority of this scholarship has, whilst recognising the mutability of gender identity, not specifically or extensively engaged with identification outside of the binary of male and female. The small amount of scholarship to date which has considered non-binary individuals is addressed at the end of this chapter. Only the most recent examples of this scholarship recognises non-binary identification as an (umbrella) category in its own right, with older work implicitly illustrating non-binary variation before the term 'non-binary' entered academic or queer community contexts. Whilst some of this broad cross-section of transgender literature recognises the possibilities of identification outside of the gender binary, there is a dearth of sociological consideration of non-binary experiences as a specific focus. I will conclude this chapter by highlighting how the scholarship reviewed may inform future directions, and discuss how drawing from a theoretically diverse body of work benefits the consideration of non-binary gender identities.

The Ethnomethodological Approach to Gender

First developed by Harold Garfinkel, ethnomethodology can be defined as “the body of common-sense knowledge and the range of procedures and considerations by means of which the ordinary members of society make sense of, find their way about in, and act on the circumstances in which they find themselves” (Heritage, 1984, p. 4). Ethnomethodology challenged contemporary sociological approaches, which were primarily concerned with macro-sociological structures. Instead, ethnomethodology addressed how individuals navigate (and in part, construct) social orders. The positioning of sociological facts as objective was problematized, with a greater emphasis instead placed on the processes by which individuals construct and experience their realities – the organisation of their everyday lives. The ethnomethodological consideration of gender was to propose and illustrate how rather than simply a biological manifestation, gender is 'achieved' through action, interaction, and presentation. This paved the way for later academic theorisation of 'doing' gender (Butler, 1990; West and Zimmerman, 1987).

Garfinkel considered how gender was achieved and negotiated through the case study of an individual originally believed to be intersex (Garfinkel, 1967). Contemporary medical discourses of the 1960s positioned intersex people as rare 'abnormalities' (Stoller and Rosen, 1959), and thus Garfinkel considered the medical and social

process which a young woman named Agnes, presenting as intersex, needed to navigate in order to be recognised as a woman. Agnes was referred to the medical practice of Robert Stoller (with whom Garfinkel collaborated), in 1958. Assigned male at birth due to the presence of a penis and testes, Agnes reported that she spontaneously feminised during puberty, developing breasts and a highly feminised appearance. Agnes articulated that her feelings concerning her penis were of no greater consequence than “having had a painful wart that had been removed” (Garfinkel, 1967, p. 66), and that she identified and lived fully as a heterosexual woman. In order to access vaginoplasty, it was necessary for Agnes to undergo exceptional scrutiny, including factors such as her sexuality (diagnostic criteria specified that heterosexuality was necessary for medical verification of her womanhood), interests, gendered appearance, and mannerisms. This illustrates a form of what Foucault described as discipline – whereby the medical establishment (in this case) has the power to legitimise what bodies and identities are desirable and permissible (Foucault, 1978). Garfinkel’s paper was originally to demonstrate how an intersex person such as Agnes could successfully integrate into the social role of ‘female’, in spite of her ‘condition’. However, of critical importance was the fact that long after accessing the surgery she sought, Agnes revealed that she had been surreptitiously taking her mother’s hormone replacement pills from the age of 12, and it was the luck of this timing in relation to puberty that led to physiological developments which allowed her to ‘pass’ as a woman in all respects except for her genitals, when medically scrutinised years later (Stoller, 1968).

This significantly altered how Garfinkel’s original paper could be read – Agnes’ status as a “natural, normal female” (Garfinkel, 1967, p. 61) was due to how remarkably feminine (yet ‘appropriate’) she appeared to Garfinkel and her physicians. Had her accurate history been known, she would have been dismissed as a ‘male with a mental disorder’ and been denied access to the surgery she sought. Agnes’ transgender status illustrates how particular biological traits were essentialised as gender. With the benefit of hindsight, the gendered assumptions Garfinkel himself made regarding Agnes’ ‘authenticity’ become highly obvious. This evidences how gender is essentialised, and reveals the culturally constructed biases and values which Stoller and Garfinkel displayed when scrutinising Agnes.

Viewing this work with the benefit of the feminist and gender scholarship that followed over the next 40 years, it is clear how Garfinkel’s considerations were limited by restricted notions of masculinity and femininity, as well as ‘maleness’ and ‘femaleness’,

together with an uncritical biological essentialism (Bologh, 1992; Rogers, 1992). Davy asks the questions “What if Agnes’ presentation had been of a non-normative femininity? Would Garfinkel’s analysis have been the same? Would her ‘true’ (inter)sexuality have changed?” (Davy, 2011, p. 63). These questions illustrate how critical evaluation has developed since the context of Garfinkel’s work. Whilst a valuable contribution that considered how Agnes negotiated the necessary social factors to be found to be an ‘authentic woman’, the limitations through lack of critical reflexivity from the research are very apparent.

It is reasonable to conclude that Stoller’s and Garfinkel’s essentialist positions and policing of gender expression contributed greatly to Agnes’ treatment. Should she have been found lacking – such as through presenting a non-normative femininity, it is reasonable to hypothesise that she likely would have been positioned as male – a ‘transsexual male’ rather than ‘intersex female’. Such language that erases trans and intersex realities illustrates how gender is essentialised primarily to binarised genitals, with this ‘fact’ only then being revised with swathes of normative and disciplined evidence that Agnes provided. This example serves to contextualise how transgender people have exhibited resistance in their interactions with and navigations of medical services to procure their desired outcomes. The gate was now opened for the academic consideration of social interactions in the study of gender.

The work of the ethnomethodologists Kessler and McKenna (1978) took Garfinkel’s concepts further, by exploring how the significance of biological structures in defining sex/gender is as culturally constructed as notions of masculinity and femininity. Their discussion recognised ‘cultural genitals’ – the penis or vagina an observer assumes to be present, when attributing a gender to another individual based on social interaction or observation. This concept was used to underpin an analysis that recognised how choices and behaviours contribute to gender, with the ability of transsexuals to ‘pass’ as their identified gender used as evidence.

Kessler and McKenna’s critique of earlier medical research impacted on the consideration of gender within the natural sciences. Their discussion of biological factors including chromosomes, hormone levels, internal reproductive organs, genitalia, and secondary sexual characteristics (such as body hair patterns and fat distribution) has been developed considerably by Anne Fausto-Sterling (2008; 2005; 2000b). Her work has bridged natural and social scientific analyses which have considered biological differentiation, whilst recognising the considerable interplay and restrictions

of cultural factors – including consideration of a ‘five sex system’ (Fausto-Sterling, 2000a; 1993).

Such research has been important in highlighting how there is still a lack of clear evidence for a dimorphic neuroanatomy, as “there are no stable criteria that distinguish sexes reliably or concretely” (Gauthier, 2014, p. 42). Fausto-Sterling’s analyses also serve to critique a binary model of gendered/sexed physiology, and also challenge an over-simplistic reduction of ‘sex’ to ‘genitalia’. Such logic can be equally proposed as regards identity, in that a bimodal model (of male and female identification) fails to represent the complete population. Despite this, no work has ethnomethodologically considered the everyday practices of people with non-binary gender identities.

In illustrating gender categories as contextually situated, Kessler and McKenna drew upon non-Western articulations of gender (Herdt, 1993), which had historically been considered by anthropologists, albeit in a problematic manner (Mead and Boas, 1928; Malinowski, 1927). However, whilst Kessler and McKenna recognised the interpretation of gender as socially constructed, they did not suggest or recognise the possibility of intelligible genders other than male or female. Individuals who did not identify with the gender they were assigned at birth were used to illustrate how gender is ‘done’, though their doing of gender was still highly binarised.

Kessler and McKenna would later write “It did not even occur to us that within 20 years there would be some people who would want to confront others with the contradiction between their gender presentation and other “facts” such as their genitals or gender history” (2000, no pagination). Transsexual people were expected to construct their bodies, presentations, and identities to align with normative ideas of gender, unavoidably therefore, within the gender binary. Kessler and McKenna showed how even binary-identified individuals who challenged expectations of a normative medicalised ‘transsexual narrative’ (by not seeking or desiring genital surgery for example) were not considered, nor was the idea of non-binary gender identification within a Western context.

The legacy of ethnomethodology on the study of gender has been through its shift away from the ‘hegemony of sex’, dictated by the epistemology and methodology of the natural sciences. It has directly influenced feminist work that has looked at how gender is done within the context of relationships (Sanger, 2010), relating gender to sexuality (Schilt and Westbrook, 2009), and influenced the use of methods such as conversation analysis (Kitzinger, 2009). My own research questions benefit from recognising

ethnomethodology. Thus, the lack of work on non-binary means that giving space for participants to make sense of their own circumstances (in relation to queer communities and medical practice), as this approach encouraged, makes possible broad, rich data. However, these early ethnomethodological discussions lacked particularity (Hines, 2006) or recognition of the possibility of gender plurality. Indeed, it would take time for transgender discourses to be further developed, chiefly through interaction with feminist scholarship.

Feminism and Transgender – from Radical Exclusion to Queer Embrace

As awareness of cross-gender identification grew, tensions arose with then-burgeoning second-wave feminism. Stryker illustrates this with a case history of the trans woman Beth Elliot, showing how transgender women were viewed as men undertaking an “unwanted penetration into women’s space” (Stryker, 2008a, p. 102), particularly by cisgender lesbian separatists. Stryker’s choice of words is no coincidence, with anti-trans critics commonly positioning trans women as rapists due to their entrance to woman-only environments (Raymond, 1979). Whilst transgender women bore the brunt of feminist criticism, transgender men were typified as ‘women’ attempting to access patriarchal “male power and privilege” (Hines, 2007a, p. 18).

Such anti-trans sentiments were present in feminist scholarship as well as activist and social networks. The most infamous example of such work is Janice Raymond’s book *The Transsexual Empire* (1979), where she argued that transgender women are ‘actually’ men articulating hyper-feminine, servile parodies of womanhood. Raymond’s arguments relied upon an essentialist, biologically based definition of womanhood, and claimed transgender women rape ‘real’ women through cultural invasion. Similarly, Sheila Jeffreys (2014; 1997) has argued that transgender rights transgress upon women’s rights, and claims that gender affirming medical interventions (such as vaginoplasty) are mutilations. Davy summarises such arguments by saying “doctors stand accused of conspiring with transwomen to prop up patriarchy, by surgically and hormonally transforming them into “pseudo-women”, who may, therefore, duplicitously infiltrate “womyns” (especially radical lesbian feminist) spaces by “*pretending*” to be lesbian women and consequently subverting feminism” (Davy, 2011, p. 47, emphasis original).

Further, trans-exclusionary radical feminists have made claims that transgender women fetishise womanhood, wishing to ‘become’ women in fulfilment of erotic fantasy. This relies on Blanchard’s theory of autogynephilia (1989b), as discussed in detail in

the previous chapter. Essentialised notions of womanhood, and the socially constructed patriarchal biases that entered scientific research on gender were critiqued by second wave feminist thought, and yet were relied upon in trans-exclusionary radical feminist arguments.

Trans-critical 'feminism' has been regarded as problematic by many (Califia, 2012; Stryker, 2008a; Hubbard, 1996). One of the earliest and most important critiques of trans exclusion came from Sandy Stone, who was a target of personal attack by Raymond in her work. Informed by the feminist work of Donna Haraway (1991), Stone's *Posttranssexual Manifesto* (2006) utilises a postmodern analysis to deconstruct "the foundationalist assumptions that support Raymond's narrower concept of womanhood, and by claiming a speaking position for transsexuals that cannot be automatically dismissed as damaged, deluded, second-rate, or somehow inherently compromised" (Stryker and Whittle, 2006, p. 221).

Stone also encouraged an opening of transgender narratives, stating how the medically informed narrative of being 'trapped in the wrong body' had dominated, creating a hierarchy between normative, 'good' transsexuals, and other more stigmatised articulations of gendered difference (such as transgender people who did not seek surgery). Stone challenged the ubiquity of 'transsexual' as the approved label by the "body police" (that is, the medical establishment) in their erasure of "a vast heteroglossic account of difference" (2006, p. 229) due to its origin within pathologising and disciplining medical discourses. Such an appeal to legitimise gender plurality was an important step in genderqueer and non-binary identities becoming articulable within queer and trans communities.

In the wake of challenging radical feminist discourses, Stone's deconstruction would go some way in laying a foundation for postmodern feminist discourses of the 1990s, and marked the development of queer theory. Judith Butler opened up radical new considerations of sex and gender through her seminal works *Gender Trouble* and *Bodies that Matter* (1993a; 1990). Butler developed the concept of performativity, through consideration of the construction of identity in social interactions. In articulating performativity in relation to gender, Butler argues that identity categories and politics limit possibilities which feminism aims to make available (Butler, 1990).

In challenging the notion that genders are inescapably restricted by a 'mimetic relation' to a binary of sex, and by also illustrating the capacity for sex to be constructed within culture, Butler draws upon the philosophy of Merleau-Ponty in claiming the body as "a

set of possibilities to be continually realised” (Butler, 1988, p. 521), though with contextual constraints. The advent of non-binary identities into increasingly public awareness suggests such contextual constraints are shifting to allow greater gender plurality, highlighting the necessity of study. Butler sought to avoid early misinterpretations of her work that conflated performance with performativity, which sometimes occur due to her deconstruction of drag performances. Performativity is not a conscious iteration of the self in response to an environment, as this, by Butler’s analysis, “presumes a [gendered] subject” (1993b, p. 21). Rather, performativity indicates a relationship between gender and selfhood which simultaneously creates and challenges the idea of a given subject, which Butler positions as only recognisable through interactions with the culturally idiosyncratic system or ‘matrix’ of gender (Butler, 1993b).

Butler’s work has been critiqued, with Raewyn Connell arguing that transgender realities are appropriated and erased in order to discuss abstract theorisation on identity, without recognising transgender experiences of oppression and violence (Connell, 2012; Namaste, 2009; 2000). Prosser has raised concerns with how Butler’s deconstruction may be used to undermine claims of stability in transgender identities (Carrera et al., 2012; Prosser, 2006). Prosser further explains how it can be assumed from reading Butler that “transgender is queer is subversive” (Prosser, 2006, p. 262), and critiques notions that imply a hierarchy of authenticity – with drag potentially celebrated as (transgressively but permissibly) performative, yet transgender marginalised as ‘merely performance’. This can be related to discussion of medical power and authority in the previous chapter, as the clinical gaze functions to suppress subversive behaviour, ‘disciplining’ the genders of those seeking medical transition. The relationship here is that in order to be legitimised within the clinical context, trans people must allow a display of their genders to be scrutinised by practitioners. Transgender people are more likely to succeed in accessing treatment if ‘doing’ gender normatively. This is due to better fulfilling practitioner’s expectations of what it means to ‘be’ a man or woman. Being trans in and of itself may already be taken as subversive through the association Prosser highlights; posing any additional challenge to hegemonic gender roles (such as by being non-binary) may be punished, though being positioned as a ‘complex case’, and delayed or denied treatment (Roller et al., 2015; Cruz, 2014).

Snyder (2008) explains how third wave feminism responded to the ontological collapse of the category ‘woman’ in essentialised terms, such that a wider range of

heterogeneous feminist voices could be empowered. Inclusivity and reflexive self-critique were to be increasingly emphasised, rather than attempts to create a single all-encompassing narrative of womanhood. This not only increased the recognition of specific queer and black feminist issues but allowed for a wider range of feminist positionalities (Boux, 2016; Harris, 2010; Duggan and Hunter, 2006; Glick, 2000), particularly important given the 'sex wars' of the 1980s (Martindale, 1997; Willis, 1981). Nagoshi argues that transgender theory has benefitted feminist and queer analyses by helping to connect such scholarship to social work and advocacy, so as to more directly challenge different forms of social oppression (Nagoshi, 2010). Examples given include how transgender scholarship has not only considered gendered language use and transphobia, but emphasised how lived experiences have transgressed particular normalised narratives, revealing gendered oppression. Such oppression can then be resisted through the negotiation of transgender identities which serve to empower, which social workers benefit from understanding in order to work effectively with transgender clients.

Halberstam's queer analyses of gender (2005; 1998) made the point that the flexibility and fluidity of gender has allowed 'dimorphic gender' (the gender binary) to socially dominate. This is due to how "so few people actually match any given community standards for male or female, in other words, gender can be imprecise and therefore multiply relayed through a solidly binary system" (1998, p. 20). Whilst the binary does not inherently reduce social capital for non-stereotypical articulations of gender, individuals who actively mix, subvert, or exist outside of such gendered practice (such as non-binary individuals) are rendered socially impossible. This has been recognised by Butler through the idea of cultural intelligibility (Butler, 1993a), which may be understood as being how the construction of a given social phenomenon (such as gender) renders particular individuals or identities invisible, through a lack of factors that act as symbolic social cues for a particular embodiment (Lloyd, 2007). For example, individuals scrutinise others whenever making a gender ascription, which within a contemporary Western context, is invariably either male or female. Ambiguous presentation or mixing of gendered traits is not enough for *ascription* as non-binary, but leads to greater levels of scrutiny to ascertain 'the truth' (looking for an Adam's apple, or signs of facial hair growth in androgynous individuals, for example). The pervasiveness of cisnormativity (Worthen, 2016; Bauer et al., 2009) results in non-binary identified people going unrecognised as 'legitimate' subjects by other social actors, and therefore being rendered unintelligible.

The continual development of empirical, feminist, transgender studies have articulated a politics far removed from second wave criticisms of transgender. Similarly to Stone, Hines illustrates how arguments such as Raymond's and Jeffreys' "exemplify how a gender binary understanding is unable to incorporate transgender into feminist theory and politics" (Hines, 2007a, p. 20). However, critical philosophical engagement with questions of gender via third wave and postmodern feminisms lead to more emancipatory and intersectional feminist scholarship (Yuval-Davis, 2006). Such scholarship valuably informs this thesis, in situating analyses of non-binary within a broadening emancipatory feminist framework. Such a dimension is also necessary to appreciate how misogynistic practices may impact non-binary people (Desmond, 2015), as has been done in relation to trans women (Connell, 2012; Serano, 2007).

Questions have been raised about how Women's Studies can respond to the emergence of new gender categories, and the reinterpretations of how gender is embodied and lived. Gayle Salamon has argued that gendered judgements on the basis of bodily signifiers (such as bilateral scars on a man's chest) can lead to assumptions being made about what knowledge such signifiers deliver – in this case, a transgender history/identification – as such scarring would symbolise mastectomy, whilst accompanying masculine presentation. Salamon positions transfeminism as an evolution that would allow feminists to "ethically engage otherness without the fear of mutual annihilation" (Salamon, 2008, p. 136). This phrasing clearly references the historical tensions seen between feminist and transgender communities and voices.

Whilst the underlying principles of a transgender inclusive feminism have been present at least as early as Stone's *The Empire Strikes Back* (originally published in 1991), Koyama produced *The Transfeminist Manifesto* (2003) in order to guide a trans movement that centred around discussions which connect feminist and transgender discourses. Issues of concern within the manifesto include experiences of male privilege, transmisogynistic violence, and healthcare. The recognition of how gendered oppressions fundamentally connect feminist and transgender scholarship has resulted in increased discussion of their synergy (Gomes de Jesus, 2014; Van der Merwe and Padi, 2012; Halberstam, 2006; Scott-Dixon, 2006).

There has now been a range of academic considerations of how feminism, queer theory, and transgender are situated in relation to each other, and the ways in which they overlap (Marinucci, 2011; Richardson et al., 2006; Hines, 2004; Heyes, 2003). By deconstructing essentialised notions of womanhood and increasing the visibility of gender variance through queer analyses, transgender feminist scholarship has

expanded. Julia Serano has argued how a great deal of transphobic and cisnormative manifestation is strongly linked to traditions and expressions of misogyny (Serano, 2007). Dan Irving has considered how capital can relate to transgender legitimisation, incorporating intersectional consideration of race, class, and non-binary identification into transgender experiences of stigma (Irving, 2014). Interdisciplinary attention has allowed nuanced empirical methods and broader theoretical considerations to develop outside of the abstract theorisation and textual analyses that earlier feminist and queer scholarship primarily relied upon and produced.

Richardson has emphasised that a common criticism of postmodern analyses is a lack of translation from texts to the real world. She criticises the academy for being overly abstract in its considerations, and failing to situate knowledge within the lived experiences and political needs of queer subjects (Richardson, 2005). This bears a similarity to the criticism levelled by Connell (2012) – that there is a moral as well as intellectual imperative for scholarship to be connected directly to lived experiences. Over the last twenty years, there has been a response to this concern through a now well-emerged empirical sociology of transgender, which has built on postmodern scholarship (Valocchi, 2005) whilst pragmatically engaging with lived experiences of transgender.

The Sociology of Transgender

The sociological study of transgender followed on from theoretical postmodern debates around gender, and also early work and biographical accounts originating from the transgender community (Cromwell, 1999b; Hewitt and Warren, 1995; Bornstein, 1994; Castle, 1992; Feinberg, 1980). Some of the earliest sociological work specifically considering gender variance was by Devor, who considered the expression of masculinity in women as a direct challenge to the gender binary (Devor, 1989; 1987). The focus of this work was not to consider the gender *identities* of the women involved in the research as potentially neither male nor female. However, Devor's work may be reinterpreted with the benefit of 25 years of further development of transgender studies. Due to how the contemporary emphasis on understanding gendered articulations was primarily psychological rather than sociological (Hird, 2002), Devor assumed that participants:

Learned from their parents, grandparents, and siblings that the behaviors and attitudes associated with maleness (masculinity) earned one power, respect, and authority while the behaviors and attitudes

associated with femaleness (femininity) epitomized weakness, incompetence, and servility.

(Devor, 1987, pp. 14 - 15)

Such a conclusion centres the explanation of gendered behaviour and identification on macro structures whilst under-recognising the potential importance of individual agency. Devor concludes that individuals who are assigned female at birth may adopt masculine coded behaviours and appearances, due to the preferential regard for masculinity under patriarchy. Further, despite some participants expressing significant interest in medical gender transition, they were still positioned exclusively as women within the research. That some participants spoke of 'being a boy/girl' rather than in terms of masculinity/femininity opens the possibility of genderqueer identity negotiation:

I sort of was a dual personality. I still wanted to be a boy and I still wanted to wear jeans and climb trees... One day... I decided that I wanted to be a girl that day.

(Devor, 1987, p. 21 - 22)

Due to how the individual had negotiated masculine behaviours and presentation, this prevented social acceptance when deciding to articulate a feminine presentation, despite being assigned female at birth and thus being 'less transgressive' in doing so. This introduced the important dimensions of individual agency, and how microsocial interactions may allow or constrain particular articulations of resistance to gendered hegemony. Being a masculine girl was possible, but going 'back and forth' was not. Whilst clearly related, this early work by Devor did not specifically claim to be studying trans people, per se.

Two of the first sociologists to collaborate on an empirical consideration of transgender were Patricia Gagné and Richard Tewksbury. Following from Kessler and McKenna, their research considers how "the institution of gender is taken for granted" (1998, p. 81), and that transgender people²² simultaneously experience pressure to conform to heteronormative expressions of masculinity and femininity, whilst resisting factors that position assignation at birth as the 'correct' indicator of how their gender should be

²² Gagné and Tewksbury's definition of transgender somewhat differs to common contemporary usages, in that it specifically differentiates between transsexual and transgender. Transgender in their context includes a wide range of gender variance including cross dressers and drag queens, but not individuals who sought medical transition.

enacted. Gagné and Tewksbury's work made the claim that most of their trans women participants believed in the 'correctness' of normative gender roles – that men and women 'should' express masculinity and femininity, respectively (Gagné and Tewksbury, 1998), and that transgender people should aim to be indistinguishable from the rest of society (Gagné et al., 1997). Whilst the term transgender was yet to be used in reference to individuals identifying as neither male nor female, the sample appears to contain individuals who exhibited non-binary articulations of transgender, which was explicitly recognised:

A small number of persons (n = 5) who cross-dressed and had no desire for SRS²³ referred to themselves in more politically oriented terms... Their intent is not to "pass" as women but to challenge the idea that gender is a "natural" expression of sex and sexuality. This group of five includes one "radical transgenderist"... who uses cross-dressing as a means to express feminine aspects of self and to challenge traditional binary conceptualizations of sex, gender, and sexuality... one "ambigenderist", an individual who lives alternatively as a man and a woman. Depending on how he or she feels, he or she frequently went out "in between" – as neither a man nor a woman (with long hair, makeup, high heels, tight pants, and a two-day growth of beard). In addition, this group includes three people who self-identified as a "third gender".

(Gagné et al., 1997, p. 484)

These individuals' experiences of gender were not the subject of further discussion. Gagné and Tewksbury viewed transgender women as outside of the gender binary by virtue of crossing it. Such a conceptualisation problematically renders all binary transgender people as failing in authenticity of their identified gender on the basis of essentialised physiological factors. Their conclusions that transgender women homogeneously believed in the importance of being normative as regards gender expression has also been called into question. Hines shows that transgender assimilation was often "a contentious political issue", and that "concerns around assimilating amongst transgender women often diminished through the stages of transition" (Hines, 2006, p. 60).

²³ Sex Reassignment Surgery.

The lack of recognition of (potential) non-binary identification by participants and by researchers may be explained through consideration of Plummer's analysis of sexual stories (Plummer, 1995). Plummer illustrates how the social context in which a narrative is expressed can limit the ways that narrative may be interpreted. As a result, the increase in transgender visibility over the past 25 years has produced a greater potential for individuals to recognise, and feel able to explore gender variance. This functions in a manner analogous to how gay 'coming out' narratives became possible, gained visibility, and shifted over time (Saxey, 2008). Such possibilities have also depended upon the accessibility of queer communities, as "for narratives to flourish there must be a community to hear; that for communities to hear, there must be stories that weave together their history, their identity, their politics" (Plummer, 1995, p. 87).

Plummer explains how stories may encourage political changes, as they can inspire shifts in attitude amongst members of the public through education and normalisation – which has been aided by 'slice of life' television shows such as the highly successful *My Transsexual Summer* (Mangan, 2011). It is also argued by Plummer that cultural dominance of particular stories can prevent other stories from being heard (such as the medically sanctioned narrative of being 'trapped in the wrong body'). Plummer illustrates this using the example of how narratives of pornography consumption tended to be overwhelmingly negative, and were used to position pornography as addictive and associated with extreme deviance, rather than positive, mixed, or neutral. A parallel can be drawn with the dominance of particular transgender narratives within both the popular imagination and the academy, as the early hegemony of medicalised narratives and the gender binary means that heterogeneity and particularity of transgender continues to emerge (Hines, 2006; Namaste, 2000).

Hird (2002) made one of the earliest attempts to formulate a 'sociology of transsexualism' through the discussion of authenticity, performativity, and transgression. Hird specifies how shifts from concerns with 'authenticity' to 'performativity' have been brought about by a rise in sociological analyses, and a decline in an emphasis on psychological approaches to transgender. Hird argues that the discipline of psychology, as a natural science, still makes essentialist and positivist assumptions concerning gender, which struggle to 'keep up' with the diverse and expanding articulation of identities (Hird, 2002; 2000). This critique evidences an epistemological shift, with postmodern analysis not making claims of the 'realness' of identities, but the importance of recognising different 'enactments' of the self. This

sociological development was clearly influenced by the theoretical deconstructions of queer theory, as highlighted in the previous section.

In addition to discussing the typologies of authenticity and performativity within transgender studies, Hird also positions 'transgression' as a critical theme, as transgender narratives have called into question the traditional relationship between sex and gender. This analysis made the assumption that sex and gender can be differentially defined and demarcated unproblematically, which has been challenged (Fausto-Sterling, 2008; Kitzinger, 1999). Parallels are drawn between gender and sexuality, usefully illustrating how homosexuality, lesbianism, and heterosexuality have all been acknowledged as socially constructed, as transsexuality/transgender was coming to be understood outside of medical contexts (Jackson, 1999; Esterberg, 1996; Weeks, 1996; Ingraham, 1994; Ringer, 1994; Greenberg, 1990; McIntosh, 1968). Hird recognises that within Gagné and Tewksbury's work as well as that of Hausman (2001; 1995), transgender identity negotiation was interactive. This was consistent with sociological consideration of the self, and with personal narratives (Plummer, 1995; Gecas, 1982; Goffman, 1959).

Hines has specifically acknowledged the significance of transgender communities in the production of transgender sociology. This work illustrated the importance of community movements for trans people, in contrast to earlier decades when stigma, together with guidance from doctors, encouraged transsexuals to go 'deep stealth' – sharing their trans history with no-one. In focussing on how care is articulated, she argues that transgender social movements not only 'fill in gaps' left by professional services due to lack of provision and effective training, but serve to challenge the efficacy of a system that requires grassroots resistance and support (Hines, 2007b). Similarities and differences with how non-binary people use community interactions has yet to be investigated, which supports the inclusion of research questions examining this within this thesis. Care within medical systems was also discussed by participants, highlighting feelings that there was a need for greater awareness and training. This raises questions not only over practices of care used by members of non-binary communities, but whether there are concerns (and if so, what) with how medical care is given. In further work, Hines has flagged a lack of theoretical recognition of the heterogeneity of transgender identities (Hines, 2006). Increased recognition of non-binary narratives would serve to assist in the production of a 'politics of difference' (Hines, 2013), a system which encourages interaction between organisations which

create policies and minority groups so as to allow for flexible and optimisable treatment of members of those groups.

In understanding how gendered difference is accommodated into legal systems and social policy, Surya Monro has produced scholarship looking at UK transgender politics and citizenship (Monro, 2005b; Monro and Warren, 2004). Further, Monro is among the first to explicitly recognise gender beyond male or female within the sociology of transgender, once again building from, but also critiquing, earlier postmodern theory (Monro, 2005a). Systems of categorisation struggle to be consistent, and in granting equal ease of participation, as they “fail to address the fluid and developmental nature of identity” (Monro, 2003, p. 442). Monro highlights this using the example of Hijra in India, a non-Western, non-binary gender identity (Nanda, 1993; 1990). Further, the significant and specific manner in which intersex citizenship is troubled by the embedding of the gender binary in law and policy is positioned as twofold, due to how the binaries of physical attribution (‘male or female genitalia’) and identity can both be challenged by intersex. Such work also bridges demarcations between different non-binary experiences (intersex and non-binary trans) through common problems in relation to equal citizenship.

Under the hegemony whereby the interpretation of bodies is binarised, transgender bodies (that are assigned a gender unambiguously at birth) do not challenge systemic interpretation in the same way as intersex. The increasing visibility of non-binary people however does call into question how ‘non-binary bodies’ are interpreted ontologically, as whilst this could mean intersex, it may also signify those bodies belonging to those who possess a non-binary gender identity. This remains an important point of consideration in the continuing discussions of gendered citizenship, similarly to how bisexuality and queer identification challenge binarised analysis with regards to sexual citizenship (Monro, 2015b; Monro and Richardson, 2014).

Diane Richardson has discussed how through the rise of a neoliberal politics of normalisation, questions are raised about “what communities and which individuals are becoming *acceptably* visible, as others are being marginalised” (Richardson, 2005, p. 524, italics original). Analysing neoliberalism recognises how identity politics have interplay with consumption under capitalism – with media discourses subsequently

proclaiming the 'transgender tipping point' (Steinmetz, 2014)²⁴. Earlier work considering sexual citizenship raised the importance of recognising the institutionalisation of heterosexual and male privileges (Richardson, 1998), yet the relationship between sexuality and gender identity meant that a logical extension from such work was how gender identity may limit equal experience of citizenship (Monro and Richardson, 2014; Hines, 2013; Richardson, 2007; Monro, 2005b; Monro and Warren, 2004). Such analysis implies a potential hierarchy of gender variance, with citizens normatively integrating, producing, and consuming possessing greater social capital (Portes, 2000). This disadvantages non-binary identification under a politics of normalisation, as the unintelligibility (Butler, 1993a) of 'non-binary' is inherently transgressive of gender norms.

In highlighting further problems caused by the gender binary's dominance, Monro has considered challenges to the gender binary through a cross-cultural comparison between India and the UK, in order to support diversity and challenge systemic inequalities (Monro, 2007). Vidal-Ortiz importantly recognises how transgender narratives have also become considerably more fractured in terms of intersectional considerations such as race and class (Vidal - Ortiz, 2008), though this remains under-researched. These intersectional considerations are an important development since the sociological development of transgender studies, as the methodologies of postmodern approaches, and less culturally nuanced natural scientific/medical research failed to recognise heterogeneity amongst trans experiences. The increased recognition of transgender people of colour was an important development within Transgender Studies (de Vries, 2015), such that analysis of transgender embodiment and experience is not reduced to consideration of gender 'in a social vacuum', with no further recognition of additional factors entwined with how gender may be experienced.

In addition to the structural implications that considering citizenship has for policy formation, the sociology of transgender has allowed scholarship of bodies outside of the context of medical, aetiological theories. Davy (2011) discusses transgender in relation to bodily aesthetics, and the politics of embodiment. In relation to medical transition, a performance of femininity from transgender women and masculinity from transgender men was necessary to access a diagnosis, hormones and surgeries (as discussion of Agnes particularly emphasised). Davy points out that "transsexuals were

²⁴ Within the 2015 Louis Theroux documentary *Transgender Kids*, a non-binary narrative was explored to illustrate gender variance amongst children, showing how media representation is bringing discussion of non-binary to a wider audience.

concerned with the rights to medical intervention for their 'Gender Dysphoria' rather than critiquing psycho-medical constructions of Transsexuality" (Davy, 2011, p. 146). This is an important example of how trans populations acted pragmatically to ensure their needs were met, rather than attempting a bottom-up re-conceptualisation of gender.

Further, Davy articulates how "being recognised within a binary system is seen to allow transmen and transwomen to accomplish gender normativity, which is also seen as having grave consequences for all women and gender minorities who do not abide by the gender order's notions of masculinity and femininity" (2011, p. 147). This can clearly be connected to the previous discussion of citizenship, as embodiment in relation to the demands of 'the gender order' impacts whether and how an individual is legitimised. Thus, the way in which some members of the transgender population access and negotiate medical services may impact upon how others then experience those services, because of potential generalisations and homogenisation of transgender amongst medical practitioners. However, a sociological analysis of the views of non-binary transgender people in the UK on their experiences of medical care has yet to be undertaken. How the body is considered (both medically and socially) remains fertile ground for scholastic investigation with regards to non-binary transgender people.

In addition to providing important analyses of transgender embodiment and body image, scholastic consideration has been extended to body image amongst the partners of transgender people (Pfeffer, 2008), the concept of agency within transgender families (Pfeffer, 2012), and partnerships (Sanger, 2010). Pfeffer makes a valuable point in her discussion on lesbian partners of transgender men being difficult for researchers to reach, "due to their failure to "fit" neatly into researchers' operationalisation of what constitutes lesbian sexual orientation" (Pfeffer, 2008, p. 327). This raises a cross-discipline methodological consideration of how research is designed to examine transgender realities, but may risk the failure to reach potential non-binary participants if language is uncritically binary. Further, the manner in which intimate transgender connections problematize labels of sexual orientation illustrates tensions of identity that may manifest in the personal lives of transgender partnerships. For example, a gay cisgender man in a relationship with a gay transgender man may need to (re)negotiate gay identity in relation to the association between genitals and sexual orientation.

It is also argued (Beauchamp, 2014) that transgender body narratives are constructed within a context of great pressure to conform to medical expectations. It is important to

recognise how interplay between dysphoria and the strategic performance of particular body narratives (in order to access medical services) may affect others who encounter these narratives, be they transgender, or a transgender person's partner (Gamarel et al., 2014). The relationship non-binary people may have with dysphoria as the dominant model for understanding the desire to make changes to embodiment, or how trans community discourses impact non-binary people, are currently unexplored. It is reasonable to infer that non-binary individuals will be as heterogeneous as in the binary trans population (long-recognised by the demarcation on the basis of surgical desire into 'transsexuals' and 'transgenderists'). Whether specific non-binary identities relate to particular embodied desires – such as being partially masculinised or feminised, or androgynous – also merits exploration. Such non-binary desires may be modulated by interactions with both queer community and medical practice.

Whitley has considered the negotiation of relational identities amongst who he terms 'SOFFAs' – Significant Others, Family Members, Friends, and Allies of transgender people (Whitley, 2013). Participants were conceived as 'undoing' and 'redoing' their understandings of gender based upon the new embodiments and identities SOFFAs were exposed to. Tensions between factors such as concern for the transgender person they know, anxiety to not offend, and how to be effective in their support were considered in contrast to stigmatisation that SOFFAs registered from external sources or recognised in themselves. Such work raises the question as to how transgender people conceive and perceive the interactions they have with their friends and loved ones – with regards not only to coming out and any potential transitions, but in the navigation of routine life.

Similarly utilising an image of undoing and redoing, Catharine Connell has discussed gendered interactions within the workplaces of transgender people, and uses such situational negotiation to critique West and Zimmerman's ideas (Connell, 2010; Connell, 2009; West and Zimmerman, 1987). Rather than 'doing gender', Connell argues for 'doing transgender' as a framework to consider workplace inequalities with specificity. This is due to her findings that "regardless of whether they are stealth or out, transgender positionality sensitizes transpeople to gender discrimination, thereby opening up possibilities for the collective contestation of gendered inequality by transpeople and feminists" (Connell, 2010, p. 51).

Schilt has looked specifically at transgender men's experiences of inequality in the workplace. Whilst explaining how there has been a "weakening of the hegemony of the deep stealth model" (Schilt, 2010, p. 33). Lack of representation and recognition is also

highlighted – with particular note given to the fact that the World Professional Association for Transgender Health (WPATH) only gained its first transgender board member over 20 years after the organisation's formation (Minter, 2006). This particular example emphasises how trans voices being actively involved in trans healthcare practice is a relatively recent initiative. Experiences with workplace discrimination and rights were also discussed in relation to legal protection, stressing the tension that exists given that individuals who hide their transgender status to mitigate discrimination risk or out of a simple sense of privacy may by doing so sacrifice legal protections.

Whilst transgender scholarship has emphasised negative experiences such as dysphoria, stigma, and discrimination, positive aspects of transgender identity have also been specifically recognised within the literature (Riggle et al., 2011). In their work which considered positive aspects of transgender self-identification via an online survey, Riggle et al. recognised eight central themes – “congruency of self; enhanced interpersonal relationships; personal growth and resiliency; increased empathy; a unique perspective on both sexes; living beyond the sex binary; increased activism; and connection to the GLBTQ communities” (2011, p. 147).

Many of these factors illustrate how experiences of positivity in relation to transgender identification were negotiated over time in relation to processes – such as disclosure to friends and family, and coming to terms with internal feelings. That one third of participants expressed that recognising and living beyond the gender binary was positive for them in and of itself invites more detailed consideration of the interplay with lived experiences. It is important to note how even binary transgender identification provided insight and empathy into gender expression that more radically challenged the gender binary (a further example to challenge the earlier claims of Gagné and Tewksbury that transgender people exhibited strictly normative views on gender).

The sociology of transgender has considered a diverse range of factors affecting the interactions which transgender people experience. In shifting from consideration of transgender as an inherently radical disruption of gender, increasingly nuanced consideration has been given to questions of identity. Abstract theorisation has been enmeshed with empirical examination of transgender experiences. Working to achieve legal protection and equal rights has been of central concern to transgender activism, and so interdisciplinary scholastic consideration of the law and transgender is of importance in contextualising the study of gender variance.

Transgender Rights – The Law, and Activism

Legal discourses and shifts have had a significant impact upon transgender narratives, experiences, and academic discourses. One of the most significant events in relation to this was the passing of the Gender Recognition Act in 2004 in the UK, coming into effect in 2005. This allowed for the potential acquisition of a new birth certificate and access to the (then exclusively heterosexual) institution of marriage. Prior to this, there was a significant intersection between activist writing and appeals for changes to laws and social policies (Lloyd, 2005; Spade, 2003; Sharpe, 2002; Whittle, 2002). Spade criticises how legal decision-making prioritises medical narratives as evidence, due to systemic assumptions that medical research carries an authority that sociological consideration or activist experience does not (Innvær et al., 2002; Elliott and Popay, 2000). In order to access medical services, Spade discusses how transgender people “suggest different ways to get around the requirements” and “know all about what it means to lie and cheat their way through the medical road-blocks to get the opportunity to occupy their bodies in the way they want” (Spade, 2003, p. 23). This further contextualises how from a medical practitioner’s perspective, there may appear to be greater homogeneity amongst transgender service users than may be accurate.

Greenberg has considered the legal precedents which constructed contemporary law in relation to race, so as to make a direct comparison with the legal construction of gender as it relates to transgender (Greenberg, 2002). Greenberg begins by describing how both race and gender have a history of being enforced as a binary, before being increasingly recognised as a cultural construction. She highlights how natural scientific data has been relied upon, and epistemologically privileged so as to set legal precedents, illustrating institutional power wielded by medical practitioners performing gender research. This work also provides an early incidence of suggesting gender nonconformity as a possible criterion under anti-discrimination law, which may directly improve the ability for non-binary transgender people to access equal citizenship.

Legal scholars have addressed the conception of transgender rights as human rights, and have recognised how historical, stigmatising policies have functioned to allow structural discrimination (Balzer et al., 2012). Balzer and Lagata illustrate the beginnings of a paradigm shift, such that laws based upon medical discourses are replaced with those based on human rights discourses (Balzer and Lagata, 2014) as a partial result of the Yogyakarta principles. These principles addressed “the application of international human rights law in relation to sexuality and gender identity” (The

Yogyakarta Principles, 2007). Wilkinson discusses the notion of 'cultural competency' as a way to understand how a minority population may have its needs and diversity understood and addressed effectively (Wilkinson, 2014). Education is emphasised as essential in establishing permeation of gendered knowledge throughout all aspects of society, particularly for key service providers – and that this is a continual process, rather than a topic that can begin and end with a single diversity workshop.

Spade highlights the complexities between consideration of the law, transgender citizenship, and intersectional politics (Spade, 2006), relating the law to the earlier discussion of sexual and gendered citizenships. He makes a distinction between struggles for non-discrimination rather than equality, and how (within a US context) low-income gender variant individuals are particularly disadvantaged by “sex segregation and the gendering of legal identity” (2006, p. 231). This can be related to Tam Sanger’s work on gendered governmentality (Sanger, 2008). Originally conceived by Foucault (Lemke, 2001; Foucault, 2010), governmentality concerns systems of power flowing between governments and subjects, in order to shape citizens such that governmental policies can be more easily fulfilled. Sanger explores how across disciplines, the privileging of particular transgender voices has resulted in a relatively “homogenous conceptualisation of trans” (Sanger, 2008, p. 44). This agrees with Hines’ critique of a lack of recognition of trans particularity (Hines, 2006). The point can be made that even with explicit identification outside of the gender binary, individuals will be read and positioned within the binary by others, due to the extent of a binary-assuming hegemony and the lack of cultural intelligibility non-binary currently struggles with (Butler, 1993a).

Within a specifically UK context, Alex Harris has considered how queer theory can be linked to, and used, in the analysis of the treatment of transgender people under legal systems (Harris, 2013). A critical deconstruction of the Gender Recognition Act (as problematically essentialist) is made, due to the Act’s requirement to ‘live in the acquired gender’ for a two year period prior to legal recognition and to agree to make no subsequent gender change following legal transition. The Act continues to reify a system which “treats transsexuals as individuals subject to assimilation within a heteronormative framework” due to the imposition of particular notions of gender positioned as objective and absolute (Harris, 2013, p. 68). Harris highlights systemic epistemological problems within legal decision making, utilising Butler’s work. Such a usage poses a direct challenge to the common criticism of postmodern scholarship –

that it is too abstracted from the material world to be applied to problem solving. Therefore whilst the sociology of transgender in the previous section demonstrated the influence of postmodern work in relation to empirical studies, hermeneutics of policy documents shows direct application. The argument also illustrates in particular how the generation of empirical considerations of gender beyond the binary are necessary in order to continue to effect emancipatory social changes. The range of academic studies considered so far often contained participants who articulated themselves as neither male nor female. However, these works did not expressly focus on understanding non-binary identities.

Activist work has provided recent evidence to further highlight increases in both non-binary visibility, and needs. The UK transgender charity *Action for Trans Health* produced data illustrating that 62.5% of their funding support was granted to non-binary people – illustrating not only the increased visibility of the non-binary population, but simultaneously how they may be at greater risk of forms of vulnerability that render them eligible for charity support (Action for Trans Health, 2015; Harrison et al., 2012). Finally, the recent extension by the charity Stonewall to include transgender equality under its remit involved the production of a report, after hearing from hundreds of transgender people (Hunt and Manji, 2015). Non-binary people were the second largest contributing demographic to this report, illustrating how the transgender population contains a sizeable number of non-binary people who wish to be recognised. The final section of literature to be considered is the comparably small number of works which expressly look at those identifying as neither male nor female.

Non-Binary Articulations of Transgender

The earliest considerations of gender outside of the Western binary paradigm of male and female were to be found in the field of anthropology (Herdt, 1993; Jacobs, 1968; Lurie, 1953; Malinowski, 1927). However, whilst gendered expression and identity were recognised as differing to Western organisations and expectations, explanations and analysis were framed in Western terminology, which resulted in the simplification of non-binary gender identities and the loss of nuance in cultural differences. Jacobs, in his analysis of North American *Berdache*²⁵ gave the definition as “one who behaves

²⁵ This term was used within anthropological literature to refer to a wide range of North American First Nation gender identities across different tribes. The term is often considered offensive due to its origin from a French word for prostitute, and the term ‘two-spirit’ is now preferred as an umbrella term, originating from First Nation communities – however tribally specific terms may be argued as offering greatest

and dresses like a member of the opposite sex” (1968, p. 25), implying analogousness with cross-dressers, which is not the case. Kessler and McKenna explain how:

The Winnebago people were reluctant to discuss their Berdache honestly with white men because the Winnebago could tell that the white men regarded the institution negatively. Reluctance could stem not only from embarrassment at revealing behavior that was being judged by outsiders as immoral, but also from beliefs in the sacredness of the institution and an unwillingness to share this aspect of their culture.

(Kessler and McKenna, 1978, p. 31)

This illustrates how lack of reflexivity amongst researchers meant their own relationship to the research went under-interrogated, resulting in flaws in reliability. This methodologically valuable lesson retains its salience in establishing rapport and considering relative social positions when engaging with transgender research participants, as already recognised in Vidal-Ortiz’s work (2008).

As Hines has summarised, early works that came to be collectively viewed as ‘transgender theory’ opened alternatives to how transgender had been medically constructed, which could be used to challenge the stigma associated with being pathologised (Hines and Sanger, 2010). In performing this critical deconstruction, the stage was set for more nuanced investigations of how transgender can be understood. One of the earlier pieces of literature which opened discussion on Western non-binary genders (beyond problematic claims of binary transgender people being ‘other than male and female’, or discussions centred on sexuality) was Kate Bornstein’s *Gender Outlaw* (1994). In addition to discussing non-binary transgender people and providing an academic nucleus for further study (Bornstein and Bergman, 2010; Stryker and Whittle, 2006; Hausman, 2001), Bornstein’s work also acted as one of the seminal texts in the development of Transgender Studies. This differed from contemporary literature of the time by not being driven by postmodern theory explicitly, but was rooted in grassroots community voices. Such voices were however potentially informed by the postmodernism in queer theory (Rollins and Hirsch, 2003; Nicholson and

respect and specificity. See Epple, C. 1998. Coming to Terms with Navajo Nádleehí: A Critique of Berdache, " Gay," " Alternate Gender," and " Two-spirit". *American Ethnologist*. **25**(2), pp.267-290.

Seidman, 1995). In addition, Bornstein's work has been discussed and positioned as postmodern, through their radical queerness (Bell, 1994).

In *Gender Outlaw*, Bornstein outlines a clear list of 'social rules of gender' and how non-binary identities challenge or break such statements. By deconstructing the criteria that are commonly used to define individuals as being male or female, permission is created for non-binary transgender narratives which defied much then-contemporary medical intervention, such as active erasure of an individual's transgender history²⁶.

Bornstein discusses 'passing' (as male or female) both sympathetically and critically. On the one hand, "most passing is undertaken in response to the cultural imperative to be one gender or the other. In this case passing becomes the outward manifestation of shame and capitulation. Passing becomes invisibility. Passing becomes lies. Passing becomes self-denial" (Bornstein, 1994, p. 125). Whilst damning the reification of a compulsory gender binary (or movement between oppressively gendered categories), Bornstein states that to pass is to 'have' one's gender, to be viewed and accepted as one wishes to be. Thus, passing by choice in order to validate one's sense of self is firmly differentiated from 'enforced passing'²⁷. However as one can only pass as man or woman due to the entrenched nature of the gender binary, it is currently impossible for non-binary people to pass as their identified gender, again as a result of the unintelligibility of non-binary as a subject. The potential for such unavoidable erasure to cause a minority stress experience (Herman, 2013; Hendricks and Testa, 2012) in non-binary people places additional emphasis on exploring potentially important modalities of stress management, such as queer communities.

Whilst the vast majority of sociological consideration of gender variance has focused exclusively on transgender men and women, there are examples whereby a diversity of transgender narratives beyond the gender binary are acknowledged. Ekins and King

²⁶ Historically it was deemed necessary by medical practitioners that, in order to be socially accepted, transgender people needed to hide their trans status, even relocating and establishing an entirely new social network when post-transition. This practice has been criticised as preventing the normalisation of transgender narratives, as well as limiting transgender communities and political mobilisation by creating pressure for self-erasure even from each other. See Namaste, V. 2000. *Invisible lives: The erasure of transsexual and transgendered people*. Chicago, London: University of Chicago Press.

²⁷ The passing of a trans person as the gender they were assigned at birth (that is, passing as cisgender) for work, comfort, or safety reasons. An example would be a transgender woman 'passing' as a man, due to being socially read as male.

provide a model that accommodates and explores this in writing of a sociology of transgendered bodies (1999). Transition narratives are opened beyond 'male-to-female' or 'female-to-male', but as potentially 'migratory', 'oscillatory', 'erasing', or 'transcending'. Gender beyond male and female is directly referenced via the category of transcending, allowing space for a sociology of non-binary transgender bodies²⁸. In setting up such a framework, Ekins and King proposed the next step to be to "set such a psychobiological focus firmly within the study of social interaction, social situation, social structure and social system" (Ekins and King, 1999, p. 600) of which medical and queer social experiences play a significant part, supporting this project's lines of enquiry. However, Ekins and King do still draw conclusions which make certain 'binarising' assumptions. For example, they make the argument that:

The critique of the binary gender divide and the ideas of gender fluidity and impermanence would seem to rule out surgical and hormonal substituting because of their permanent and binary nature.

(Ekins and King, 1999, p. 597)

This fails to recognise how only particular *combinations* of biological traits are legitimised as normative (such as breasts, vagina, feminised fat distribution, female hair growth patterns). Accessing medical services may result in some biological structures/patterns associated with maleness, and others with femaleness (for example, taking estrogen and receiving breast implants but retention of the penis and testicles). The motivations for accessing or not accessing surgical and hormonal interventions are heterogeneous and potentially complex. Finally, in ascribing all hormonal and surgical interventions as 'binary in nature', Ekins and King are not recognising how it is only hegemonic gender discourse that is inscribed onto physiology, and that this may be resisted. For example, the queer possibility of 'breasts' to be understood as male or non-binary, rather than inherently female – granting space for the personal inscription of meaning onto bodies, and onto medical interventions.

An important contribution came from Bilodeau (2005), where explicitly non-binary transgender identities were analysed by repurposing the D'Augelli (1994) lifespan model of sexual orientation identity development. This analysis came before much of the larger empirical studies of binary trans individuals within sociology, contextualising why a model for understanding sexual orientation was deployed. In focusing on analysis of two participants, detailed analysis was possible, finding connections with

²⁸ That is, the bodies of non-binary trans people, rather than intersex bodies.

themes already explored within this chapter, such as negotiation of feminist and trans identities, and postmodern gender identification (such as simultaneous identification as non-binary and as woman). Valuable support is illustrated for the importance of transgender communities in the exploration of non-binary identification, and also recognising potential in-group tensions, as one participant suggested how trans women may “take much of their [male] privilege with them” (Bilodeau, 2005, p. 42). This echoes challenges made to trans women by some cisgender radical feminists (Stone, 2006), however the positionality as an intracommunity tension deserves greater attention.

Differences in individual’s views regarding the gender binary as constructed or essentialised, and the validity of difference between transgender narratives has led to problematic hierarchies of ‘transness’ within some transgender communities (Schilt and Waszkiewicz, 2006; Roen, 2002). A key example of this is the phenomenon of ‘Truscum’ – an online community of binary identified trans men who support the medical model of ‘transsexualism’, or consideration of gender dysphoria as a medical condition, whilst articulating harsh criticisms of non-binary identities (referred to as ‘trans-trenders’ and considered inauthentic). The ‘Truscum identity’ operates a politics of exclusion that judges the experience of dysphoria and binary identification necessary to ‘allow’ an individual to identify as trans (Schmitt, 2013)²⁹. Such tensions within transgender communities are not new, with accounts of post-operative transgender women experiencing social exclusion from transgender women who had not had surgery (Keatley, 2015). Such developments recognise how the internet is an increasingly important site of trans community interactions (Dragger, 2012; Pearce, 2012).

Investigation into differences between the experiences and identities of binary and non-binary transgender people has received limited specific attention. One important exception is an analysis of the 2008 National Transgender Discrimination Survey by Harrison et al. (2012). The data from the 860 respondents who did not identify as ‘man’ or ‘woman’³⁰ were compared with the 5590 binary trans respondents who did so

²⁹ No peer reviewed material yet exists which references the social phenomenon of Truscum. This further highlights the space for research into the nuances of binary/non-binary transgender community interactions.

³⁰ These 860 respondents did not include individuals who were living part time as one gender and part time as another, as might be the case with a binary transgender person who is not out in some environments such as work, but out in others.

identify. A significant observation of the study included these 860 'Q3GNLs'³¹ being refused medical service at lower rates, but being more likely to avoid seeking professional medical care when sick or injured. It is possible this reflects a greater anxiety in non-binary people of ignorance in medical practitioners concerning their gender identities, but it is also important to recognise the American cultural context within which this research is situated³². Q3GNLs were also more likely to have attempted suicide when compared to the binary trans population, have higher levels of educational attainment, be more likely to have participated in "underground or informal economies for income" (Harrison et al., 2012, p. 22) such as sex-work or drug dealing, and were significantly less likely to be white, assigned male at birth, or over the age of 45. Such information may be helpful in contextualising the experiences of non-binary communities, as the interactions that people experience (and produce meaning through) will be influenced by demographic membership.

Some important, recent work specifically looking at narratives of non-binary gender identities has been conducted by Tracey Yeadon-Lee (2016). Qualitative analysis was performed of online forums and blog posts that discussed non-binary identification. Analysis of personal negotiations of gender were delineated into two categories, younger (twenty-nine and below) and older (thirty and above) generations. Within the blogs examined, Yeadon-Lee found evidence that suggested how the wide array of identity labels that now exist can be a positive resource fostering self-determination in some cases, in others there could be a pressure to 'find the place you fit', and feel insecurity and uncertainty. Discourses also related back to older binary trans narratives, with the suggestion that engaging with these narratives aided in interrogation of the internal sense of self, rather than acting to constrain. Yeadon-Lee also discussed how labels could create "a sense of outsidersness", citing a particular blog writer who said "I feel like sort of an imposter among non-binaries" (Yeadon-Lee, 2016, p. 29). Instability

³¹ An acronym created and used by the authors standing for 'Question 3 Gender Not Listed', a reference to respondents' answers to question three of the survey, where non-binary participants indicated their gender identity as neither man nor woman, and therefore 'unlisted'.

³² Important examples of this include the pervasive culture of religious conservatism that exists in certain parts of the United States, which may result in serious fears of discrimination, rejection, and ridicule. Also the private healthcare system of the US changes the dynamic and implications of receiving healthcare, with poorer individuals likely to avoid visiting a doctor if at all possible due to costs (if uninsured or underinsured), or due to the risk of losing a job if taking time to attend medical appointments, far less possible under the legal framework of the UK.

and insecurity of identity, and the (re)production of an artificial hierarchy of transness are themes I explore in relation to data this project produced.

Conclusion

This chapter has examined the ways in which transgender has been considered through academic writing over the past 50 years. This has ranged from the first recognition that gender is more than demarcation on the basis of reproductive physiology, to postmodern expansions of gender categories, through to the extensive empirical attention given to transgender identities, citizenship, and embodiment in particular. Whilst valuable in nucleating the shift away from essentialist medical discourse, the position of ethnomethodology is rarely seen in contemporary analysis. The ethnomethodological enterprise of considering how individuals navigate, and relate themselves to social structures/orders was vulnerable to deconstruction popularised by queer theory. Thus, there was a shift to the consideration of gender in terms of power dynamics between individuals, or through the analysis of subjective experiences of interpersonal interactions. This was more compatible with postmodern analysis in that focus moved away from the roles of social structures.

The value that feminist scholarship has played in situating analyses of transgender in a context of wider gender inequalities and emancipatory politics continues to be significant, particularly as a system for relating transgender to ideas of race, class, disability, sexuality, and other factors through the concept of intersectionality – which originated through the work of black feminist thought (McCall, 2005). However there remains a thorough lack of literature considering these factors in transgender contexts, particularly race. It is no coincidence that early appearances of genderqueer narratives closely followed from some of the most significant postmodern contributions. Queer communities were collectively influenced by work from individuals such as Butler and Bornstein. Therefore these literatures are part of a history of interventions vital for the contextualisation of non-binary.

The development of an empirical sociology of transgender has had specific benefits. For example, Love points out that “accounting for *material* experience” (Love, 2014, p. 174, my emphasis) positioned transgender studies as able to more effectively account for transgender embodiment. Recognition of the explicit presence of participants not identifying as male or female in older research on transgender has demonstrated the value that revisiting such work with the benefit of a contemporary lens can provide.

Secondly, this grounds this non-binary research within an existing research narrative, which is not initially obvious.

The growth of the sociology of transgender has occurred rapidly over the last 20 years, with continued engagement over issues including body image, embodiment, practices of care, identity formation and narrative, experiences of discrimination, and how these debates have impacted upon communities and policies. However, as I have highlighted, there has also remained a lack of empirical attention to the experiences and voices of non-binary transgender people in particular, despite their increasing acknowledgement within theoretical discussions, and cultural visibility. In the following chapter, I articulate the methods and analytical framework used in this project.

Chapter 3 – Methodology

Interactionism insists on being a humble theory, not claiming too much and not dealing with major abstractions and false dualisms. Indeed the real task of an interactionist is to simply look at social life as people “do things together”: its core interests lie in the doing of ethnographies and in an intimate familiarity with ongoing social (sexual) worlds.

(Plummer, 2003, p. 524)

Introduction

This chapter will reflect on the project’s research design and execution. Theoretical considerations were also central to the process of assessing the ‘fit’ between research questions and methods. I begin with an explication of the lens through which this research was undertaken, discussing the epistemological position of symbolic interactionism. The connection between this approach and the choice of methods – diary-keeping and follow-up semi-structured interviews – are then explained.

The research is then contextualised through discussion of the study’s objectives, and their relationships with my research questions. Decisions made in the design and practice of this research was informed by minority group insider politics (Kanuha, 2000; Zinn, 1979), emphasising the importance of emancipatory political potential in its applications, together with ethical rigor. This project used a multi-method approach. I then illustrate how this allowed for a synergy which ameliorates some of the limitations that can be found when diaries or interviews are used alone. My construction of ‘mixed media diaries’, which allowed diary-keepers to record entries via any number of creative forms, is explained and justified, together with discussion of semi-structured interviews, and how the research was executed. I follow with an explanation of the research design. Further, I discuss some important reflexive points that informed my decision making, enhancing rapport and access.

Recruitment of participants is subsequently discussed. Access to non-binary individuals was gained through a wide range of leads, which are outlined. Attention is then turned to the sample, where I present demographic data on the research participants. I then discuss my approach to data analysis, so as to empirically demonstrate trends and tensions within the participants’ accounts in relation to queer communities and medical practice. Further, the results of ethical decisions such as choice by participants regarding their anonymity are reflected upon. This leads into a final, broader discussion of ethical considerations.

Epistemology of Symbolic Interactionism

Symbolic interactionism (SI) considers the meanings ascribed to objects and actions by social actors. Williams (2008) points out how SI differed from most mid-20th century sociological practice, in that it did not make “the epistemological assumption that the social sciences could be modelled after the biological and physical sciences to produce verifiable “facts” that explain social behaviour and predict future behaviour” (p. 849). SI has a history of being anti-positivist³³ and interpretive. Further, by using a symbolic interactionist framework, I reject the premise that microsociological knowledge can be acquired or generated independently from the subject.

Symbolic interactionism is rooted in the philosophical tradition of Pragmatism. This system of thought holds that reality is best understood in terms of the different perspectives that individuals may hold, rather than modelling a singular (objectively knowable) world. Whilst an objective material world may exist, Pragmatism recognises that all understanding of the world must pass through the lens of human experience, which is unavoidably constructed and constrained by social context (Hamati-Ataya, 2014).

Pragmatists focus on the *uses* that modes of understanding have, as opposed to objectivist attempts to mirror, uncover, or explain some ‘truth’ of reality. No singular truth is believed to exist, with personal realities being “actively created as we act in and toward the world” (Hewitt, 1984, p. 8). However, the absence of an objective truth about the world does not preclude the existence *of* the world, separate and apart from individuals. Rather, individuals act on the basis of the meaning that things have for them, and it is this interaction between individual and object that produces meaning (Benzies and Allen, 2001).

Individuals form their views and construct their own truths of the world, on the basis of the interactions they experience – with other people, objects, and ideas. The role of (social) scientific enquiry thus becomes “a moral endeavour”, concerned not with an abstract knowledge production for its own sake, but with the purpose of application to the improvement of human lives (Williams, 2008, p. 850). Thus, my theoretical position

³³ Positivism is an epistemological position which argues that scientific analysis of data is the exclusive source of knowledge. Thus the existence of absolute truth is presumed, with little to no scope for relativistic positionality. Positivism infers that natural laws may be formulated to predict and explain social interactions. This has been widely challenged within the social sciences, ranging from Weber’s *Verstehen*, to the formation of critical theory.

may be understood as ontologically relativistic – the purported understandings of reality are not attempting to access any objective truth, but all have value in and of themselves, derived through application.

During the development of symbolic interactionism, two separate branches of pragmatism were used – by Mead (1934) on the one hand, and Dewey (1905) on the other. Lewis and Smith argue that Mead’s pragmatism has been conceived as philosophical realism³⁴ which has macro-sociological overtones (Lewis and Smith, 1980). In contrast, Dewey produced a ‘nominalist’ pragmatism – which recognises macro-social structures, but attributes greater importance to *individual* interactions in shaping identities and behaviours (Lewis and Smith, 1980). The use and understanding of symbolic interactionism in this work leans towards Dewey’s position, with a focus on how the meanings that objects have for individuals are personal and subjective, and symbolically associated with objects however the actor interprets (Ritzer, 2008).

Qualitative methods are most often chosen when using a symbolic interactionist framework, due to their usefulness in elucidating nuanced analysis from microsociological interactions. Utilising diaries as a method creates a shift from “participant observation towards the observation of participation” (Tedlock, 1991, p. 69). Tedlock describes how this change also alters the research dynamic away from a researcher-self versus researched-other to a “single narrative ethnography” (p. 69). This allows for co-production of knowledge between participants and investigator, fitting with the epistemological premise within SI that “rejects the idea of a disembodied researcher” (Williams, 2008, p. 849). Further, this assists in avoiding a problematic power dynamic that can be seen particularly in historical medical research on (rather than with) trans people, and has led to alienation and suspicion of researchers among some in the trans community (Tagonist, 2009).

Symbolic interactionism is epistemologically well suited to the study of gender, and has previously been rehabilitated in order to act as a framework for a feminist sociology of sexuality (Jackson and Scott, 2010). In arguing that interactionism accounts for the processes by which sexuality is constituted through cultural, interpersonal, and intrapsychic interactions³⁵, the same approach can be followed in an analysis of (non-

³⁴ Realism places an emphasis on societal structures and the ways in which control and influence occurs over individuals.

³⁵ Jackson and Scott draw on Gagnon and Simon’s 1974 work *Sexual Conduct* in considering these three categories as the key divisions of ‘scripting’, that is “the application of sociocultural scripts that imbue [objects] with meaning” (2010, p. 814).

binary) gender identities. Jackson and Scott also draw some comparisons between Postmodern and Interactionist social construction (Gagnon and Simon, 1973), though specifically with reference to Foucault. The most critical comparison by Jackson and Scott explains that “Foucault’s terminology does not permit a distinction between sex as erotic acts and sensations, and sex as sex difference – what we would call gender” (2010, p. 819). Whilst this can be resolved, it is argued that it is at the expense of broader conceptualisation and investigation of the nuances of gender in social interactions. The argument that interactionism accounts for the processes through which sexuality is constituted can be followed in an analysis of gender identity.

As non-binary narratives have little specific precedent as a named category, the stories participants tell in relation to identity illustrate new possibilities of being. Plummer asserts that “for narratives to flourish there must be a community to hear” (1995, p. 87), which highlights how structuring the research to consider queer communities in particular has epistemological justification. The growing significance of non-binary identity labels (Williams, 2014) also reflects the ontological importance which the epistemological position of SI grants. This articulation of real life experiences necessitated Plummer to ask “how might stories work to perform conservative functions maintaining dominant orders, and how might they be used to resist or transform lives and cultures?” (1995, p. 25).

Plummer explains how the telling of some stories can empower, whilst others can reduce possibilities or exert control (1995, p. 123). In drawing from Jackson and Scott’s analysis of SI for sociological consideration of sexuality (2010), I likewise use interactionism to consider the ‘cultural, interpersonal, and intrapsychic processes’ which influence non-binary identities. Indeed, Harrison et al. specifically state that this awaits further study when asking “how does nuance or multiplicity in gender identity and expression play out when interacting with gender policing structures and forces?” (2012, p. 20). Thus the epistemological relationship between this project’s methods and questions strengthens claims of effective knowledge production, via theory-driven method selection, and question articulation.

Cultural interactions are had between the individual and social structures, such as a government. The interpersonal indicates those interactions that occur between an actor and other individuals, whilst the intrapsychic is when an individual introspects, viewing the self from a third person perspective.

Research Objectives

The overarching objective of this research was to explore factors important for people negotiating non-binary gender identities. The discussions of previous scholarship on transgender supports the argument that access to gender affirming medical services is essential for those who experience gender dysphoria (Richards et al., 2015; Bouman et al., 2010). Additionally, due to the multifaceted stigma, discrimination, and inequalities trans people can experience in everyday life, community interaction is of critical importance for many in resisting the impact of minority stress, and being validated or reassured (Hackimer and Proctor, 2015; Pilecki, 2015; Hines, 2010). Focussing on these two critically important milieus of queer communities and medical practice allowed for enough specificity to comparatively analyse participant data. In keeping with the pragmatic goals of symbolic interactionism, this research aims to illustrate non-binary views and experiences³⁶ of social interactions and processes, in order to offer recommendations for their improvement.

Taylor and Whittier state that “to understand any politicized identity community, it is necessary to analyse the social and political struggle that created the identity” (1992, p. 352). Queer communities and medical practice were selected as potentially important sites impacting non-binary identity negotiation, due to precedent from binary transgender narratives of the importance of such contexts (Schmitt, 2013; Hines, 2010; 2007a; 2007b; Bauer et al., 2009; Gagné et al., 1997). This is not to say that other potential avenues of focus – such as experiences in the workplace, of family, youth or old-age, or of education – lack importance. However, discourses around transition and community are by far the most overarching contexts of transgender research, due to their extensive and heterogeneous relevance in the attainment of needed or preferred embodiment, social inclusion and legitimacy. Such an objective informed the construction of the research questions:

- How are non-binary identified individuals involved with and integrated into queer communities?
- How do non-binary identified individuals negotiate existing medical practices?
- What does the emergence of non-binary gender identities imply for queer community organisation and activism?

³⁶ This includes infrequent interactions, such as a potential GIC appointment or significant GP appointment, and everyday or frequent interactions, such as talking with friends.

- What does the emergence of non-binary gender identities imply for trans/queer healthcare?

These questions can be grouped as two pairs. The first pair was conceived to consider non-binary participant's interactions with queer communities, and medical practice, respectively. The questions necessitate attention to how non-binary people respond to and feel about the interactions they have within these contexts, and how their conceptions of such communities and medical practice (and of themselves) are accordingly shaped. Whilst this first pair of questions looks at how communities and medicine impact non-binary people, the second pair looks at how non-binary as a phenomenon is impacting communities and medicine. In answering the second pair of questions, analytical attention is turned to how these interactions, meanings, and realities can be interpreted and acted upon in wider social contexts. The data generated were not only reliant upon the participants and researcher, time and place of the research, but also the methods selected and methodological decisions made during the research process. Recognition of the subjectively situated nature of the knowledge produced however, does not serve to limit its applicability, but indeed strengthens its sociological nuance within an interactionist tradition.

Mixed Media Diaries – Adding New Dimensions to Participant Voices

Participants were invited to express themselves freely during the period of diary-keeping, and could articulate their thoughts and feelings utilising any media they preferred. Resultant data included hand-written prose, typed prose, audio recording, poetry, doodles, collages, photography, and drawings³⁷. The goal of this was to allow participants to express themselves in the manner with which they felt most comfortable and able, so as not to inherently privilege any one mode of communication above another.

Using diary-keeping as a research method provided a range of advantages for this research. Alaszewski points out how diaries “provide a rich source of data for researchers who wish to explore the development of an individual life, and the activities and relationships of particular groups in society” (2006, p. 33). As the research questions specify that the key points of interest are how participants' gender identities are negotiated in relation to particular settings, a method allowing participants to record

³⁷ Examples of audio recording – which were vocal, rather than musical – were not ultimately used within the final analysis. However this data did still serve to influence my thinking, and enrich my reflection on non-binary perceptions.

interactions they deemed relevant resulted in both detailed and highly varied data. Further, Bolger et al. point out how diaries allow “the examination of reported events and experiences in their natural, spontaneous context” (2003, p. 580), reducing the time between an experience occurring and it being recorded. Research methods such as interviews or focus groups in isolation are comparably disadvantaged, as greater retrospection is relied upon in participant recall. By these methods’ natures, gaps and inaccuracies in recall of a longitudinal account are considerably more likely.

Hyers et al. (2006) note in their discussion of using daily diaries to examine every-day prejudice-related experiences that retrospective methods, such as interviews, tended to result in the discussion of more extreme and unusual happenings due to their memorable nature. This potentially obscures more routine happenings and interactions, which are important sites of identity negotiation. Hyers et al. also mention how the discussions of some particularly sensitive topics may mean “that coping mechanisms, including efforts at sense making, may create distortions in recall.” (2006, p. 317). The diary method encourages participants to create a record of their thoughts and feelings in relation to their gender identities soon after an interaction. Thus, one can gain access to a more intimate and detailed sense of the social phenomena under study. This is the case whether that interaction is with an institution or social structure, another person, or within oneself – the cultural, interpersonal, and intrapsychic, respectively (Jackson and Scott, 2010).

Precedent for the use of diaries which go beyond text can be seen in the work of Bragg and Buckingham (2008), who used scrapbook-style diaries to conduct media research with young people. Bragg and Buckingham followed this with interviews, focus groups, and surveys, highlighting how diaries in research can synergise with a multi-method research design. When commenting on the outcomes of their research, Bragg and Buckingham noted that the ‘voices’ that emerged from the scrapbooks could be very different when placed in the interview environment – “some wrote extensively in their scrapbooks but were shy in interviews, and vice versa” (2008, p. 121). This evidences that combining methods which offer different modalities of expression increases the ability of participants to express themselves clearly – helping to access a wider range of voices, and thus richer data. The method thus allows for patterns to be examined in the experiences and feelings of non-binary people, whilst recognising the power of individual voices (Karnieli-Miller et al., 2009). Flexibility as to how diaries could be recorded also served to be emancipatory through the lens of disability, as multiple

participants expressed that producing data with a computer helped mitigate both dyslexia, and CFS³⁸

Additionally, I would suggest that the method is particularly appropriate for transgender research. Ken Plummer points out that “sociology could learn some lessons... from queer theory” (2003, p. 522). He is particularly referencing how innovative methods such as “drama, personal narrative with multiple voices, and poetry” (2003, p. 522) have been used to improve access to marginalised voices. This destabilises hegemonic notions of ‘correct form’ within the research paradigm, opening up new possibilities. This can also be applied to interviewing practices (Kong et al., 2001).

The use of diaries to produce reflections upon social interactions is another factor that places my methods in constructive synergy with SI. Plummer (1990) has written on how Blumer used life histories, and one can regard diary entries as a partial telling of a period of one’s life (Bolger et al., 2003). Plummer himself has set a precedent as a symbolic interactionist ethnographer using narratives (specifically, the telling of stories) to investigate questions of sex and sexuality (Plummer, 1995). Indeed, Plummer states that he takes as his topic “the personal experience narratives of the intimate” (Plummer, 1995, p. 19) – which also accurately describes the non-binary gender identity narratives accessed in this research. The link between interviews and SI has been similarly made, with Miller and Glassner stating how “interview subjects construct not just narratives, but social worlds” (1997). By this, Miller and Glassner indicate that interviews can access a view of meanings ascribed to social worlds, experiences or events, people, and indeed symbols generally.

Semi-Structured Interviews – Collaborative Construction of Data

The importance and extent of interview use within sociology is captured by Benney and Hughes’ (1956) claim that “sociology has become the science of the interview” (p. 137). Many forms of interviewing have been deployed within sociology (Kajornboon, 2005) in a manner dependent on the research questions. Semi-structured interviews involve the researcher having prepared topics and questions for discussion, but with topic deviation and substantial difference between participant interviews being permissible (Fylan, 2005). The focus on participant identities positions semi-structured interviews as an apt choice, due to the flexibility this method may accommodate.

³⁸ Chronic Fatigue Syndrome, also called ME – Myalgic Encephalomyelitis.

The use of follow-up semi-structured interviews is highly compatible with diaries, as limitations encountered when using each method alone may be avoided, by filling each other's gaps. Bolger et al. (2003) note how personality factors of participants (such as conscientiousness or forgetfulness when engaging with diary-keeping) or health factors (such as cognitive impairments, or addictions) may create selective biases in diary data. In contrast, the environment of the interview means that data production is more structured, able to be observed directly, and 'guided' by the researcher to some extent. Further, whilst diaries allowed for detailed recall and reflection upon events and experiences whilst relatively fresh in participants' minds, the opportunity to reflect upon and discuss interactions at a later time in the interview setting allowed access to a different set of related data (Elliott, 1997).

In order to minimise disruption when interviewing participants, I travelled to locations convenient and local to them wherever possible. However, lack of mutually possible meeting times and restrictive travel costs meant that video interviews via Skype were used as a cost and time-effective solution. Concerns over potentially significant differences between remote and in-person interviews have been raised (Irvine et al., 2013). It has been argued that synchronous (real-time) environments using video are, whilst not identical to face-to-face interviewing, are significantly similar – particularly when the interview is unstructured or semi-structured (Sullivan, 2012; Berg, 2007). By ensuring a two-way video link, body language and facial expression could be seen by both researcher and participant, allowing a closer approximation to interaction in person. Whilst drawbacks have also been identified in using Skype interviews such as increased risk of withdrawal, or technological difficulties acting as a barrier to rapport (Deakin and Wakefield, 2014), many of these were ameliorated by earlier interactions with participants in relation to making interview arrangements, and during the diary phase of research.

The interview gave the opportunity for diary contents to be discussed, allowing for reflection from participants, and questions related to their diary specifically, as well as for questions to be structured around themes that emerged from all participant responses overall. By this logic, considerations of non-binary identity inspired from diary entries could then be tested and refined in the interview settings, so as to cogently articulate themes for analysis.

Research Design – Data Collection Strategy and Practicalities

The diaries were kept by participants for four months. This time-frame was chosen so as to strike a balance between enough time for the potentiality of community and/or medical ‘events’ to occur, but without being so long as to unreasonably burden participants. The use of diary-keeping over a four month period is an example of an intensive, short-term, longitudinal method (Fraley and Hudson, 2014). This allows not only for frequent and ongoing reflection on lived experiences, but for participants to potentially revisit their diaries prior to their return in order to make amendments, or produce entries inspired by their own earlier contributions. The function of the semi-structured interviews to discuss diary contents and collaboratively produce meanings with participants that occurred during the diary keeping (and more generally) allowed for multiple levels of insight into participant experiences and perceptions. Whilst the diaries in and of themselves emphasised freedom of direction and depth, the interviews complemented this through more targeted questioning, and the clarifying benefit of dialogue. The fixed length of time for the diary-keeping period positioned the research design as time-based (rather than event-based, whereby a certain minimum number of predefined occurrences are needed to trigger the end of data production), in order to allow participants definitive knowledge of the length of their participation (Iida et al., 2012). The emphasis on the depth of data rather than quantity of infrequent events (such as potentially GIC appointments, or other necessary medical care) so as to reduce the timeframe of fieldwork also has the benefit of greater accessibility for those who experienced barriers to the ease of recording their diaries.

Each participant was posted an A5, 192 page, lined, hardback notebook to use during the project. It was made clear that use of the provided book was not compulsory. Articulating to participants that entries could be instead be produced using other media, particularly on computers, was important to maximise the potential range of expression seen in the diaries. Each diary included three pages of guidance, for referral during the project (appendix 5). This contained open-ended advice on the topics of consideration, as well as protocol for practicalities including naming any computer files and saving digital diary entries, and how to return the diaries at the end of the recording period.

Diaries were posted to participant’s addresses of choice, using a name specified for this purpose by each participant. This was an important factor to consider, as name-use may be situational and conditional for transgender people, particularly if not ‘out’. Some participants used names for postage that differed from the name they wished to be referred by in all other contexts, such as during email correspondence.

Participants were encouraged to write (or otherwise produce entries) in their diaries as frequently as possible, without being made to feel pressured to produce data. During recruitment, many of the participants asked how often they should use their diaries. This was indicative of a range of concerns, including whether they would have enough time to commit to the project, and anxiety over having 'enough' to say. Whilst I emphasised that there was no 'correct' way to use the diary, I suggested that being able to produce something every week would be desired, but that I also recognised some people might prefer fewer, longer entries whilst others may favour producing a larger number of smaller pieces. I thus needed to negotiate the tension between participants being given space to tell their stories in their own ways, whilst not being unclear such that participants lacked direction or experienced uncertainty about what to do.

Engagement with diaries was encouraged by sending weekly 'reminder' emails to participants. The decision to do this is supported by work done by Horvath et al. (2007), who received all diaries back on time except one, which was only a day late (out of a total of 26) when sending daily email reminders. In comparison to a previous study (Usdan et al., 2004) which did not send email reminders, an 82% non-completion rate was seen.

Weekly emails also acted as a useful way to develop rapport with participants, many of whom would reply to these messages. I ensured that the content of the messages differed every week, in order to avoid immediate deletion without being opened, or seen as irrelevant or annoying. In these messages I would offer potential suggestions of how the project might be approached, and also provided links to online material concerning diaries, or queer content that I thought might be found interesting. Finn for example said of the emails "they're really helping me structure some entries and know what's relevant to put in". Alex responded to one weekly reminder that they felt "a bit adrift" and that they "just worry about putting stuff that isn't going to be of any use". Whilst this demonstrated Alex's commitment through their concern, it was also a useful chance to attempt to reassure, and offer guidance and advice which may have helped Alex in engaging with the diary-keeping. Many of the participants used the weekly emails as a way to 'check in', offering their assurances that the diary had been received at the outset, and they were engaging with the project. In order to allow time for organisation, I used the final month of the reminder emails to prompt arrangements for conducting an interview with each participant.

Upon completion of the diary-keeping period, participants returned their diaries using a pre-paid stamped addressed envelope (included when diaries were sent out). Those participants who made diary entries digitally returned their entries by email. In advance of the interviews taking place, all participant diaries were read, in order to produce a general interview guide (appendix 6). Before each interview, additional questions were added which related to the specific content of the individual participant's diary – such as clarification or discussion of diary entries. Thus, guides were idiosyncratic, yet maintained comparable themes through the relationships observed between diary entries and the original research questions. Interviews were conducted in different locations at the convenience and comfort of participants. This included private meeting rooms booked at the University of Leeds, or public spaces such as cafes. Participants assured their comfort with interview locations prior to conduct. In cases where it was not possible for a face-to-face meeting for the interview, video calls via Skype were used. Six out of the eighteen interviews were remotely performed by this method.

The number of questions prepared for each interview also allowed for an approximation of how long interviews would take, which was useful for both researcher and participant (Turner, 2010). Interviews were estimated to take one hour, although most participants were both able and willing to continue beyond this (in cases where a participant needed to finish by a certain time, these times constraints were observed). Interview length ranged from 47 to 140 minutes, with an average length of 90 minutes. The extensive nature of these interviews was a result of the depth and breadth of the majority of the participants' answers, and the passion with which interviews were approached.

Recruitment of Participants

Emmel has highlighted how consideration of the practicalities of sample size is given relatively little attention, and that “to ask how big the sample size is or how many interviews are enough is to pose the wrong question. It is far more useful to show the ways in which the working and reworking of relationships between ideas and evidence in the research are a foundation for the claims made from that research” (Emmel, 2013, p. 137). This relates strongly to the notion of theoretical saturation, the assertion that an increase in the sample size will not generate significantly new codes/points of theoretical import (Guest et al., 2006). This concept is rooted in the context of work utilising grounded theory, and thus does not consider the additional dimension of a

multi-method approach. However the concept can still inform sample size decision-making, by giving a sense of the ratio of labour to yielded themes.

Guest et al. conducted sixty interviews, coding and analysing in batches of six, so that originality of contribution and redundancy could be looked at in terms of both individual codes, and their relative importance. Whilst there is an (arguably arbitrary and under-evidenced) precedent for sample sizes of thirty within postdoctoral qualitative projects (Mason, 2010), Guest et al. found the yield of theoretically significant codes dropping off as early as following twelve interviews. With this evidence born in mind, a sample size of twenty-five participants was originally selected. Given the large time investment required by participants, this number was chosen to allow for enough data to still be produced should several participants choose to withdraw, fail to submit diary entries, or if multiple participants only produce a very limited number of entries.

With hindsight this was a prudent decision, as seven participants withdrew from the project at various stages, leaving a final sample of eighteen participants. This was for a range of reasons, including feeling unable to dedicate enough time to the project, personal reasons, and in one case, loss of the diary and unwillingness to perform a stand-alone interview. One participant, Jess, also lost her diary, but was willing to be interviewed for the project. Thus, seventeen diaries and eighteen interviews comprised the final data set.

In order to recruit participants, I produced a poster for use in both physical and digital spaces (appendix 1). In order to simplify the poster, the only criterion for participation mentioned was 'identifying outside of the gender binary', with the intention to explain further details and requirements upon expression of interest. The poster also explained briefly what participants would be asked to do, and provided contact details, and a reference number to prove the ethical approval of the work by The University of Leeds. I also produced an information sheet, which was provided to any potential participants who made enquiries about the project (appendix 4). The information sheet spanned two A4 pages (in the original format), so as to avoid inundating potential participants with too much information. I included an explanation of what the project was investigating and why, along with full eligibility criteria, what was required of participants, and a description of participant rights including withdrawal, and anonymity. In order to recruit from communities, I produced a template email to be sent to online groups to request circulation of my poster within their membership (appendix 2). These documents were all ethically reviewed and found satisfactory by the University of Leeds (AREA) Research Ethics Committee.

Recruitment of participants was pursued through multiple avenues. These include networking at queer oriented activist and academic events. I used pre-existing networks with The University of Cambridge and the University of Leeds LGBTQ societies. In addition, I made contact with non-binary groups and spaces, both physically and digitally. Building on this, snowball sampling from individuals accessed in these ways allowed further access to non-binary members of LGBTQ communities and friendship networks (Atkinson and Flint, 2001). Calls for participation were also spread through digital networks such as Facebook, Tumblr, and Twitter, with requests for people to share the information widely.

A potential limitation of snowball sampling is that data may lack variation, and insufficiently reflect the demographic under consideration (Biernacki and Waldorf, 1981). This is due to recruitment occurring within networks of individuals likely to be demographically similar. It must be remembered that no piece of research can claim to be 'truly' or 'completely' representative. Here I am drawing on Haraway's feminist concept of situated knowledges (Haraway, 1988), in that knowledge generated is not positioned as generalisable 'fact', but can be used to inform theorisation – in this case, processes of identity negotiation. The synergy of recruitment methods I used provided a sample with reasonable cross-demographic variation, considering the non-binary population is relatively small in comparison to research involving cisgender men and women. Estimating the size of the non-binary population is extremely difficult due to lack of reliable data and lack of cultural intelligibility, as well as shifting definitions of categorisation. However, detailed community-oriented work estimates the non-binary population as up to 0.4% (Titman, 2014). The reachable population for research will be significantly smaller.

Three specific non-binary oriented groups were approached, with requests to distribute information on the project to their membership. These were Non-Binary South West, the Non-Binary Inclusion Project, and the UK Non-Binary/GQ meet-up network (which exists specifically as a closed Facebook group, but which I was able to access with the assistance of existing connections). The project was also posted on the 'Beyond the Binary' working group Facebook page. My recruitment poster was also displayed in the CliniQ waiting room in London, the only UK sexual health service aimed specifically for queer and transgender people.

Posting on social media was an effective method of recruitment, with friends and community members reposting information to give a wider pool of potential interest. Digital recruitment methods did however highlight the importance of appreciating the

loss of control the researcher experiences over where a call for participants may be shared. This was brought to my attention when I received multiple enquiries by e-mail from interested persons in the United States, despite my project recruiting from people living in the UK only. The inclusion of this criterion was in order to make the broad cultural context of the research more consistent and comparable across the sample.

Reflexive Positioning

Having been defined as the “thoughtful, self-aware analysis of the intersubjective dynamics between researcher and the researched” (Finlay and Gough, 2003, p. ix), reflexivity offers important ways to perform social scientific research with heightened ethical considerations (Wasserfall, 1993). The demand for greater and sometimes difficult reflection from the researcher is an attempt to sensitively address power relations between researchers and their subjects/collaborators (England, 1994) – particularly where participants are already members of a disenfranchised population, as is the case for the non-binary transgender people in this research.

It has been argued that whilst ‘being reflexive’ is often recognised as important in social scientific research, the practicalities of ‘doing reflexivity’ have not been emphasised (Mauthner and Doucet, 2003). Scholars can still problematically infer that “the researcher, the method and the data are separate entities rather than reflexively interdependent and interconnected” (Mauthner and Doucet, 2003, p. 414). With this in mind, my personal relationship with this project is significant and necessitates contextualisation. Whilst this thesis is not an auto-ethnographic piece of work, my history and identity have influenced important dimensions such as participant access and interactions.

My experiences of transgender narratives have been highly personal and poignant. I shared a long term relationship with a binary trans man, during which time I indirectly experienced some of the emotional and bureaucratic difficulties of gender transition through the NHS. This was illustrative of the potential for systemic road blocks to progression, or unequal treatment between cis and trans patients under current policy and practice. In addition to this, I mourned the suicide of a close transgender friend, who had not only grappled with accessing medical services but also struggled with unrelated mental health conditions, compounded by transphobic stigma. Such personal exposure to the tremendous difficulties that trans people can experience, and the deficiencies in systems designed to provide support, means that I situate my research also within an activist tradition – in that the production of social change is as vital as the

production of knowledge (Warner, 2013; Ackerly and True, 2010). Further, my positionality in having a non-binary gender identity has synergised with these personal motivations in producing robust and rigorous scholarship in recognition and support of people's lives.

Audrey Kobayashi has discussed the negotiation of the personal and the political in critical qualitative research, in the context of her as a researcher introspecting on the wellbeing of her participants (Kobayashi, 2001). Valuably, Kobayashi underscores the importance of both understanding and taking responsibility for how one may set in motion complex emotions, that 'flow back and forth' in the course of a research encounter. Whilst this may be more obvious in the context of an interview and how respondents may feel about personal questions concerning identity, diary-keeping also entailed a potential impact. Such considerations shaped the ethical dimensions of my methodology.

Ethical Considerations

Before this research was conducted, the project was reviewed by the University of Leeds (AREA) Research Ethics Committee. The reference code given to this research was AREA 14-044. I structured the research to grant as much autonomy as possible to participants, without incorporating unacceptable levels of risk.

A range of safeguards were used to protect participants from potential harm. All participants were required to sign a consent form before official recognition of their participation (appendix 3). This explicitly stated that participants were not required to share anything (in written/artistic form in the diaries or verbal form in the interviews) which they did not feel comfortable with. I outlined the right to withdraw from the project, with a specific deadline of one month following the date of the interview. Justification of this deadline was that proximity to the final submission of the PhD thesis would threaten the project, if too little data remained without time for replacements to be found. However, no participants withdrew consent following their interview. Participants could also change their anonymity status (becoming anonymous when formerly identifiable or vice versa) during the three months following their interview. The difference in dates reflected the comparative ease in anonymising/de-anonymising a participant relative to complete removal and replacement of an individual in the research.

Within my paradigm of working with participants rather than 'studying subjects', I considered it a reasonable ethical decision to give participants the choice of whether to

be identifiable or not. The ethical consideration of that decision has been academically explored (Giordano et al., 2007). By assuming the state of anonymity to be essential, researchers risk “acting paternalistically and might be denying participants’ autonomy... and/or depriving participants of a “voice” that confers personal meaning to their enjoyment to the research and its effect(s), outcomes, and goals” (Giordano et al., 2007, p. 265).

Whilst I do not claim that allowing participants to share their names is always ethically justifiable, this is a context-dependent decision that must be critically considered in relation to risk. Given that only first names were used in this work, there exists no risk of identity theft, and I have no reason to doubt or question the ability of participants to accurately assess the meanings or impacts that real name use could have. Participants also were given the option to choose their pseudonym, if one was used. This further emphasised their collaborative involvement and autonomy. I chose pseudonyms for participants who did not wish to be identified and did not express any pseudonym preference. Of the eighteen participants, eight elected to be anonymised with ten choosing to be identifiable, demonstrating a slim majority of participants felt safe in being identifiable, and appreciated the option. Several participants were glad to choose their own pseudonyms as it allowed them expression through the choice of a name they liked, or which held some personal significance.

Each method used had specific ethical considerations. As the diaries contained information on participants’ gender identities (a personal and potentially sensitive topic), I advised participants to be mindful of when and where they wrote, and how they stored their diaries. In the case of handwritten diaries, participants were advised to keep them in a safe and secure location. For entries written or produced on a computer, I advised that files were stored in a well-hidden folder, or password protected to ensure privacy. These precautions were particularly salient for participants who were not fully ‘out’. Upon receiving diaries (digital or handwritten) I stored all data in password protected files and in a locked filing cabinet respectively. Similarly, consent forms from participants were kept in a locked filing cabinet.

Interviews also followed practices of sensitivity to ensure participant comfort during discussions. The negotiation of a non-binary transgender identity may be considered a sensitive topic, due to participants potentially having experiencing stigma, discrimination, or other upsetting associations in relation to trans status (Lee, 1993). Before each interview began it was clearly communicated to each participant that they did not have to answer anything they were not comfortable answering, and they did not

have to give any reason for doing so. Further, they could end the interview at any time, without communicating a reason. Participants had the right to refuse consent for particular topics of conversation to be written about, without necessarily fully withdrawing from the project. These explicitly communicated concerns for participant well-being served to reassure participants and add to rapport-building.

Building Rapport Throughout the Project

Schuman draws attention to the importance of language in the research encounter, in saying “all answers depend upon the way a question is formulated. Language is not a clean logical tool like mathematics that we can use with precision... as if this complexity were not enough, our answers are also influenced by who asked the question” (Schuman, 1982, pp. 22-23). Therefore, given the comparably extensive contact between researcher and participants prior to interview (via email), the development of rapport over this time was important for the interviews’ success. Rapport was developed during the recruitment and diary-keeping phases by engaging with participants with respect and reciprocity, which synergises with feminist ethical practices (Oakley and Roberts, 1981). Where asked, I shared of my personal experiences and motivations with participants. Due to the interviews being undertaken after the diary-keeping period, some important interaction with participants had already occurred when participants enquired about participation, and via email in the form of the weekly email prompts. During recruitment for example, Leon wished to ask me a range of questions, to inform their decision about participating:

Before I go any further, though, I wonder if you could let me know a bit more about yourself. What brought you to this research? What do you hope to achieve and what impact do you hope your research will have? How did you come to your research methods and what challenges do you envisage this particular methodology posing? What ideas/theories/scholars/writers (academic and non-academic) have inspired you?

Answering Leon’s questions in detail served to reassure them that my work was sympathetic towards non-binary emancipatory politics, rather than critical or transphobic, as with some scholarship that has come before (Jeffreys, 2014; Raymond, 1979). My willingness to answer questions and discuss what brought me to a study of transgender lives, and the political convictions which guide my approach, served to improve both my access to, and interactions with participants.

It was important to continue to build a sense of trust and rapport with participants during the interviews. This was partly fostered through beginning the interaction by thanking the participant for their time and effort with the diary, and to affirm the pronoun they wished to be used. Whilst in the context of an interview referring to the participant in the third person generally did not come up, it was important for accurate writing about participant's interviews and diaries. Further, this demonstrated to participants the centrality of their validity and respect in this research.

Participant Demographic Information

The below table summarises the participants who contributed to this research, and central demographic information that was collected following receipt of signed consent forms. When anonymity is listed as 'yes', the name shown is a pseudonym. Pseudonyms followed by an asterisk were chosen by the participant, un-asterisked pseudonyms were chosen by the researcher. Thus of the eight participants desiring anonymity, four elected to choose their pseudonyms.

| Name | Anonymous? | Age | Town/City/County | Pronoun(s) |
|---------|------------|-----|-----------------------|------------|
| Alex | No | 20 | South Yorkshire/Leeds | They, he |
| Ash | No | 33 | Northamptonshire | They |
| Bobby | Yes | 23 | Surrey | They |
| Charlie | No | 21 | Nottingham | They |
| David | Yes | 31 | London | They |
| Finn | No | 22 | Sheffield/Leeds | They |
| Frankie | No | 25 | London | They |
| Hal | Yes | 42 | London | They |
| Jamie | Yes | 24 | York | They |
| Jen | No | 29 | Leeds | She |
| Jess | No | 26 | Manchester | She, they |
| Leon* | Yes | 34 | Nottingham | They |
| Mark | No | 43 | Norwich | He |
| Pig | No | 30 | Manchester | They, it |

| | | | | |
|---------|-----|----|-----------------|-----------|
| Rachel* | Yes | 28 | Manchester | They |
| Ricky* | Yes | 43 | Nottingham | They |
| V* | Yes | 28 | Nottinghamshire | He |
| Zesty | No | 22 | Cairo/Leeds | They, any |

Table 4: Participant names, anonymity, ages, locations, and pronouns.

An interesting detail was that multiple participants felt able to use their name as their pseudonym, due to the name they identified with being chosen, and different from that given to them at birth. In some cases (such as Pig, for example), this chosen name would not be recognisable to anyone from whom anonymity would be desirable, but would be recognisable to those who knew them in queer communities (who they did not feel a need to be anonymised from). Names could thus disrupt the ‘anonymised/identifiable’ binary, through their intelligibility in some contexts, but not in others.

Participants lived in a total of twelve different cities or regions. Counties were used in cases where individuals lived in a location smaller than a city, in order to protect location privacy where necessary. The age range represented was 20-43, with a mean age of 29.1, and a median age of 28. Ages were recorded at the point of recruitment to the project. Whilst it could be argued that this data set does not provide adequate representation of older non-binary people, research by Harrison et al. demonstrated that (in a North American cultural context) non-binary people were significantly less likely to be over the age of 45 (Harrison et al., 2012). An explanation of this may be due to the way language use has changed with relation to transgender and gender variant people over the past several decades. This is similar to how ‘transgender’ has increasingly replaced the older term ‘transsexual’ both within academic literature, and as an identity label (Stryker, 2008a). The specific ‘naming’ of non-binary/genderqueer people is recent in Western contexts. As Plummer would put it, shifts in language have only recently allowed such stories to be told (1995). Older people are considerably less likely to associate with labels which were not known or not used for much of their lives, with ‘queer’ in particular being understood as a slur, more exclusively. Indeed, Plummer says “I feel that the use of the word “queer” is a younger person’s game. Knowing the history of the word, and how it was used on my childhood playgrounds, I found it very hard to use for a long while. Even now, I use it reluctantly” (Plummer,

2003, p. 521). Therefore this sample arguably offers a reasonable age range over those who identify with the term non-binary.

The following demographic data shows participant ethnicities, educational attainment, sexuality, and whether they had any experience with keeping a diary prior to this project:

| Name | Race/Ethnicity | Education | Sexuality | Kept a diary? |
|---------|---------------------|-----------------------|------------------------------|----------------------|
| Alex | White Welsh | Undergrad in progress | Queer | In the past |
| Ash | White | A-levels | Fluid | In the past |
| Bobby | White British | Undergrad in progress | Pansexual | In the past |
| Charlie | White British | Undergrad in progress | Queer | In the past |
| David | White other | Masters | Gay | Blog project |
| Finn | White British | Undergrad in progress | Queer | Yes |
| Frankie | White British | Undergrad | Dyke/queer | Tried but failed |
| Hal | White | Masters | Primarily attracted to men | As a teenager |
| Jamie | White | PhD in progress | Gay | In the past |
| Jen | White Scottish | Masters | Queer | No |
| Jess | White other | PhD in progress | Pansexual/tend not to define | In early adolescence |
| Leon | White other | PhD | Queer | No |
| Mark | White British | Undergrad | Mostly gay | Kept a blog |
| Pig | White | Undergrad | Queer | In the past |
| Rachel | White German Jewish | Undergrad in progress | Lesbian | No |

| | | | | |
|-------|---------------|-----------------------|------------|-------------|
| Ricky | White British | Masters | Bisexual | In the past |
| V | White British | Masters | Unfussed | No |
| Zesty | Mixed | Undergrad in progress | polysexual | In the past |

Table 5: Participant names, ethnicities, educations, sexualities, and writing experience.

The above demographic data was collected in order to further contextualise the reached community members in this research. All except for one participant identified their ethnicity as white. This runs contrary to Harrison et al's. (2012) non-binary population data, where 30% were non-white, but in a North American context. Whilst the 2011 UK census data estimates the proportion of the UK population who identify themselves as white at 81.9%, lack of racial/ethnic diversity may be symptomatic of snowball sampling. Alternatively, compounding minority statuses (non-binary, non-white) may result in more vulnerable/marginalised individuals who are more difficult to access (Mutch et al., 2013).

Educational attainment was significantly higher than the general population, with all participants except one currently attaining, or having already attained, at least one degree. This may be indicative of the class positions of participants, however more detailed consideration of class intersection was not examined. A wide range of different descriptors of sexuality were given. This is perhaps to be expected, as non-binary gender identities disrupt the binary foundation on which many sexualities are based. Despite this, some participants did identify as gay or lesbian – though no participants identified as straight/heterosexual. It is also noteworthy that the majority of participants had prior experience of diary-keeping. It is possible that advertisement of the method in recruitment material impacted interest in participation, such that individuals with a lack of writing experience may have been put off prior to initial enquiry. This may be positioned as a limitation of the research, however the method may have also served to make the research more attractive to some respondents.

A Multi-Method Analytical Strategy

Multi-method research poses particular challenges to analysis, given the different forms the data takes. I thus took inspiration from multiple frameworks in order to synthesise a frame that could be applied with an appropriate degree of flexibility. Thematic analysis had the advantage of allowing disparate data types within diaries to be concurrently assessed. Tuckett (2005) has considered how thematic analysis of qualitative data

works in practice, in relation to a symbolic interactionist framework. As symbolic interactionism recognises that the symbolic meaning ascribed to an object or idea can vary, comparison between different participants was vital in order to suggest explanations and recognise social patterns.

An iterative analysis process was used, in that the multi-method nature of the research meant coding and analysis began before all data was collected. In the first instance, this began with initially reading participant diaries as they were returned. The nature of researching non-binary gender identities justified a combination of inductive and deductive coding, which has sociological precedent (Fereday and Muir-Cochrane, 2006). Inductive coding, where codes are generated without predeterminations, was necessary because of the lack of attention that non-binary identities have received as of yet. However, the small amount of specific research that exists (Yeadon-Lee, 2016; Harrison et al., 2012), as well as an anecdotal sense from community interaction and involvement, meant that some deduction (and thus, deductive coding, informed by prior contexts) could be applied – particularly in relation to medical practice where some experiences are comparable to binary transgender narratives.

No notes were made during the first read-through of each diary. This was in order to allow me to focus on the narrative sense of the data as a whole, and become closer to the raw data (Sandelowski, 1995). On a second read-through, initial themes were identified and colour coded, and cross-referenced with the other diaries. Themes were identified between diaries through cross-sectional comparison, and within diaries, between different entries over time (Thomson and Holland, 2003). Thematic interpretation of images, poetry, etc. was frequently discussed during interviews which allowed both an additional perspective and assessment of participant intentions. Regular academic supervision meetings also allowed for refinement of data analysis (Manzano et al., 2014).

These read-throughs informed the construction of personalised topic guides. Each participant's topic guide contained 'core questions' (appendix 6), but also notes of topics to discuss that were particular to individuals. For example, Finn included a poem in their diary but highlighted that much of the meaning was dependent upon performance, therefore in the interview setting I asked Finn to read/perform the poem which lead to a discussion around it³⁹. Recurring themes that were identified between

³⁹ Whilst this was a beneficial decision due to the insights that were generated, this particular poem was not used in later analysis due to space constraints and overall fit with discussed themes.

diaries, for example, 'feeling insecure as trans', inspired the wording of questions. There is a certain parallel with a grounded theory approach here (Glaser and Strauss, 2009) in that no assumptions were made about what would be found in the diaries, and by allowing diary content to inform interview guides, participant voices do not test existing theory, but rather produce it.

Following the participant interviews, the audio recordings were transcribed. This was done near-verbatim, with the only omissions being occasional conversation asides that did not pertain to the research (but within the interview setting, contributed to rapport). The same approach was then taken to the transcripts as to the diaries – an initial read-through without notes, followed by note-making and coding that was then cross-referenced. Interviews were also compared back to the participant's diary, and more broadly across the entire data set of others' diaries and interviews.

Limitations of Methods and Recruitment

It is important to recognise potential limitations of using diaries and interviews as research methods. The length of time and level of commitment required from participants in keeping a diary was significant. This placed a relatively heavy burden on individuals, which contributed to the high dropout rate. This is however common in diary-based research (Bolger et al., 2003; Schroder et al., 2003) I attempted to reduce this by clearly highlighting the nature of the commitment before participation was confirmed, together with the use of weekly reminder emails as previously discussed. It can however be argued that participant autonomy is privileged within the diary-keeping method because, as Ruth Holliday highlights with the use of video diaries, participants may go back to consider earlier entries and edit as they see fit before passing their entries to the researcher. Holliday posits that this sort of research method therefore offers participants the "potential for a greater degree of reflexivity" (Holliday, 2000, p. 510), which may increase participant confidence in the accuracy of their data in reflecting their views and experiences.

As with other research methods (such as interviews), participants may attempt to adapt both tone and answers to fulfil what the perceived expectations of the researcher. I attempted to minimise this by clearly signposting the freedom of expression participants had in producing entries relating to their sense of negotiating their gender identities. Interviews may potentially be accused of focusing on exceptional events; however this was ameliorated by the multi-method approach.

As previously mentioned, the sample itself can also be critiqued, in that more intersections of diversity may have been possible through a more nuanced recruitment strategy. Although the question was not asked specifically when collecting demographic information, many participants in their diaries and interviews made specific reference to experiences of disability. Thus, intersections between non-binary gender identity and disability were able to be explored, whilst race (for example) was not. The theory of situated knowledges (Haraway, 1988) challenges any claim that individual representation of a particular marginalisation (disability, race, class status, age, sexuality, etc.) grants group representation in and of itself.

Research is often limited in some manner on the basis of a researcher being an insider or an outsider in relation to the researched population. Whether or not the researcher has lived experience that provides familiarity with participants, this will impact (and shape) the knowledge produced (Griffith, 1998). Despite identifying as queer prior to conducting this research, I positioned myself as an outsider researcher due to my not (then) identifying explicitly as non-binary.

However, the process of conducting the research significantly shaped my relationship with my own gender, and this was certainly informed by the manner in which participants responded to me. For example, within interview settings, informal aspects of conversation (not recorded) could involve participants articulating thoughts expressly about 'our' community, rather than 'their' community. Despite my ambiguities around identity labels, my closeness with the trans and LGBTQ communities prior to the research means it is more accurate for me to be considered an insider researcher, particularly as it was during the research that I explicitly articulated my own non-binary gender identity. Indeed, these experiences challenge an overly-simplistic modelling of an insider/outsider binary in relation to groups. Researcher involvement can indeed necessitate becoming an insider with particular forms of ethnographic study, such that study of community also allows autoethnography (Throsby, 2016; Crossley, 2006). Whilst I would not position this research as 'creating' my identity, it arguably produced an effective environmental circumstance for transformative reflection upon identity (Breen, 2007; Ganga and Scott, 2006). By being reflexively conscientious of my own positionality in relation to the subject matter, I aim to sharpen my appreciation of factors that shaped the production of the analysis (Kanuha, 2000). Further, working from a position as an insider has multiple recognised advantages, as was demonstrated by my relative ease regarding recruitment and rapport (LaSala, 2003).

Participant Pen Portraits

Alex is a white Welsh 20 year old student, who lives in South Yorkshire/Leeds. They identify as queer. They are polyamorous, and in an open relationship.

Ash is a white 33 year old sex worker who lives in Northamptonshire. They identify as having a fluid sexuality, and are in a relationship.

Bobby is a white British 23 year old student who lives in Surrey. They identify as pansexual, and are currently single.

Charlie is a white British 21 year old student who lives in Nottingham. They identify as queer, and are in a relationship.

David is a white 31 year old policy researcher who lives in London. They identify as gay, and are married.

Finn is a white British 22 year old student who lives in Sheffield/Leeds. They identify as queer, and are in polyamorous relationships.

Frankie is a white British 25 year old sexual health and wellbeing worker who lives in London. They identify as a queer dyke, and are in polyamorous relationships.

Hal is a white 42 year old market researcher who lives in London. They are primarily attracted to men, and they are currently single.

Jamie is a white 24 year old PhD student who lives in York. They identify as gay, and they are married.

Jen is a white Scottish 29 year old PhD student who lives in Leeds. She identifies as queer, and is in an open relationship.

Jess is a white 26 year old PhD student, teaching assistant, and proof-reader, who lives in Manchester. She identifies as pansexual (though tends not to define). Their relationship status "is complicated".

Leon is a white 34 year old lecturer, who lives in Nottingham. They identify as queer, and are in a civil partnership.

Mark is a white British 43 year old personal carer who lives in Norwich. He identifies as "mostly gay", and is currently "single-ish".

Pig is a white 30 year old youth worker who lives in Manchester. They identify as queer, and have a long term partner.

Rachel is a white German Jewish 28 year old student who lives in Manchester. They identify as a lesbian and are in a relationship.

Ricky is a white British 43 year old counsellor and trainer, who lives in Nottingham. They identify as bisexual, and they are married.

V is a white British 28 year old artist, writer, and performer who lives in Nottinghamshire. They describe their sexuality as unfussed, and they are currently single.

Zesty is a mixed-race 22 year old student chef who lives in Cairo/Leeds. They identify as polysexual, and they are currently single.

Conclusion

In this chapter I have given a thorough grounding of the symbolic interactionist framework used to demarcate and consider interactions that participants experienced. The methodological basis of this work has emphasised the privileging of non-binary voices in being able to tell new stories (Plummer, 1995). I follow this by descriptively grounding and clarifying how fieldwork was done, and laid the theoretical foundations that situated mixed media diaries and semi-structured interviews both in relation to each other, and this project overall. I have fully elucidated the decisions made in this research so as to successfully recruit participants, develop and sustain rapport, and most importantly ensure rigorous ethical safeguarding. The methodological decision to construct a multi-method project was made use of in my analytical practices, as the ability to begin the coding of diaries gave greater security in the ability of interviews to cover material deemed salient by participants.

Recognising additional demographic dimensions of participants was important in avoiding positioning consideration of gender identity in a social vacuum. Demographic similarities (such as age) and differences (such as race) to prior non-binary-specific research samples (Harrison et al., 2012) may be understood in relation to method limitations, the demographic make-up of the UK overall, and who may be more or less likely to be able to articulate a non-binary identity and be accessible to research.

Whilst no work is without its limitations, I have presented an argument for how my choice of methods served to produce data in an effective way, whilst also being compatible with an emancipatory transgender politics, and the theoretical framework of symbolic interactionism. Rejecting a positivist approach, this combination of framework, methods, and analysis has allowed for a process of collaborative knowledge production,

with resultant analysis illustrative of both researcher and participant synergy. The contents of diaries and interviews provided some of the first data to consider non-binary identities as a discrete yet amorphous set of realities, negotiating social and medical differences or needs relative to binary transgender people. The following chapters will detail and analyse central themes identified within the data.

Chapter 4 – ‘Not Trans Enough’: The Relationship between Non-Binary Gender Identities, Uncertainty, and Legitimacy

Using queerness itself as a category of analysis seems to invite a new round of debate devoted to who is “really queer”. A voice that originated from one set of margins begins to create its own marginalized voices. These twin problems of identities – boundaries and hierarchies – emerge whenever we try to base politics on identity.

(Wilchins, 2002, p. 29)

Introduction

Among non-binary people, there is a vast heterogeneity of experiences and self-conceptualisations. Despite such differences, a striking commonality was observed amongst participants – insecurity in relation to gender⁴⁰. This could manifest as an internal uncertainty in being trans enough, or anxiety over not being seen as trans enough by other people. This chapter will explore this phenomenon, whilst considering how hegemonic gendered expectations impact not only the ability to socially exert, but also the ability to internally formulate a non-binary gender identity. This exploration cuts across the original research questions, as feelings of insecurity were manifested in relation to experiences of queer community interaction, everyday experiences, and accessing (or concern over accessing) medical support. Further, intrapsychic interaction (with the self) through introspection was, perhaps predictably, strongly influenced by societal norms of gender (both within and outside queer communities), which could be internalised, or resisted, or both simultaneously.

I begin this chapter by highlighting how non-binary people could view those who access gender affirming medical services as ‘more legitimate’, even if not wishing for medical transition themselves. Simultaneously, participants could have a strong sense that such feelings are problematic, illustrating critical self-reflection. Whilst individuals were themselves concerned with being trans enough as non-binary, participants were clear that they respected the self-identification of others – highlighting how the anxiety of ‘realness’ often operated at the level of the self. Participants were inconsistent with the standards by which they judged their own validity relative to how they judged others,

⁴⁰ Whilst I say ‘despite’ because of insecurity being endemic across different experiences of non-binary identification, gendered idiosyncrasy may potentially contribute to this phenomenon, as affinities with each other’s experiences may be less pronounced.

generally being harsher with themselves. This may be suggestive of difficulties with, or low self-esteem in relation to, gender identity (Neff, 2003; Brown, 1986).

I then argue that hegemonic medicalised narratives of what it ‘means to be transgender’ have impacted queer community interactions. I show how community tensions can manifest around non-binary people being made to feel ‘not trans enough’ by other members of the trans community. Binary transgender people could potentially exhibit hostility towards particular identities, or construct implicit hierarchies of legitimacy in order to self-validate. Such practices serve to evidence the problematic nature in which transgender identities of all kinds are often only validated (by doctors, legally, by family or friends, or in the social interactions of the day-to-day) once potentially difficult social processes have been navigated or performed. These include, but are not limited to, vocal and repeat performances of ‘coming out’, name changes, and alterations of gendered presentation, as well as accessing hormones and surgeries.

Participants also voiced anxieties over not being seen as trans enough when accessing (or wishing to access) gender affirming medical services. This was navigated by some participants by presenting themselves to clinicians as binary transgender individuals, or by discussing their non-binary experiences of gender in binary terms in order to render themselves more compatible with clinical precedent. This impacted the support individuals sought from queer community networks, and correspondingly shaped strategies of empowerment, resistance, and navigation of medical services.

The Impact of a Binarised Medical Narrative on Non-Binary Feelings of Validity

As outlined in chapter one, hegemonic Western transgender narratives were constructed and constrained through processes of medical gatekeeping. Whether a participant wished to access gender affirming medicine or not was significant in shaping how gender was considered:

Ben: Have you ever had feelings of not being trans enough?

Jess: Yeah all the time (laughs). I think partially it’s because I don’t really feel a great need to access hormones or surgery. That I... don’t, I often feel like I’m some sort of fraud. Operating within this woman’s space – or within a trans space because I don’t really... I’m not really that bothered about changing my body. I kind of feel like my body is my body? And that it is what it is. I wouldn’t be against changing it, but on balance it’s probably more effort to change it than not to. Maybe that

balance will shift over the years, especially if my hair decides to fall out, I might be more interested in taking hormones or whatever. But essentially because of my ambivalence towards these medical interventions, I do feel like I'm often not trans enough. And especially as somebody who's working in trans healthcare, as an activist and on the scene, I feel like people often expect me to be wanting to engage or be going on some sort of binary transition pathway or something like that. Sometimes I do think, what am I doing here, why am I claiming trans, why am I claiming womanhood, why am I claiming non-binary when I'm not particularly interested in changing my body? But being called he, being called my birth name, whatever, does make me feel uncomfortable. So, I do have some form of dysphoria, but it doesn't seem to be as soul destroying as a lot of peoples' physical dysphoria can be. (Jess, 26, interview)

Thus, Jess had a sense that her ambivalence over her embodiment had produced self-doubt, due to how central and ubiquitous narratives of embodied dysphoria⁴¹ have been. It is also apparent that different aspects of embodiment hold differing levels of significance, as evidenced by the feeling that experiencing (male pattern) baldness would likely cause 'the balance to shift'. Hair and hairstyles function as significant sites through which gender can be socially enacted (Duesterhaus et al., 2011; Lawson, 1999). Mentioning how hair loss might particularly affect her feelings with regards to hormones may be due to baldness being positioned as a signifier of maleness. Thus how this particular gendered, embodied trait shifts over time was positioned as potentially altering Jess's medical wishes.

By emphasising that "my body is my body", Jess implicitly articulates that being 'really' transgender need not rest upon narratives of desiring to alter the body – typically assumed to be the result of also loathing the body, or at least parts of it. This has been centralised in medical diagnosis, as shown by the criterion of the 10th edition of the International Statistical Classification of Diseases and Related Health Problems (ICD-10, the current edition), which particularly characterises Gender Identity Disorder as

⁴¹ I use the term 'embodied dysphoria' to refer to negative feelings that transgender people may experience specifically relating to their body itself – such as the presence or absence of primary or secondary sexual characteristics, or genitals. I use this term to differentiate from dysphoria caused by social interactions with other people, whereby the body is subjected to gendered interpretations which may be distressing (misgendering, etc.)

comprising “The desire to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make his or her body as congruent as possible with the preferred sex through surgery and hormone treatment” (Meyer III et al., 2002, p. 6).

To not desire embodied change is discursively and symbolically positioned in medical policy as ‘unusual’, even whilst practitioners in GICs frequently and increasingly encounter individuals who desire hormones, but do not desire surgical intervention. Similarly, it remains comparably rare and difficult to access surgeries without, or prior to, hormones, even as it has become possible for such a desire to be met. In terms of diagnostics, this has come about through the construction of a standard that individuals trying to access gender affirming treatments may be held to. In order to be medically legitimised, transgender people are required to conform to (binarist) medical norms. Not doing so risks rejection, or increases the time taken to receive a diagnosis. This illustrates the power which medical practitioners possess, and their potential to exert social control (Salzmann-Erikson and Eriksson, 2012; Waitzkin, 1989; Freidson, 1960).

Charlie articulated a related concern in their diary – “A brief thought – am I still trans if I don’t want to transition?” – further emphasising that the approach to understanding what trans ‘is’ remains connected to an assumed desire for medical transition, even among some non-binary people. This is particularly conceivable for individuals in the early stages of exploring their gender identities – who are less likely to have experienced the rich community discourses of what transgender and non-binary can be taken to mean. Alex discussed how when they met a partner who identified as trans, this was the first time they had knowingly met a trans person:

This person is choosing not to socially transition for their own personal reasons, but I hadn’t known you could do that. I kind of thought it was all or nothing? You know how you get that trope of like uneducated people saying ‘oh have you had the operation yet’? And that was kind of my understanding of it until I got to know more people. (Alex, 20, diary)

Alex’s experience illustrates how connecting with other binary and non-binary transgender people can expand an individual’s potentiality of gendered self-conception, through accessing discourses previously unknown to them. This also shows how Alex’s relative community/knowledge position now means that they associate their past self as uneducated, rather than merely inexperienced. Further, it also emphasises the

importance of interpersonal interactions in gaining knowledge and awareness about non-binary/transgender communities, which can impact the intrapsychic interactions that allow for negotiation of the self.

Communities can share politicised knowledge that resists hegemonic positioning of homogeneous, historically situated narratives of coming out, and both social and medical transitions. For example, when individuals explore communities for the first time, they may be introduced to deconstructions of maleness and femaleness, in order to help reassure individuals of the validity of their identities. An example would be Jess's recognition of experiences of dysphoria that are not situated in the body, resisting an essentialised model of transgender and allowing for a more varied possibility of gendered narratives. This however may then lack intelligibility within clinical settings. Hal made the point that transgender communities are something that people are more generally aware of than specifically non-binary communities. Finding similar individuals with whom to bond or receive support over identity negotiation may therefore begin more generally, before becoming more nuanced. Indeed, Alex demonstrated this through admitting their comparative ignorance when first interacting with other trans people.

Non-binary self-conceptualisation was not universally tied to a transgender identity. Whilst almost all participants discussed their non-binary identities as either explicitly transgender or being situated under 'the transgender umbrella' (Currah, 2006), Zesty expressly distanced themselves from the label of transgender, due to associating the term with medical transition:

Oh, I don't identify as trans. If someone were to make that mistake I'd just correct them and be like 'no I'm not trans'. From what I've gathered, being trans is that how you think isn't how your body actually is, so they change the body more towards how they think. (Zesty, 22, diary)

Zesty's conceptualisation rests on acceptance of a 'classic' trans narrative - 'feeling trapped in the wrong body', and experiencing embodied dysphoria. Thus being desirous of embodied change is positioned as central to being transgender. By Zesty's understanding, having a non-binary identity is not connected to desires for embodied change. There is a certain parallel with how Alex conceived being trans prior to meeting trans people. As Zesty discussed being well situated in queer community

involvement, such a view is not necessarily a product of lack of contact, but may also potentially change over time.

Whilst the narrative of transgender people being considered as men or women 'trapped' in 'women's or men's bodies' has been critically deconstructed (Bettcher, 2014), Rachel subverts the hegemonic interpretation that this produces uncomplicated, negative feelings. This is illustrated by figure 3, taken from Rachel's diary

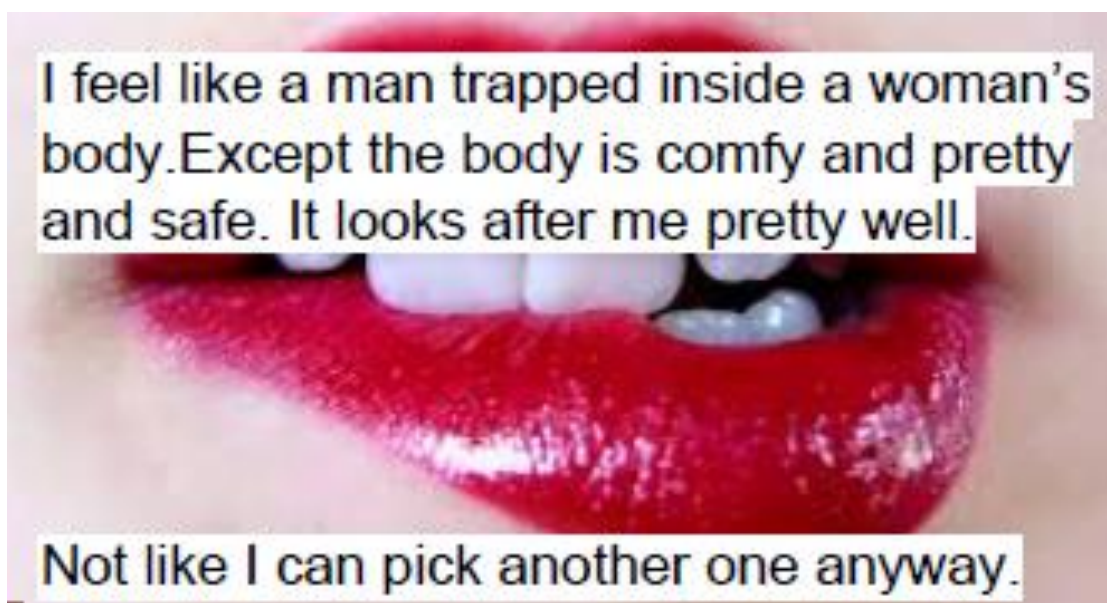


Figure 3: Image of lips, from Rachel's diary.

Rachel's diary was digitally produced, and comprised entirely of short passages of text overlaid on images that were thematically connected to the context of the text as a multi-media form of expression. Whilst Rachel does experience embodied dysphoria, in articulating that they find their body "comfy and pretty and safe" they challenge a narrative that constructs transgender bodies as exclusively problematic and negative for the trans individual. This is a narrative which can result in oversimplification and erasure of how trans/non-binary people negotiate their relationships with their bodies.

Rachel also highlights the importance of recognising trans people who have (at least partially) positive relationships with their bodies prior to, or without, hormonal and surgical changes. The image of lips wearing red lipstick, with the teeth biting the bottom lip is open to a wide possibility of interpretations. Whilst the lipstick may incite the viewer to instinctively gender the lips as female, the accompanying text allows for the reflexive reinterpretation of the image – recognising the fact that there is no available information to make a confident attribution of gender to the disembodied lips. There is

concordance between text and image in that both challenge assumptions that might be made in relation to gendered discourse.

Finn experienced uncertainty over their gender in different terms. Whilst it was shown that Charlie doubted their 'transness' due to not feeling a need to access gender affirming medical services, Finn doubted their right to access medical transition services on the basis of not possessing a binary gender identity:

Too often I fall into the trap of thinking 'well I don't identify as a man so I shouldn't really be medically transitioning' but that's ridiculous. Just because I don't fit nicely into a binary trans narrative, doesn't mean that I shouldn't be able to get access to a body I will be much more comfortable in and that will align more with my inner image of what I actually look like, so that I'll be able to navigate the world and people will really see me. (Finn, 22, diary)

Finn's description of what they hope for from medical transition resonates with historically traditional binary trans narratives (McGuire et al., 2016), which position the 'inner image' as stable and constant (Eliason and Schope, 2007). Non-binary and binary trans motivations for transition may thus be similar – yet potentially still broader than medical hegemony is comfortable recognising (Baril and Trevenen, 2014).

Ash (33) was the only participant to explicitly state that at this stage of their life, they never felt 'not trans enough', stating "I'm about as trans as most people get!" This may be explicitly related to Ash's extensive history of accessing hormones and a wide range of gender affirming surgeries. It is notable that this feeling was dynamic. In having altered their body, Ash has fulfilled the requirements of a (problematic) discourse of trans legitimisation. Surgery may then serve to provide even greater feelings of legitimacy than hormone access, due to being seen as 'more major'. In their diary, Ash shared a self-portrait of their body in order to provide a physical map of embodied change, also functioning to some extent as a timeline of their gender-related medical interventions:

Friday 6th february

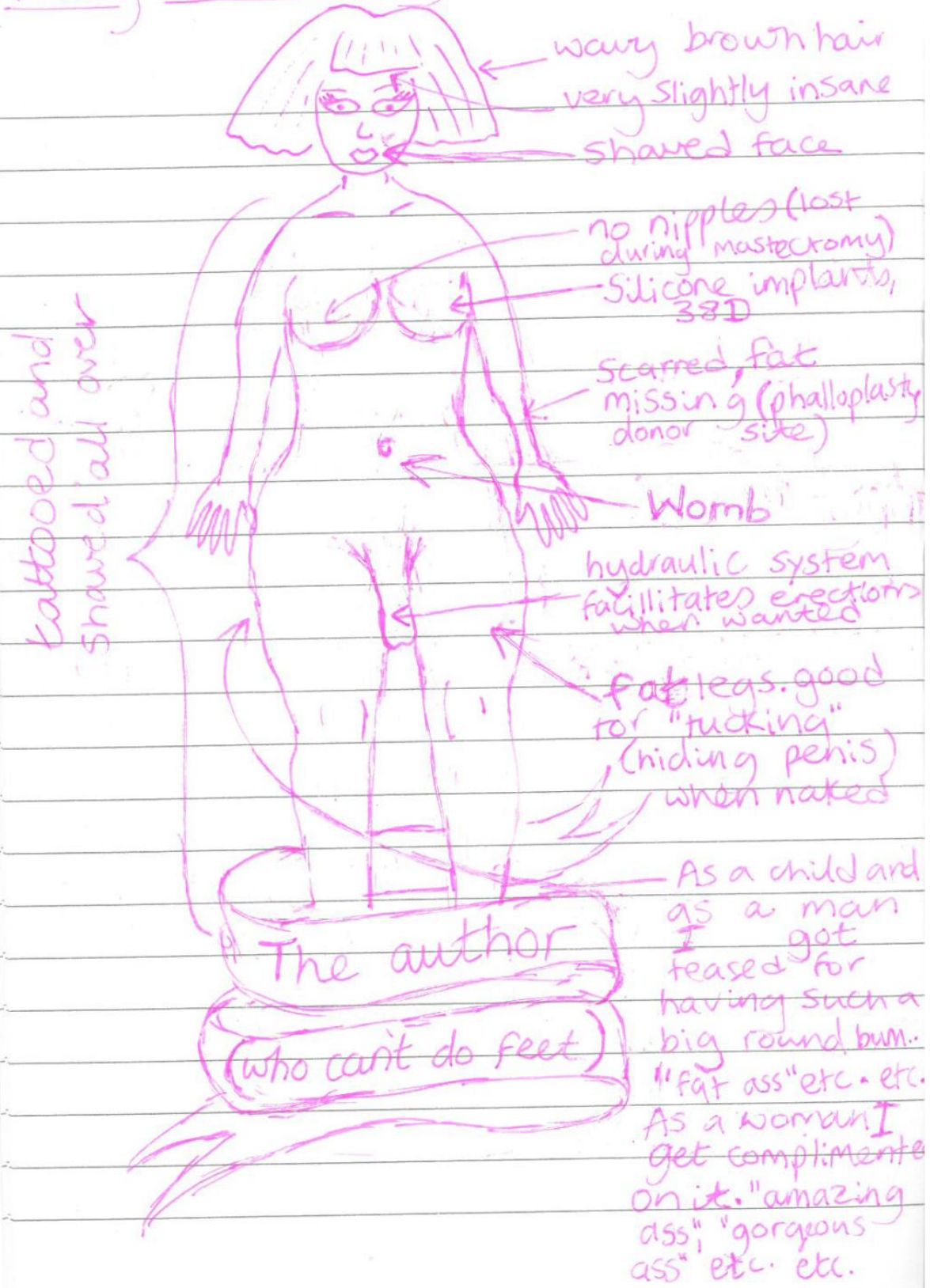


Figure 4: Image mapping the body, from Ash's diary.

Ash had by far the most experience of gender affirming surgical interventions of all participants. They also occupied the relatively rare position (for someone never diagnosed with an intersex condition) of simultaneously identifying outside of the gender binary and also possessing a combination of physiological structures that are typically socially positioned as 'female' (breasts) or 'male' (penis). Extensive engagement with medical services synergised with long-term involvement with queer communities to result in strong feelings of legitimacy and validity for Ash in relation to being both transgender and non-binary. One can argue then that extensive medical (in particular, surgical) access is significant in Ash's security as non-binary and transgender.

It is important to note that whilst some participants expressed discomfort with aspects of their bodies and others did not, the general idea that accessing a medical transition allows one to be viewed as more authentically trans cut across these different non-binary experiences. Further, some participants, such as Finn, would challenge their own feelings as problematic and remind themselves of political arguments that transgender status need not rest upon embodied dysphoria. This bears a striking overlap with findings by Catalano (2015) who found that a sample of trans male undergrad students could rely on medical discourse, even whilst critiquing it. Others such as Zesty consolidated their understanding through highlighting how they personally understood and used particular terms in relation to themselves. Jamie wrote that:

I knew I wasn't female but thought I couldn't be "really trans" because I hadn't experienced dysphoria etc. consistently for long enough... of course I'm both non-binary and trans, if you have to see them as separate things which I don't believe you should (I tend to think you're either cis or not cis). It drives me mad how well that story of repression and "coming to terms with" my trans identity and going through a 'NB stage' works: it reaffirms everything that's wrong with the way people think about gender. It drives me mad too, that when people hear it they're super relieved to be able to use male pronouns for me and never have to deal with these pesky gender-neutral ones again. And it drives me maddest of all that experience keeps proving that that story is the only way to get people to take me seriously, to actually try hard with pronouns, to pay more than lip service to the pain being misgendered causes me. (Jamie, 24, diary)

This quote from Jamie illustrates again how an uncertain relationship with dysphoria of the body troubled their ability to embrace a transgender identity. Further, the use of language around dysphoria not being ‘consistent’ or for ‘long enough’ resembles a medicalised consideration of the assessment of symptoms in relation to illness. Individuals are thus more likely to feel insecure of the ‘validity’ of their gender identities when less certain that they are fulfilling medically validated discourses of transgender.

In addition, Jamie’s relationship with pronouns (preferring singular they, but also accepting ‘he’, at the time) meant that in circumstances where explanations of ‘singular they’ as their pronoun might be too difficult – that is, emotionally exhausting or posing a risk of disenfranchisement, ridicule, or violence, they possessed an intelligible and personally acceptable option. Jess also navigated gendered interactions similarly, using both ‘they’ and ‘she’, though without particular preference. She pointed out:

I give ‘she’ or ‘they’ as pronouns. And I say use them equally, I pretty much exclusively within the trans community get called she. And this is because I think even if trans people were... we want to be in the binary or want to put people in the binary. (Jess, 26, interview)

Jamie and Jess’s narratives show how constructing an understanding of dysphoria that is broader than a medicalised perspective resting on the body, allows for a sense of validation and inclusion. By constructing their negative feelings around being misgendered as a form of dysphoria, this utilises pre-existing diagnostic language (gender dysphoria) to challenge and resist any internal sense of inadequacy or fraudulence.

Jess’s example emphasises that even in transgender communities, binarised language can be preferred when the choice is given. This positions gender neutral pronouns as harder to use and easily erased, especially where permission has been given for a binary pronoun to be used. This emphasises the potential difficulty in navigating being non-binary and intelligible, even in queer spaces. The sense of feeling ‘trans enough’ was thus not exclusively rooted in internal policing or insecurity, with some participants reflecting upon how community interactions could foster or stimulate a sense of not belonging.

A Hierarchy of Transness within Trans Communities

Jen expressed feeling that whilst labels had helped her to articulate her identity, they could also act to make her feel like an outsider. Her relationship with ‘trans’ further

illustrates the connection between feeling 'trans enough' and medical transition, whilst introducing how those feelings can impact interactions within the trans community:

I often feel like an outsider among trans people because I can't transition. So if I'm in Girl Mode and I choose to present as female, and I'm with a bunch of transwomen, I feel like the odd one out. Transwomen are usually transitioning or have transitioned. Of course they are. They aren't drag queens (no offense to drag queens). If I'm not transitioning, am I really a transwoman? I guess the answer is no. I'm a guy in woman's clothes, which isn't the same thing. I don't think that's entirely true (I don't feel like a guy at the time) but that's how I feel in terms of being an outsider. (Jen, 29, diary)

At the time of the research Jen identified as bigender, experiencing her gender as shifting between what she termed 'boy mode' and 'girl mode'. Jen expressed that she cannot medically transition, because she felt that whilst she would want physiological traits associated with being female when in 'girl mode', she would want her body to remain as it is when in 'boy mode', such that no physiological configuration would be satisfying at all times. An androgynous or mix of physiological traits would also not be what Jen wanted, as she understood her gender in distinctly bimodal terms. Experiencing gender differently from (medically constructed and validated) narratives of transgender caused Jen to doubt her 'transness'. This echoes Charlie's insecurity over being trans if not transitioning. Jen was amongst several participants who articulated a sense of a 'trans hierarchy' within queer community spaces between those accessing or wishing to access medical transition services and those not:

I still get some problems from some trans people, but in this comment I'm meaning more people who are understanding loosely what trans is and are okay with Caitlyn Jenner⁴², they're like 'what are you then, because you're obviously not a trans woman'. You're just faking it, or not sure? (Jen, 29, diary)

Jen's articulation of a bigender identity meant that she felt that, by the standards of those interacting with her, she was 'obviously not a trans woman'. Being confronted with questions such as 'you're faking it, or not sure?' within transgender communities

⁴² Caitlyn Jenner won the 1976 Olympic men's decathlon title, and established a television career most associated with *Keeping up with the Kardashians* prior to her heavily publicised gender transition, in 2015.

illustrates that there is not always an equivalent sense of awareness, acceptance, or sensitivity towards non-binary people. Those trans individuals who most closely fit a narrative that does not challenge any aspects of the clinical expectations of what being transgender 'is' are those also positioned as 'most sure' or 'most real' within some trans communities. Binary trans people⁴³ are thus positioned as less likely to be viewed as 'faking it or not sure' than non-binary people, in Jen's view. However, discourses of binary trans women as 'gender deceivers', particularly as a form of transmisogyny, have been recognised and explored (Serano, 2007). Further, community members' feelings on transgender hierarchies of authenticity have been previously recognised (Hines, 2007a), and found to stress the need to move beyond such practices. Jen's feelings may be better explained as an intrapsychic interaction where she ascribes meaning to herself and the trans women she sees, rather than other community members acting to delegitimise her.

Even when 'not being seen as trans enough' was not a factor, anxiety over other community members' thoughts could impact how participants felt, evidencing how anxieties over being viewed as 'real' might affect an individual's experience of queer communities:

Ben: Have you ever had feelings of not being trans enough?

Frankie: Oh lord yes. Oh lord yes. I think I have to be honest – hormones were a really validating experience in that sense. Prior to hormones, I had those feelings constantly. That was a real demon that I was battling for a long time. There is a hierarchy of transness amongst trans communities, there just is. And it's really damaging and really hurtful and really horrible.

B: In that people are seen more real when they access medical services?

F: Abso-fucking-lutely. And whether there's been an internalisation of that I think it's pretty apparent there has. (Frankie, 25, interview)

Frankie's experience of medicine as validating reemphasises how her experience prior to accessing medicine felt less stable, that she felt more vulnerable to being seen as

⁴³ Or at least trans people choosing to access medical services and 'pass' as male or female in a normative fashion, as Caitlyn Jenner typifies. Some individuals who strongly identify as non-binary may choose or desire to 'pass' as binary some or all of the time, for example, Ash.

invalid or illegitimate by other trans people. Rachel's diary also emphasises how insecurity due to not accessing a medical transition need not only be rooted in ambivalence towards embodied changes, but may well illustrate important considerations such as how disabilities may intersect with accessibility or desirability of medical transition. This discussion is expanded in chapter six. David illustrated a different connection between medicine and insecurity over being accepted as trans:

Ben: Have you ever had feelings of not being trans enough?

David: Oh god, all of the time.

B: What causes that?

D: I think largely, the lack of any medical transition, ultimately the only thing people have to go on with me describing myself as trans is my word. I have no evidence for it whatsoever. Not even... I don't even have any official documents in the name that I go by, because I've changed my name a couple of times now and it's a hassle and I can't be arsed. And because I think that I might be in 'name transition' at the moment? So I might yet change it again. And I don't want to have to go through the entire process again. So yeah, but it is mostly the medical stuff that makes me feel like... I think if I was on hormones no-one would ever question it. (David, 31, interview)

It is worth recognising how David's use of language – not having 'evidence' of their transness – mirrors that of evidence-based medicine, sometimes concerning itself with 'proof' to legitimise an individual's identity (for example, surgeons can demand this before performing gender related surgeries). This evidences how medical practices and medical knowledge have impacted upon queer communities, shaping community discourses. This may then feed back, through how trans people interact with their doctors. Likewise, Frankie's mention of hormones as 'validating' relates to how experiences of 'treatment' validates and legitimises 'illnesses', as within Parson's Sick Role paradigm (Parsons, 1951). This highlights the significance of the medical establishment in the production of transgender narratives, and how they may impact how individuals think about and express their conceptualisation of selfhood. Further, whilst even clinical sites of knowledge production are increasingly explicit that being transgender is not an illness or disorder (Richards et al., 2015), this can fail to adequately recognise how practices of treatment access are rooted in and (re)produce discourses around trans as *if* dis-identification with the gender assigned at birth were a pathology.

Finn stated how they felt the view of not feeling trans enough due to not accessing medical services could be reinforced through the beliefs of some binary transgender people:

I think there's a lot of problems in trans communities of like, oh well if you're not dysphoric then you can't be trans, like being non-binary isn't a thing, non-binary people don't belong in trans communities. (Finn, 22, diary)

This adds traction to the ways in which Jess and Jamie constructed their feelings of discomfort over being misgendered and deadnamed⁴⁴ through the language of dysphoria specifically. By articulating distress in relation to language used to address them as dysphoria, this justifies inclusion under the transgender umbrella to those who may attempt to police boundaries of transness in terms of distress and discomfort.

V discussed how he views it as important that those with normative⁴⁵ transgender identities and experiences do not 'set a standard' for the community as a whole:

I've certainly heard it, and I think [hierarchies in trans communities are] a bit insidious in some of the groups without being overt; you get a feeling certain people switch off when you start being a bit more nuanced about it. Because all they're bothered about is being read as blah. As a stereotype, and that's it. And then they want to get on with their lives. And they're not really interested in the nuance of identity; they just want to be comfortable and not hassled, which is fair enough. But again, that sort of thing is not helpful to the community at large. If that's how you want to be, that's fine. But don't make that the structure of transness, or the social acceptance of transness. Interestingly, I recently came across someone who said they'd got hassle as quite a binary trans person for being binary, from people who were non-binary! And I have honestly never heard that before. Never heard that before, that they... normally it's the other way around [...] So that was quite

⁴⁴ 'Deadnaming' is a term originating within transgender communities to refer to the practice of calling a trans person by the name they were given at birth, after they have taken a new name and asked to be referred to only by that name. For more detail of the political ramifications of deadnaming, see: <http://fusion.net/story/144324/what-deadnaming-means-and-why-you-shouldnt-do-it-to-caitlyn-jenner/>

⁴⁵ Who may be more likely to identify within the gender binary, but not necessarily.

interesting because a little part of me felt that perhaps they'd said that because they felt a little bit, I don't know, insecure about people being non-binary. And that's sort of the impression I got from them as a person, talking to them. That their identity was affirmed in a very binary way and so being non-binary they kind of didn't connect with, and felt a little bit threatened by, perhaps, or just not comfortable with it. Which you know, is alright but it's a bit... to kind of promote that socially is uncomfortable I think. (V, 28, interview)

V argues that it is important for trans people not to articulate a sense of validity and self-affirmation through the denigration of other people's gender identities and expressions. Non-binary people will be inherently disadvantaged in any situation where individuals appeal to historically-legitimised transgender narratives as more certain, real, or stable, due to the relatively recent recognition of non-binary identities within policy or medical practice. Further, whilst Jen had previously articulated insecurity due to a comparative lack of acceptance and intelligibility from binary trans people, V highlights the possibility of binary transgender people feeling threatened by, or negative about non-binary identity labels and expression.

Transgender rights have a cultural and legal history of being hard-won (Hudson-Sharp and Metcalf, 2016; Green, 2010). Thus, inclusion of individuals under the transgender umbrella who have identities and/or gender expressions that challenge the gender binary and cisnormative hegemony may sensitise or even anger those binary trans people who possess more conservative notions of how gender operates. This suggestion is borne out through Jamie's description of interactions with some members of a trans support/social group they attend. Jamie contextualises by describing a particular older transgender woman, who regularly interrupts others and dominates discussions. She is characterised as conservative, resulting in tensions with some younger members who problematize such an ideology. Jamie explains how:

[She] not last night, but the time before, went on a rant about the word 'queer' – because it was used as an insult when she was young. And said 'and there's this booklet over there which says you can identify as 'genderqueer', and I want to rip it up!' and my friend who identifies as genderqueer got really upset and said 'you can't do that, you're erasing peoples' identity' and at that point I would have wanted someone in charge to step in and say 'just to remind people everyone

has the right to identify how they like' but they didn't. People who were nominally in charge were just sitting in the corner awkwardly and this really quite heated discussion going on. And [she was] interrupting everyone, expressing this unpleasantly privileged way of socially interacting. (Jamie, 24, diary)

Thus, tensions regarding the reclamation of language ('queer' historically functioned as a slur, though now also as an identity category), and how that has become incorporated into identity politics can illustrate not only a lack of understanding but catalyse hostility that can be difficult to manage. This example illustrates the possibility of heterogeneous community spaces as disputatious. There is potential for trans people whose validation has been achieved within normative terms to exercise community-surveillance, and sanction non-normative behaviour. This may be compared to homonormative policing particularly within communities of gay and bisexual men (Eguchi, 2011; Taywaditep, 2002)

Within the same community group, Jamie shared another anecdote in order to illustrate that they felt they were "really forcefully reminded of how little most trans people seem to actually understand about gender". At a meeting of the same group, Jamie was criticising a particular form sent out from a Gender Identity Clinic (GIC), which contained a tick-box question for 'biological gender':

The phrase makes literally no sense! I said this at [group] as an example of "look how obviously self-evidently awful this form is" – and like I said, thank god [friend] was there. They laughed immediately; other people looked confused; some made 'ah well, they can't get everything right' sort of noises; [name] (who now seems to see himself as some sort of coordinator, I think it's his personality) started saying kind of performatively as if explaining to the group "well, yes, some people would say sex instead..." SOME PEOPLE?! Yes, those apparently very few people who know what words mean! I wasn't raising this as a concept up for debate, I was trying to draw on shared knowledge, but once again I'd forgotten that even the trans community don't know what on earth to make of non-binary people. It's partly a generational thing, and I understand why they might not have been exposed to the idea before identifying as trans, but why not after? It's

not like it's even complicated. (Jamie, 24, diary, underline and capitalisation original).

Jamie's understanding of the form rests on the demarcation of 'sex is biology, gender is social', which can be critiqued in and of itself as an oversimplification, which Jamie recognised (Westbrook and Saperstein, 2015; Butler, 1988; West and Zimmerman, 1987). They attempted to gain catharsis through critical expression in an environment they hoped would both understand and be sympathetic to their concern over language. However the lack of mutual understanding, which they thought they could presume on the basis of transgender identity, was taken by Jamie as illustrative of a lack of intelligibility of concerns with gender that non-binary people in particular may have.

Mark's view of transgender communities was that some individuals could validate themselves through reliance on comparison to other community members, such that some individuals would justify their identity through an exclusionary politics of being 'more real'. Mark drew a parallel with his experience of veganism:

Ben: Do you find there can be quite a lot of conflict in group settings?

Mark: Oh absolutely. I mean even in our little group, we have like 8-10 people along, I don't think I'm breaking any confidences here when I say for some, they identify in a very binary way, and that's how they're going through their transition, that's how they are knitting everything together for themselves. And we have probably 2 or 3 people... in addition to myself who would probably identify as non-binary, and it can be sometimes that... it's not so much conflict, as I say, we're drinking cups of tea and eating Victoria sandwich, so there's not going to be any pitched battles, but there is a bit of one-upmanship almost. [...] everybody's I suppose... trying to kind of... grab the label for themselves; that makes it seem very conscious, and I don't think it is. But we all want to be right, don't we. [...] In the kind of 'transgender world'... there's such a kind of chorus of people who are singing more or less the same song, off a similar sort of hymn sheet, but maybe using a different key! None of which is wrong. And that, well, very little of which is probably wrong, but that's where the trouble comes, it's very difficult to say to somebody else, 'I'm sorry, you're wrong about your transition', you can't say you're non-binary for reason X Y Z.

B: Well there's never any reason to do that.

M: I would hope not, but I think sometimes in the mission to find ourselves we kind of do it by stomping on other people, either deliberately or not. (Mark, 43, interview)

Jess considers the difficulty in disconnecting a transgender identity from a medical transition to be the product of medical institutionalisation, exerting a hegemonic binary of 'medical transition' or cisgender:

I think transness has kind of been stolen from us really. There's a whole wide range of gender experience that you could classify as being trans. And I think that what has happened is those experiences have been pathologised by the medical establishment and been forced into a psychopathologised binary medical pathway. Which forces you to be essentially a binary trans person, or forces what is essentially a spectrum to become a yes or no question. And so I wouldn't want to put that on the queer community, I don't think that's a queer community... I think we're living under the shadow of that rather than creating it. But I think there's a few things that we do which perpetuates the 'common sense' we've received from above. So we often expect people to want to engage in medical interventions. We often expect a certain type of presentation. We expect people to operate in those kind of ways. So yeah. I think that there's stuff that the queer community could be working on within themselves as well as engaging with non-queer community. (Jess, 26, interview)

Jess's explanation shifts the focus of critique away from binary transgender people or other members of transgender communities who may perpetuate narratives that are legitimised by operating relatively easily within medical diagnostic paradigms. Instead, Jess emphasises how the community 'lives under a shadow' of medicalisation which is responsible for intra-community policing, as well as internalised senses of not feeling trans enough in relation to how an individual does or does not access gender affirming medical services. This shifts the modality of oppression away from individuals within a marginalised population, and towards the structural constraints of the medical establishment, and the hegemonic discourses which are internalised and propagated.

Feeling Not Trans Enough in Relation to Medical Service Access

There was a sense amongst participants that non-binary gender identities could lack cultural intelligibility (Butler, 1993a) – the ability to be recognised or understood – even

within transgender communities. This concern was far stronger in relation to concerns over whether medical practitioners would be affirming, or aware of non-binary identifications and articulations even at GICs – despite the nature of secondary and tertiary care practitioners working in relation to transitions requiring more specialised knowledge and sensitivity⁴⁶. Multiple participants who were starting a process of trying to access gender affirming medical services articulated that they felt binarised medical gatekeeping is a common occurrence, and would prevent their non-binary transgender status from being legitimised if they were entirely candid.

Have I therefore made up my gender story? Yes, a bit, to concrete the impression I've given to my doctors. But not in the essentials. (Mark, 43, diary)

I've been having a lot of very difficult feelings surrounding my gender, mainly due to knowing how hard it is for non-binary people to get treated at Gender Identity Clinics, and wondering if I should lie and say I'm a trans guy (which I probably will end up doing). (Finn, 22, diary)

Ash: I think it is [different for non-binary people to access GICs]. Because when you go into an exchange with a medical professional who's assessing you for some sort of treatment, you... probably have if not a certainty about what you want to do, at least the idea that you don't want to actively cut off your options by admitting that you're not a trans binary person. Because once they decide that they've assessed you and you're not transsexual you definitely won't get any hormones etc. so there's a defensiveness and a realisation that if you go in and let them know how uncertain you are or how non-binary you are that you'll just cut off all your options for the future. I think a lot of us, if we don't lie we really deliberately present all the stuff that makes a good case for treatment because that's what we want to do, and we can

⁴⁶ It is important to note that different expectations of knowledge may be had of those secondary and tertiary care practitioners whose work clearly relates to transition-related healthcare (such as endocrinologists, and GIC practitioners), in contrast to secondary and tertiary care practitioners in unrelated specialties. Transgender awareness and sensitivity should be incorporated into the training of 'gender unrelated' secondary and tertiary practitioners, as for all primary care GPs, so that trans status does not cause problems with equal treatment access and experience.

always change our mind and not have the treatment. But once they've said no to the treatment we can't change our minds about that, not too easily. So that's what makes it difficult to be honest.

B: So do you think people try to keep their options open by presenting more binary than they maybe are?

A: Yes I think so. More binary, more certain. More... yeah. Absolutely. More like... the narrative of 'typical transsexual' experiences known to have worked. (Ash, 33, interview)

There is a sense amongst non-binary people that existing medical criteria make it more difficult for non-binary individuals to be recognised clinically and to access gender affirming services than for binary transgender people. Ash explained how when they accessed hormones and surgeries initially, they identified as a binary trans man, and then had great difficulty in accessing further services in relation to their articulation of a non-binary identity. They explained how:

When I went on the waiting list for breast surgery, I imagined that I wasn't actually going to have it. I did it because it was expected of me, and if I did everything that was expected of me, I'd get a prescription for testosterone. And I imagined I'd probably just go 'oh I changed my mind' and not having it done. (Ash, 33, interview)

However, Ash found the experience of 'becoming more butch' very interesting, and explained how their curiosity over being read socially as male resulted in continued medical access, which they felt positively about. These factors together also strongly influenced how they constructed their body outside of a clinical setting, articulating how through extensive exercise they cultured a muscular, masculine physique. Despite enjoying this period of their life, after 10 years they decided they wanted to articulate a more feminine appearance. Negotiating this with medical professionals was extremely difficult, with Ash explaining that due to not following a 'typical' trans narrative, they were turned away by at least ten surgeons before finding a private doctor in Poland who agreed to operate. Ash expresses an unambiguous happiness about their breasts, despite having previously accessed a double mastectomy. They were also happy during the period of their life where they possessed a muscular, pectoral-emphasising chest that was viewed as masculine. This serves to disrupt hegemonic transgender discourse, whereby a physiological configuration on one side of the gender binary is anathema, whilst the other is idealised. Two points (that are often implicitly positioned

as axiomatic) are challenged by this – firstly that gender, once truly reflected upon and understood, does not and cannot change, and secondly that the presentation and articulation of gender that an individual feels correctly reflects their sense of self reflects the *whole* gendered self, rather than potentially a part. This experience of embodiment illustrates potential ‘fuzziness’ around gender (Tauchert, 2002). In other words, Ash’s shift in embodied desire does not evidence remorse for their time spent presenting as masculine, nor does it imply that the allowances for medical intervention were misplaced. Further, Ash’s experience also highlights the necessity of recognising that feelings around gendered embodiment can be renegotiated or change over time, yet not fit within a narrative of ‘de-transition’.

The desire and action of Ash to modify their body in relation to how they felt regarding gender at different stages in their life defies the expectations of gender identity clinics – that gender affirming procedures are expected to be embraced permanently. This expectation is due to the ‘common sense notion’ that if something is impermanent, it is ‘less real’, which influences the standards that are considered ethical within medical practice. Thus, there is a lack of clinically intelligible narratives where individuals have continued transitioning, or re-transitioned, without it being characterised as ‘regret’. Ash’s experience also emphasises how happiness with embodiment has profound impacts beyond the internal interactions with the self. Ash is a sex worker, and thus embodiment for them is also connected intimately to economic capital. It is also clear from Ash’s narrative that they did not approach medical services attempting to articulate a binary transgender narrative whilst identifying as non-binary, but rather came to their non-binary identification over time, post-medical access.

The clinical standards that need to be met (particularly through NHS GICs, though also through private medical practice) are such that members of the non-binary community can view certain narratives as more likely to ‘succeed’ than others:

Jamie: I think medically speaking, I don’t think GICs would accept you just saying ‘this makes me happy, but I’m not super unhappy now’

Ben: You have to be pathologically unhappy?

J: Which is why again, you end up hyping up these experiences which maybe you would prefer to diminish. Because you’re aware, or you think you’re aware given there’s no transparency, of what they want to hear. And you’ve got to strike a balance between telling that and telling the truth (Jamie, 24, interview)

Jess (26) also explained how access to medical resources can become “a competition” as who can fulfil clinical expectations “in the quickest and most attractive way”. Jamie and Jess both share the view that current medical policy inherently produces a hierarchy between binary and non-binary transgender people, because of the belief that non-binary identities are less likely to be accepted as ‘needing treatment’. One can argue that within the context of the NHS, whilst doctors are limited by available budgets, they have a utilitarian responsibility for individuals experiencing pathological distress to be prioritised (Pencheon, 1998). However, as the multiple participants experiencing dysphoria that would be alleviated by gender affirming medical services illustrate, patient need cannot be assessed through consideration of whether identity is constructed in binary or non-binary terms. Further, the existence of binary transgender people who do not wish for hormones or surgeries has long been recognised, through the historical demarcation between the ‘transsexual’ and the ‘transgenderist’ (Ekins and King, 2005; Prince, 1978). Historically, those not seeking medical transition could be clinically positioned as ‘simply crossdressers’, with this fundamental demarcation used to maintain ‘transsexuality’ as the only category necessitating medical transition, which required a particular performance of gender in order to be diagnosed as such.

It is important to recognise that doctors, as with all other members of society, are subject to influence by structural, societal gendered norms (Turner, 1995). Participants could fear being judged as ‘not trans enough’ by doctors because of being less culturally intelligible to them (as clinical sensitivity on transgender patients remains uncertain on non-binary identities, even in specialist contexts), and because non-binary treatment has considerably less precedent with which to be clinically justified. This is discussed in further detail in chapters six and seven.

Frankie, who has successfully accessed an NHS GIC and been discharged due to having accessed all that she currently wished to, articulated positive feelings about her experiences. Despite this, Frankie did also say that her overall sense of *other* trans peoples’ experiences was not good, and that there exists “a lot of misunderstanding, [and] a lot of barriers put up to medical assistance”. Other participants, who articulated positive experiences personally, also believed there was a negative status quo overall:

You hear really awful stories, like, oh god, but that hasn’t happened to me, I’ve been fortunate. (Mark, 43, diary)

My non-binary friend, they've just been under the gender clinic, and they've had a really tough experience. And I think that's fairly typical from what I know. I have been incredibly lucky. (Ricky, 43, diary)

Frankie and Ricky's positive experiences are particularly important because they both identified themselves as non-binary to their GICs throughout their transition processes. This demonstrates that negative participant conceptions of GIC practice for non-binary people cannot be taken as universally representative, and as Frankie also notes, "you don't normally hear people being particularly vocal about the good experiences they've had, the ones you do hear about tend to be the negative ones". This follows, in that services perceived as problematic by the trans community inevitably garner more attention than less problematic cases, in order to seek their improvement. In addition, for those community members seeking information from other trans people prior to GIC access, interest in negative cases can be a mechanism so as to avoid an undesirable outcome, and to prepare for a 'worst case scenario'. The above quotations from Frankie, Mark, and Ricky suggest a pattern whereby non-binary people with positive clinical experiences view themselves as exceptions to the rule – "fortunate" and "lucky", as they all had anecdotal evidence of problematic transgender treatment (at all levels of care) from others.

It is possible however that Frankie's positive experience was dependent on the manner in which she articulated her non-binary identity, such as through binarised language (such as 'more female than male'). Frankie even postulates that her experiences may have influenced how her identity changed over time from non-binary to more binary: "to be honest maybe that's part of the reason for my kind of identity shift. Maybe I wouldn't rule it out that I've internalised some... GIC". Frankie also reported that during one of her appointments, one of her secondary care practitioners said:

That I was moving (I think the words he used were 'slowly drifting') towards a place that was much easier to 'treat' from the GIC's greater NHS perspectives because it had a treatment history. Much as I can understand this, it's a bit of a blow to hear it put like that. (Frankie, 25, diary)

By implying then that non-binary service users are 'more difficult' due to lack of historical precedent, it can be appreciated why non-binary people may feel the need to police how they communicate with GICs in order to make the process as quick and easy as possible for themselves. This is a product of a more general logic in medicine

of symptom identification, diagnosis, and treatment, being applied in an arguably under-critical manner in the context of gender – such that articulations of gender with less socially visible (and therefore medical) history are discursively positioned as having less medical need. This explains the commonality of some participants wishing to avoid or minimise mention of their non-binary identification within the GIC. Exhibiting a common and precedent-bearing profile could, however, be done, even if identifying oneself openly as non-binary. Ricky said that it was:

Surprisingly easy [to be out as non-binary in medical contexts], but I think that I probably had enough of a typical trans man's narrative to make it a fairly straightforward process, even though... they were very respectful of my pronouns, and of my letter finally granting me testosterone has me recorded as a non-binary trans person, with 'they' pronouns. But having said that, I've gone on a fairly standard route. I'm going on testosterone, I have no desire at the moment for surgery, but that might change as my body changes. [...] So yeah, I don't know whether my experience as a non-binary person in the gender clinic is typical of other non-binary people who might have slightly less standardised needs. I was talking, and toying with taking a lower dose of testosterone, which they're quite resistant to at [clinic]. But in the end I decided to go for a full dose, just because the changes... apparently if you take a lower dose of testosterone you get the same changes, just more slowly. And to be honest at my age, the changes will happen pretty slowly anyway. (Ricky, 43, interview)

The language that Ricky uses further emphasises the point that positive clinical experiences are positioned as something to be thankful for, rather than something that can be relied upon. Ricky positioned the ease with which they were out as non-binary as 'surprising', though ameliorated this by suggesting this was through their clinical requests fitting within binary precedent – the "standard route".

Participants exerted control over their relationships with GICs through methods other than obscuring their non-binary identities, or through policing the manner in which they spoke about their identity. Despite both coming to this project independently and both electing to be anonymous, V and Jamie were open in their interviews about knowing each other and being friends. Jamie expressed how they had received support and

advice from V, who had positive experiences of accessing a particular clinic. Jamie chose this clinic on the basis of V's recommendation, but still remained guarded:

I haven't self-defined as non-binary to the NHS. When I say I picked [clinic] because V says they're non-binary friendly, I mean I won't worry about going in in flowery shirts and earrings in both ears; that's all. That's the limit of my honesty – I'm just going to tell them I'm not female; that's not a lie. (Jamie, 24, diary)

The concern expressed by individuals accessing GICs goes beyond the desire to be respected and recognised by practitioners in the setting of consultation meetings – extending to contexts outside of appointments, such as clinical forms. Jamie discusses and deconstructs this within their diary:

So this [clinic] form. 19 pages long. Includes a section where you label almost every body part with a rating of how you feel about it, including 'beard' (is that 'not satisfied', 'I want one', or N/A?) and ears (literally this has made me feel dysphoric about my ears, ffs)⁴⁷. A section on anxiety/depression, where you mark how often in the past week you've had a variety of anxious thoughts, which of course triggers all of said anxious thoughts. A section that seems designed to see if you have an eating disorder, with three slightly differently worded questions asking whether you think your buttocks are too big (if I say yes, will they think I just have an eating disorder and am not really trans?) And a section that maybe designed to test if you're autistic, I dunno – you have to rate the extent to which you agree with statements like "I would rather go to a library than a party" (is it a nice library? Who will be at the party? Did I get enough sleep the night before?) and most bizarrely "I find it easy to remember long strings of numbers, such as car number plates". That one caused a lot of anxiety at [group] because it sounds gender related inadvertently or not: 'masculine' brains are stereotypically supposed to remember numbers better. That's the problem with asking seemingly irrelevant questions in a context where there's so little trust between practitioners and patients: we start wondering why the questions are being asked, how they're relevant to the issue at hand, and what the "right answer" that will result in us getting access to

⁴⁷ In this context, 'ffs' stands for 'for fuck's sake'.

treatment is. As if the process wasn't hoop-jump-y enough, and as if I didn't already feel obliged to lie about my NB identity, now I have to agonise over what ratio of library-to-party preference makes me trans enough. (Jamie, 24, diary, underline original)

There is a lack of transparency over how such forms are produced, why particular questions are included, and what particular purpose questions serve; which as Jamie articulates, can cause experiences of anxiety over what criteria the GIC are attempting to scrutinise. In the recent past, (binary) transgender activists have given examples of service users being expected to 'completely comply' with directions over gendered appearance and to obtain 'proof' of gender expression within the workplace (PinkNews, 2009) illustrating the possibility that some GIC interactions are intended to explicitly police gender.

The responses from the trans community in relation to this clinical form, which Jamie illustrates, raise multiple questions. The first of which are whether (and if so, to what extent) questions are justified through evidence-based research. The inclusion of questions pertaining to 'systemising' ability – such as memorisation of car number plates – may relate to theorisation within experimental psychology, postulating that brains are gendered male and female in and of themselves, which are then demarcated as 'systemising' and 'empathising' (Baron-Cohen, 2004)⁴⁸. This work has since been heavily criticised for possessing fundamental methodological flaws and enforcing stereotypical notions of gender (Rivers and Barnett, 2013; Fine, 2010; Eliot, 2009). Lack of transparency over the production of such forms also means it is unlikely (or at least, unknown) as to whether transgender service users were consulted as to their potential impact. There are also ethical implications should such data be used for research purposes even with the informed consent of service users – due to the potential for patients to feel under duress, or fearing being potentially denied transition access should such forms not be fully completed – to not fulfil the role of a 'good patient' as optimally as possible.

⁴⁸ As there is no way to access the definitive purpose of questionnaire questions, this potential explanation is inevitably a speculation. However, it remains salient because of how trans service users engage in similar processes, in order to try and approach the questions 'correctly'. Indeed, Jamie suspected these questions to be connected to autism, and Simon Baron-Cohen's work on gendered brains specifically relates to a model of autism in terms of gender – such that even if this is not the actual clinical usage of the question, it is how some patients base their interactions with it.

This section has explored some perceptions and experiences of accessing gender affirming medical services. Opinions on GIC sensitivity and their ability to treat non-binary people effectively were low, both amongst those who had and had not accessed them. However, personal experiences were broadly positive – illustrating how it is possible that potentially small numbers of negative experiences may dominate community discourses, resulting in greater levels of anxiety and distrust. Alternatively, whilst interactions with clinicians may be broadly found satisfactory, the discourses around the clinic – that is, expectations of resistance or having to prove oneself as ‘trans enough’ – lack of transparency, and anxiety over the *potential* of a distressing interaction limit how positively the clinic may be regarded. Further, the happiness and relief later experienced by individuals who are successful in accessing hormones and/or surgeries may potentially ameliorate more negative views they held at the time. This relates back to my methodological discussion of the potential limitation of retrospective discussions. Frankie’s data is thus particularly interesting as she experienced a GIC appointment during her diary-keeping period.

It must also be noted that individuals with positive interactions in the clinical setting may still problematize the reasoning or efficacy of GIC policies or practices. Whilst clinicians may be respectful and helpful, this can be recognised as occurring simultaneously with a lack of transparency, extensive waiting times (UK Trans Info, 2016), lack of universal clinic guidelines, and lack of non-binary protocols (Richards et al., 2016). It can be claimed that fear of being judged ‘not trans enough’ to access services is a serious concern for many, and relates to how communities have internalised a discourse which associates medical access with legitimacy. Thus, fear of rejection by medical providers may be also connected to fear of then being unable to be recognised as ‘authentic’ in community interactions. Medical transition services can emphasise that aspects of hormonal therapy and surgeries are permanent changes, and associate this with arriving at a static and fixed gender identity, which Ash’s experience defies.

Conclusion

Through this chapter I have illustrated how common feelings of ‘not being trans enough’ can be amongst people with non-binary gender identities. This has significant discursive interplay with the consideration of, and interaction with, queer communities and medical services oriented around gender transition. Not feeling trans enough is commonly connected to either not desiring, or having not yet accessed medical

services. This shows how the centrality of medical diagnoses and discourses to the history of transgender communities shapes contemporary experiences of identity formation. This is despite resistance to medicalisation amongst transgender communities (binary and non-binary alike), and shifts in language amongst medical practitioners and diagnostic manuals over time, as recognised in chapter one. I have used the concept of 'embodied dysphoria' to differentiate between those who experience distress with their *bodies* and those who do not, and have drawn attention to how the language of dysphoria is used by non-binary individuals to justify themselves as transgender, even whilst resisting the imposition of medical power.

I have used data to illustrate that tensions can sometimes manifest between members of transgender communities, including sometimes due to differences between binary and non-binary transgender people. Reasons for this have included generational differences in language use, and how an understanding of one's own and other's genders are subject to many sociocultural factors, constructing what individuals perceive as 'valid' or 'real'. In some contexts, insecurity around one's gender may also lead to attempts at self-validation through the denigration of others, which is problematic and entwined with medical access. This is also most likely to be at the particular expense of non-binary individuals; as if a binary trans person adopts a medical paradigm to affirm themselves, non-binary identities are then correspondingly accorded less precedence, and greater association with uncertainty, indecision, impermanence, flux, and difficulty to understand and/or 'treat'.

Whilst there is a guarded and strongly negative sense of the ability of GICs to unproblematically provide services to non-binary people, those participants who had accessed hormones and surgeries described their experiences as broadly positive. Historical context of how transgender people have been treated within medical contexts may somewhat contextualise how negative sentiment is propagated through community networks. Increased scrutiny and emphasis on cases where people have discussed negative rather than positive experiences by potential service users may also be a potential explanation. Regardless, this chapter has sought to elucidate the relationship between insecurity of non-binary gender identity, medical access, and community interplay.

Chapter 5 – Non-Binary Times, Non-Binary Places: Communities and their Intersections

While community spaces can be seen to constrain queer subjectivities, then, queer identifications are also negotiated, vocalised and performed within community politics and locales.

(Hines, 2010, p. 608)

Introduction

Whilst the naming of this chapter is inspired by Halberstam's *In a Queer Time and Place* (2005), the chapter is otherwise not directly connected to the locus of (postmodern, futurist) work linking queerness with temporality (Muñoz, 2009; Edelman, 2004; Warner, 1993). Also the chapter does not function to construct a model of time or space as non-binary in and of themselves. Rather, I draw attention to times and places that recur as sites of significance for non-binary people, and the negotiation of identity. I argue that the symbolic meaning ascribed to particular times and/or places will be fundamentally informed by the interactions had within them. I use time and space as concepts to collectively consider and connect aspects of lived experience through a sociological lens, rather than to specifically construct postmodern theory. In partial response to the non-empirical postmodern production of queer theory which the majority of the literature around queerness and temporality follows, Stein and Plummer argue that:

There is a dangerous tendency for the new queer theorists to ignore "real" queer life as it is materially experienced across the world, while they play with the free-floating signifiers of texts. What can the rereading of a nineteenth-century novel really tell us about the pains of gay Chicanos or West Indian lesbians now, for example? Indeed, such postmodern readings may well tell us more about the lives of middle-class radical intellectuals than about anything else! Sociology's key concerns – inequality, modernity, institutional analysis – can bring a clearer focus to queer theory.

(Stein and Plummer, 1994, p. 184)

In emphasising the pragmatic goals of an analysis informed by symbolic interactionism, this work not only does not seek to, but cannot be in dialogue with such works that are ultimately highly abstracted from lived experiences. This is due to a disconnect

between this study's and the aforementioned literature's respective philosophical and methodological axioms. This quotation of Stein and Plummer also highlights how queerness and queer theory are often implicitly deployed at the milieu of sexuality, which would have limiting ramifications if applied uncritically to the context of this work.

Time vitally intersects with non-binary identity negotiation across different forms of social interaction. Time spent introspecting can and does result in changes in self-conceptualisation, and time spent interacting with others can endear or alienate. How an individual responds to, interacts with, is affected by, or contributes to a particular queer community is dependent on the relationship an individual has with themselves. This changes over time, and may be shaped by communities. Further, time is a critical and direct factor in particular circumstances that intersect with non-binary narratives, such as how long an individual may wait for an appointment with a GIC, or how long an individual has benefitted from (or lacked) community support. Space is unavoidably connected to time in such contexts; for example, in cases where an individual may be 'out' in some settings but not others. The family home or the workplace may be spaces that restrict autonomy of expression, whilst queer community spaces may enable (exploration of) such.

I begin this chapter by considering how non-binary identities are negotiated over time, and how differences in subject positionality (particularly as related to communities and medical practice) inform such a process. I explore how participants felt regarding the notion of non-binary identities potentially operating as a 'stepping stone' with which to explore gender, and how some might then potentially 'arrive' at a binary transgender identity. In such a case, one's status as non-binary may then be retrospectively positioned as transient, or a time of flux. This does not necessarily mean that non-binary identification is revised to having been 'less real' than a later binary identity. Rather, that self-conceptualisation and comfort with symbolic gendering of the self may exhibit greater or lesser plasticity for different individuals, and the extent of this plasticity may also change over time.

Many participants recognised how non-binary can shift to binary – and importantly, two of the participants explained how this was specifically true for them. Participants also proposed that due to the lack of intelligibility of non-binary genders within queer communities, as well as wider society, binary transgender identities may be 'found first' – particularly prior to community involvement that may expand awareness of gendered possibilities. This is part of a process allowing the development of, shift towards, or reinterpretation of gender in non-binary terms. Thus, non-binary identities may also be

arrived at following a binary trans identification. This 'direction' of identity development (from binary to non-binary) was also experienced by some participants.

Following on from the analysis of demarcated non-binary narratives, I move to consider different contexts of community interaction that participants discussed. Some of these communities were not LGBTQ in focus specifically, yet could involve challenging gender norms or interacting with gender in ways that participants explored within the context of being non-binary.

Identity Shifts over Time – Coming to Identities through a 'Stepping Stone' Process

Experiences of feeling delegitimised by doctors, other members of queer communities, or other individuals can be rooted in problematic assumptions that being non-binary is a 'phase'. This infers that individuals identifying as non-binary will at some later point, identify within the binary as (trans or cis) men or women, and that consequently non-binary identification is inherently 'unstable'. This bears a striking parallel to the disenfranchising pressure placed on bisexual people to 'pick a side', else be stigmatised as confused, greedy, indecisive, or in denial (Callis, 2013). Jess noted with some frustration how:

I've met a lot of especially older trans women... who have quite almost patronised me, come over to me and been like 'oh okay, well when you're ready to come to terms with being a trans woman, come to me and I'll help you navigate the process', or whatever. And quite often this is trans women who have actually been out as trans, navigating that system for a lot smaller amount of time than I have. So you know, I've been, I came out as genderqueer when I was 18, I'm now just coming up to 27, that's 9 years of operating as trans and being out as trans. You suddenly have binary trans people who have been a couple of years into their transition leaning over and going 'oh come to me when you're ready', it's intensely patronising. So for a lot of the time it is seen as a stepping stone. And you know, actually, it can be a stepping stone. And there's nothing wrong with that. (Jess, 26, interview)

Jess's feelings of being patronised are connected to having been out as trans for a considerably longer time than the women who offer their advice and support. The trans

women speaking to Jess implicitly position Jess's non-binary identity as transient or unstable, a product of 'not being ready to come to terms with being a trans woman', and liable to collapse as their presumed 'true female identity' then emerges. Such communication functions as a microaggression (Chang and Chung, 2015; Sue, 2010), denying the validity of Jess's account of her non-binary identity as fixed. Further, there is an ironic sense of role reversal – as the older individuals attempt to advise the younger, yet Jess is more experienced, having been out for longer and navigating social interaction as transgender – older, in a sense 'as trans'.

Jess's nine years out as genderqueer/non-binary positions her non-binary identity as not representative of a time 'in flux', although not necessarily as inherently rigid. It is important to recognise how identification as non-binary need not be permanent in order to be respected. This is iterated through Jess's belief that the utilisation of non-binary to come to a binary (or more binary) identification is not in itself a problem ("and there's nothing wrong with that") – and thus that those with a non-binary identity have no reason to feel threatened or undermined by those who previously identified as non-binary, but no longer do.

Pig's answer to the question "do you think people use non-binary identities as a stepping stone to binary identities" was particularly interesting, because they firmly articulated the belief that it was "the opposite way around" – that is, some people use a binary transgender identity as a stepping stone to a non-binary identity. Following this, I explicitly incorporated consideration of this position into future interviews, which yielded significant support for Pig's claim:

So my colleague on the committee is post-transition for about a decade, probably a little bit more than that. He's 50 odd. And he has told me on more than one occasion that had non-binary been an option, if he had known about it before he transitioned, he may not have transitioned, or he may have adopted this as his identity. And he's really not sure at all that he is a man, trans or otherwise post that transition. And I think that's an incredibly difficult position to be in after you have spent so much time and effort. (David, 31, interview)

This example from David acts as support for Jess's conviction that trans people who are positioned as 'de-transitioning' may often be better understood as experiencing gender in a non-binary manner. Results of (social or medical) transition considered

imperfect and uncomfortable by such individuals may be at least partially a result of available options, particularly historically, being highly constrained in binary terms.

I think that probably the majority of people who previously defined as binary who then go through a transition process to then de-transition are actually non-binary, and they're not de-transitioning to a binary gender which was the gender they were assigned at birth, but they are re-transitioning to somewhere else. I think that if basically, if healthcare wasn't binary centred we would be able to explore non-binary as an option and it not be seen as a stepping stone to binary people, but actually as a valid destination in and of itself. (Jess, 26, interview)

Jess articulates how it is a significant problem that the possibility of non-binary as a consistent state of being can fail to be given space, but also acknowledges the necessity of recognising that gender identity can function in a transient manner. This deconstructs the further potential binary of permanence versus transience. The implicit links that can be made between permanence equalling stability, and stability equalling good mental health (and conversely, transience meaning instability, and instability meaning mentally unwell) are challenged. This is particularly true when related to medical transition, where trans individuals' 'change of gender role' is expected to be permanent and until death in order to be accepted as real, and in order to access gender affirming medical procedures. This is arguably not only due to the hegemonic sense that gender identity is fixed for the life-course, but that traditionally within medical terms, transition is positioned (if not explicitly labelled) as the 'cure' for gender dysphoria that may be associated with trans status (Pauly, 1974). The complexity of gender is simplified and erased when an individual re-negotiating their relationship with gender and the body is taken to imply 'regret', or that the past transition was necessarily erroneous. Greater attention is needed to the temporally-dependent context of articulated gendered desires.

In the case of David's friend, the inability to articulate a non-binary identity may have been connected to his age, and accordingly the years when he negotiated gender transition. Non-binary identities were virtually unintelligible until relatively recently (as discussed in chapter two). This supports and offers a potential explanation for evidence produced by Harrison et al. (2012), which collected survey data from 6,456 transgender individuals and found 89% of those identifying outside of the gender binary were under the age of 45 (p.18), as was every member of this study (Mark and Ricky were the

oldest participants, both being 43). The spreading of discourses of non-binary gender identification, particularly across society generally rather than specifically within queer communities, has allowed individuals to question whether they identify as neither male nor female prior to, or without being limited to only considering the possibility of a binary trans identity. It has taken time for individualised conceptions of genderqueer and non-binary identification to gain greater intelligibility (primarily within transgender-specific and LGBTQ communities), and to now be mobilised as an identity category that may be demarcated.

Contrary to David's friend, the reality of non-binary identification functioning as a transient step to negotiating binary identification is highlighted by Frankie and Jen. Both entered the project with non-binary identities, as specifically required within recruitment literature, but would later articulate a more binary, and an exclusively binary identity respectively. Frankie communicated this during the interview, whilst Jen made contact later via email having reflected upon her interview experience. Throughout the diary and interview Jen described herself as bigender, and articulated that her self-expression (with regards to gendered presentation and desired embodiment) was dependent on whether she was in 'boy mode' or 'girl mode', but other aspects of her personality were not. Jen explained how the process of discussing identity and feelings regarding medical transition services, through this project, catalysed a process of introspective self-critique which led her to the conclusion that she had been in denial over being a binary trans woman. Jen renegotiated her experiences of fluidity as more accurately describing the extent of her dysphoria, rather than her gender itself at a given time. The significance of the correspondence necessitates its inclusion in full (additional permission was obtained from Jen to use this quotation):

Just want to say thanks again for the diary project and the interview. It's been really important for reflection. You were the first person to ask, in person, if I'd thought about HRT⁴⁹ or surgery before. I'm sure I said something like "yes, I've thought about it, but I'd never do it" or something, but that conversation has had a big impact. Because you asked, out loud, I think it made me think differently about it. It's hard to explain but I guess I suddenly felt it was okay for it to be an option. Or I felt I was allowed to consider it. It's taken a long time to get from that conversation to here but I feel a lot clearer about several things. But I

⁴⁹ Hormone Replacement Therapy.

also feel kind of bad because in some ways I've been lying to myself, so that's reflected in my diary and interview.

Basically my description of sometimes feeling male and sometimes female is just not right and never has been. I think I've just told myself that so many times I kind of believe it. What's really fluid is how extreme the effects of dysphoria are (assuming I have gender dysphoria, I'm pretty sure I do but I haven't been diagnosed). What I call girl mode is me being female and having a really shit time with anxiety etc. what I call guy mode is me also being female but my mental health coping better. I still think of myself as female, I always want to transition, but because the dysphoria sort of comes in waves I can just keep my head down and get on with it. At first that meant pretending nothing was wrong. Then it meant coming out as non-binary. Then it meant describing myself as genderfluid so I could express myself but still have the option of "being normal" (yes I hate myself for that).

But really I've been asking myself the same question you asked me for months now and I feel like I've been in denial my whole life. I've gotten really good at telling myself I'm male. Anyway, I'm sorry if this messes up anything. I wasn't intentionally trying to deceive... it's more that I was lying to myself. I don't sometimes want to present as male and other times as female. I always want to present as female. It's just I've learned to present as male to get on with it. So if anything I'm presentation-fluid rather than genderfluid. Or to simplify further, I'm a transwoman in denial.

It is valuable to note that involvement with this research project assisted Jen in re-negotiating her identity in a manner which she found to be illuminating. This evidences the transformative positive impact of research participation, and in this case, of the interview specifically (Mertens, 2010; Hutchinson et al., 1994). When comparing this message to earlier text in Jen's diary, she was explicit in communicating that non-binary fit for her at that time. However, aspects of Jen's diary gain additional significance in the light of her 'confessional' email, such as "I'd love for people to see me the way I feel, which is female", and "I don't feel I fit in as non-binary, or trans, or bigender". This also highlights how not only the passage of time, but how one is

engaging during that time has great potential to impact and allow for gendered development, as the interactions within the research interview provided catalysis.

Jen recognises that non-binary identification was, for her, part of a process of negotiating feelings of dysphoria, anxiety over not being trans enough, and as she puts it, denial. These were significant factors in constructing and constraining Jen's experience of her time (socially, and to herself) as non-binary. This also illustrates how the symbolic meaning an individual associates with their identity can be quite different from another individual who experiences a sense of connection with the same term⁵⁰. That is, Jen's renegotiation of identity and her relationship with gender cannot be taken as indicative of others' experiences of bigender identification. The individual's relationship with an identity category can easily transmute as factors influence the relationship/fit between label and sense of self, over time. This also reflexively emphasises how the time spent reflecting whilst producing diary entries was inescapably time that brought non-binary into greater emphasis or focus (or scrutiny), and the interviews also served to carve out and create additional time and space *for* non-binary identities. Frankie's experience, however, was instead tied quite directly to the progression of her medical transition:

Frankie: So, I think when I was writing the diary I had a much more kind of, my non-binaryness was very apparent, relatively apparent. I think when I was writing the diary it was just at the start of kind of a bit of a shift? Which I think is evident as I kind of go through to an extent. But in the last few months I've become very grounded in actually a more binary identity. A non-conforming female identity ultimately for me.

Ben: I think you did start to say that coming to the end of the diary. Do you still identify as non-binary?

Frankie: To a small extent. I would call myself non-binary on occasion, but it's much, much less frequent than it used to be.

B: Why do you think it is that you moved away from that?

F: I'm really not sure. I think... changes in my body? Definitely a catalyst. In terms of kind of feeling a bit more grounded in things.

⁵⁰ This can also be seen in relation to Zesty's identification with non-binary but not with transgender, as discussed in chapter four.

B: Do you think it gave you a sense of more ownership over inclusion in womanhood?

F: Yeah I think it did. I think kind of remapping my body... yeah. In a way that I felt a lot more comfortable with than before. (Frankie, 25, interview)

Access to hormones allowed Frankie to feel able to take ownership of an identity that resonated with her experiences of womanhood. In one sense, prior to medical intervention, Frankie's identity was constrained by feeling unable to claim being 'woman enough'. This further evidences the point discussed in the previous chapter that due to the impact of medical discourses on trans identity narratives, feeling unable to claim particular forms of transness can be rooted in a lack of medicalised, embodied change. Further, in Frankie saying that she would call herself non-binary "on occasion" implies that context may alter how one wishes to articulate one's gender identity, such that binary and non-binary identification are not necessarily mutually exclusive.

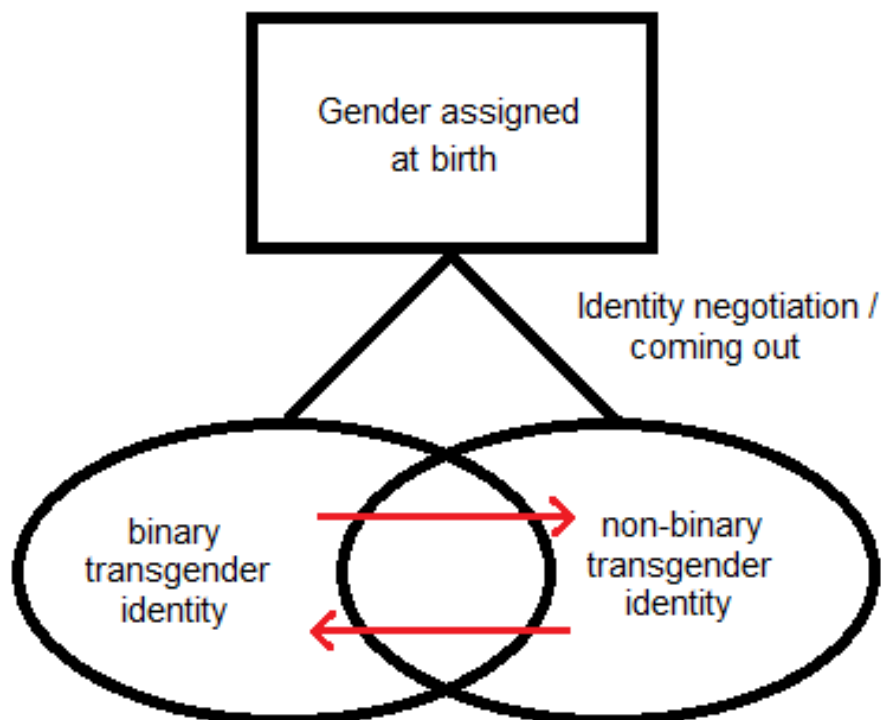


Figure 5: Model of non-binary identity as a 'stepping stone' process.

Figure 5 illustrates how gender identity as a 'stepping stone' process may be conceived. All individuals unavoidably have their early years constructed in relation to the gender

they were assigned at birth. Those who are cisgender never (need to) question this assignation, even whilst great variation in gender conceptualisation, relationships with gender norms, presentation, and behaviour exist within this 'box'. Those people who come out as transgender (at least to themselves) may articulate their identity as binary or non-binary, whether using these terms explicitly or not. The large overlapping ovals signify fields within which an individual may be situated, such that different individuals may identify with the same generalising term (binary or non-binary trans), yet still then articulate or experience gender very differently. The ovals overlap so as to signify the possibility of identification with binary and non-binary conceptions of gender simultaneously – such as identifying as a non-binary woman, as Jess did, and Frankie did to a certain extent.

Jen's and Frankie's narratives both follow the bottom arrow of the diagram, with initial negotiations of gender identity being into non-binary terms (yet very different from each other, so occupying different points within the right oval), prior to continued negotiation that led to identification as binary. Whilst Jen positioned herself exclusively as woman, because Frankie said she would call herself non-binary in some situations, this allows her identity to be positioned in the overlapping section of the ovals, or on the edge of being/becoming 'only binary'. Other participants (such as Ash) negotiated both identity and transition in a binary manner before revisiting changes to embodiment and social positionality years later, which would follow the trajectory of the top arrow in the diagram. A necessary caveat to this model is that it centralises a contemporary Western perspective, positioning non-Western gender identities as analogous or subsumed within the dichotomy of transgender categorisation in terms of 'binary' and 'non-binary'. Being in a transitional state or at the boundaries of identities can be encapsulated by the concept of liminality, which is explored within the following section.

Betwixt and Between: Understanding 'Inbetweenness' Using the Concept of Liminality

The origin of the concept of liminality was in the anthropological study of social rituals, to describe the intermediate phase of a symbolically transformative process or transition, a Western example being baptism (Van Gennep, 1960). The concept was later expanded to consider a wider range of transformative social processes intersecting with temporality, such as puberty – in between adult and child, or war – in between systems of stable rule (Turner, 1969). Monro discusses how early transgender scholars "describe transsexuality as a place outside duality" (Monro, 2007, p. 10), and

the connection with 'rituals of becoming' has been reiterated in the positioning of non-Western third gender categories, as permanently liminal (Monro, 2007; Mageo, 1996; Nanda, 1993; Fulton and Anderson, 1992). Liminality has been deployed in the analysis of a wide range of sociological contexts rendered 'in-between', that resonate with non-binary negotiations of queer communities and healthcare. These include the chronically ill or disabled as neither 'sick' nor 'well' (Jackson, 2005; Little et al., 1998; Murphy et al., 1988), identity reconstruction (Beech, 2011), and experiences and events (Szokolczai, 2009).

Liminality has been implicitly and explicitly deployed in the study of transgender. In their work on the sociology of trans bodies, Ekins and King (1999) recognise narratives which 'transcend' the gender binary, creating a practically infinite, fluid interpretations of gender that occupy a third category. Wilson has discussed the conceptualisation of liminal transgender identities, where she recognised the possibility that "gender identities will not necessarily shift within this liminal phase, rather one's physical, behavioural and psychological self will be remodelled to 'fit' with one's supposedly 'transgressive' gender identities" (Wilson, 2002, p. 432). It is important to note that all trans participants of Wilson's study identified as either transsexual or as cross-dressers, but that she "found participants often grappling to identify themselves within the limited categories and scripts available to them" (2002, p. 431). Wilson additionally models transgender community spaces as liminal, because of the possibility for trans people (who are not 'out' in their daily lives) to become 'something else' for a limited time specifically in that space.

Connecting liminality and motion to gender transition narratives, Carter (2013) discusses how in the historically significant phrase '*anima mulieris in corpore virilis inclusa*' the Latin word *inclusa*, which is translated to 'trapped' in the phrase meaning 'a woman's soul trapped in a man's body' may instead be interpreted as 'enclosed', 'included', or otherwise allowing the possibility of motion rather than stasis. Medical transition is accordingly reconceptualised as not the escape from the constraints of the body, but development and movement of identity over time, in relation to embodiment, that allows for multiple directions, or motion backwards and forwards in a manner that defies hegemonic medical conceptualisation.

Both Frankie and Jen were clear that identification as non-binary was not viewed as a stepping stone or transient *at the time*; non-binary was, then, the label they felt most accurately described themselves. Frankie said:

It certainly didn't feel like [a stepping stone] consciously. Whether there was an element of that at a less conscious level is a debate, and I would say maybe there was an element. There's probably an element of truth in that. Whether people do that consciously or not, I think it's fine? Obviously. And you know, if people need certain identifiers and terms to be able to come to terms with their journey, more power to them for finding them and owning them at that point. I don't know, I would be surprised if anybody went into identifying as non-binary with a view that would then change, but maybe people do. (Frankie, 25, interview)

Frankie's and Jen's experiences as non-binary can be understood as liminal, as this identification for them was an intermediary phase, an identity between (binary) identities. That Jen and Frankie contrast with Wilson's model of liminality (in not forcing themselves to fit identity, but renegotiating identity) may reflect the great increase in access to a multiplicity of gender descriptors and identities. Wilson's conception may be critiqued in potentially implying an overly-static, or essentialised model of gender identity. The suggestion that behaviours, presentation, and embodiment may be changing are important, but this does not imply that identity does not, or cannot, also do so. Whether gender identity itself is felt to have changed, or an individual comes to better understand and 'reveal their true gender', is dependent upon how the individual conceptualises their own gender, and is therefore tied to idiosyncratic conceptualisations of ontology and epistemology. This is seen in Frank's (1993) work on different self-change narratives in illness contexts – '(re)discovering the true self', a selfhood in the process of becoming, or rejecting 'newness'. The processual nature of selfhood is well established (Clarke and James, 2003), but not in terms of genders beyond the binary.

Support and validation from within trans communities may also be fundamental in allowing individuals to feel like they can renegotiate how they wish to be understood, as whilst not reflective of their experiences, both Jess and Frankie stated how consciously claiming an identity temporarily was entirely acceptable. Communities thus not only provide increased access to lesser-known discourses of trans, but the encouragement or security necessary to consider their relevance to one's own life, and acceptance that such relevance may be impermanent, without being of lesser validity or importance.

Liminality was of particular importance to Finn (22), who began their diary with this collage (figure 6):

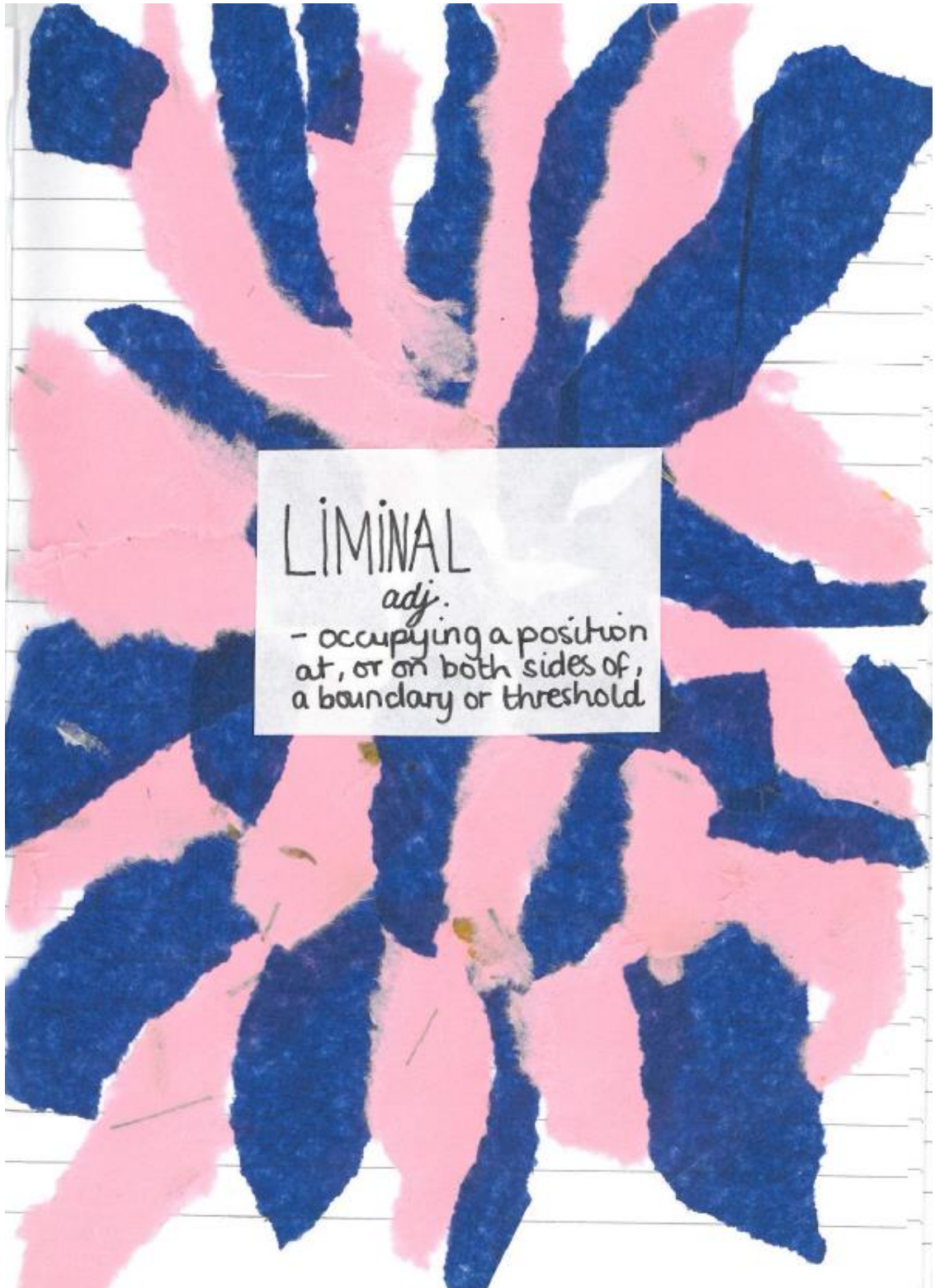


Figure 6: Image of collage on liminality, from Finn's diary.

The dictionary definition of liminality which Finn provides implicitly positions the boundary in question as the gender binary. There is the potential for a reading of gendered symbolism in the surrounding tissue paper, shattered pieces of the now-

classically gendered pink and blue. The central square box is comparably ordered, allowing for the interpretation that embracing a liminal state or identity that simultaneously occupies “a position at, or on both sides of, a boundary or threshold” may grant stability. Whilst the coloured tissue is fractured and disorganised, it is notable that Finn did not include a third colour (such as purple). This fits with how non-binary presentation or embodiment may challenge a *demarcation* of what constitutes male and female (or masculine and feminine), yet struggles to be regarded as an intelligible category without reference to such constructed phenomena. Finn follows by discussing liminality, in saying:

I don't see my identity or experiences reflected in either heteronormative or LGBT media... I felt such a relief when I found the term 'non-binary'... but it also feels like I'm very much having to embrace my life as an 'other'. (Finn, 22, diary)

This highlights that the time of coming to, or 'arriving' at an identity which satisfies cannot be simplistically viewed in only positive terms. There is also a sense of liminality with non-binary identification providing relief and sense-making of the self, yet simultaneously being uncomfortable due to its unintelligible and marginalised status. Feeling that one *has to* “embrace life as an ‘other’” can be understood as another form of constraint. Whilst catharsis may be found in identification, stigmatisation and violence may be associated or risked. In slight contrast to an understanding of liminality in relation to time (the middling, transitional point between beginning and end states), Finn's definition in the collage relates their existence as a non-binary person to the gender binary, and also to existence within physical space – as they navigate a binarised world, whilst being outside of the gender binary. The conception of selfhood transcending, breaking, or deconstructing binaries may also be a source of empowerment and validation, despite the difficulty that can be experienced in being recognised or respected.

A further example of liminal identification can be seen from Ash, in relation to embodiment. They said in their diary how “I was particularly hoping to bleed this month so I could feel like a woman on National Women's Day... But my body didn't cooperate and on National Women's Day I conceded it was an important day but not my day, not about me”. During the interview I followed up on this diary entry, to which Ash replied:

I don't think [bleeding is] essential, I think if I really was a woman who was transgender or had a hysterectomy or whatever, I could totally accept that. But I think because I'm genderqueer, any sense of being a woman or a man is fleeting or unstable, and little things my body does can make a difference to how I feel in a particular moment. I think that would've just pushed it over the edge and I would've felt a part of something even though I'm only in some way a woman and not in every way. (Ash, 33, interview)

Whilst challenging the notion of biological essentialism in relation to claiming womanhood (Hale, 1996), it is nonetheless clear that physiological factors impact Ash's feelings regarding gender embodiment, in conjunction with their fluidic, genderqueer identity. This connects back to how biological change through hormones and surgery could impact feelings of validity as discussed in the previous chapter. Ash also acknowledges that their sense of being genderqueer can also accommodate "fleeting and unstable" senses of being a woman, or a man. Ash's overarching non-binary identity can thus include situated feelings of maleness and/or femaleness, which figure 5 accommodates through the overlapping middle section. This particular example also highlights how diaries benefitted the interviews, by allowing for the emergence of discussion points that I would not have incorporated into topic guides had interviews been used alone.

Whilst Ash is no longer undergoing any gender affirming medical treatments (which historically would be associated with 'becoming' a man or a woman) their temporally specific experience in relation to National Women's Day relates their experience of gender to Finn's definition of liminality. Ash occupied a position at 'the threshold' of womanhood, with the absence of bleeding being preventative of their self-conceptualisation as woman, when viewed in the full context of Ash's gender history, rather than as a stand-alone phenomenon. Such a discourse also opens the possibility of non-binary identification being conceivable as a 'permanent liminality' – *constantly* in a state of becoming or flux, but without the conception of a static end point. Non-binary gender identification then, through the lens of liminality, can be potentially conceived as a constant, unending process of 'becoming', but with points or periods of particular impact. This is no 'more or less non-binary' than a fixed, stable sense of being neither man nor woman. However, it is also worth noting that due to the manner in which individuals change over time generally, and the centrality of gender to social interaction, the claim of 'an unending process of becoming' could also be applied to individuals

regardless of gender identity (albeit so as to ignore the specific phenomenon of 'non-binary flux' that I draw attention to).

There is precedent in the empirical study of non-binary people for fluidity in non-binary identification to be recognised. McNeil et al. (2012) asked the question "which of the following best describes you" as a method to divide data in the 2012 Trans Mental Health Survey for analysis, and included the possible answers "have a constant and clear non-binary gender identity" and "I have a variable or fluid non-binary gender identity" (p. 6). This illustrates how modelling non-binary in potentially liminal as well as static terms may be beneficial for the operationalisation of data and interpretation of non-binary lived experiences.

Charlie explored the concepts of flux and time using the outlet of poetry:

I was woman
 once
 and woman I may be
 again

but for now
 take me to the sea
 take my organs from me.
 take it all.

And leave a tail
 and clamshell bra
 and give me power
 and let me swim.

let me roam
 a world
 unruled
 by genitals (Charlie, 21, diary)

In positioning themselves as 'woman once', Charlie challenges the (sometimes strategically) essentialising narratives (Spivak, 1985) of being 'born this way', utilised by LGBTQ activists in order to demand respect and equal treatment *due* to being fixed and permanent in nature, which is discursively positioned as 'natural'. Likewise, the

necessity of positioning one's gender identity as *now* fixed is also resisted, in acknowledging that they 'may be [woman] again'. There is ambiguity in the 'organs' that Charlie is referring to – whilst mastectomy is commonly associated with identification and embodiment of transmasculinity, elsewhere in their diary Charlie expressed not desiring such a surgery, supported by the next verse (still) wishing for a clamshell bra. The organs could potentially be the uterus and ovaries, and their connection to biological processes such as menstruation may, as with Ash, be connected to a sense of 'femaleness', though undesirably so in this context. Alternatively, 'organs' may be less specific; an interpretation particularly justified by the line 'take it all'. This may be connected to the idea of death (and rebirth), where vital organs are taken (due to disease, or after death in order to be donated) to allow life, potentially disrupting the temporally-based binary of life and death as well as gender – and that being able to escape being positioned as 'woman' is to be able to articulate a new life.

The poem's ultimate focus is on recognising the distress and desire felt in the given moment, whilst recognising the possibility of changes in future desires. This forces the themes of time and liminality to be necessarily recognised more within medical transition practice, as service users may need access to 'what is correct for them *now*', rather than 'correct' for them in an absolutist sense. The refusal or inability to perform a position of guaranteeing they will wish to embrace any medicalised change for the rest of their lives can thus position such trans people as 'uncertain', making access more difficult. Should an individual articulate a fluid non-binary identity, and not feel able to definitively comment on future embodied desire or distress, this may result in denial of currently-desired treatment, even if the patient fully comprehends the significant and largely irreversible nature of hormonal and/or surgical interventions. This is contrary to practice guidelines which state "patients are presumed, unless proven otherwise, capable of consenting to treatment" (Wylie et al., 2014, p. 14). The assumption that gender is a fixed and singular experience across the life-course deeply underscores current medical practice, such that narratives which resist this assumption struggle to be afforded equally valid status.

Despite ultimately coming out as a woman, and renegotiating her prior bigender identity as 'denial' (or a liminal period), Jen articulated a point in her interview that may partially explain why she came out as non-binary first. She stated that "it seems more extreme to come out as a trans woman". Thus, with having feelings of not fulfilling socially constructed criteria of womanhood *enough*, non-binary may have felt like a 'more

reasonable' identity claim to make, when not (yet) possessing the 'legitimation' of medical intervention. This connected with V's account of having seen this in friends:

Partly because of what I've said about the binaryness historically of the trans community, they've come out as non-binary first, and then when they've felt like their identity is legitimate enough in themselves they've sort of... transitioned to a binary, or started to use pronouns relating to a more binary gender. And literally only because of not feeling that they'd be accepted as trans if they turned up and didn't really hold to binaries. (V, 28, interview)

Thus V's experience of the insecurities that trans people can encounter through fear of their experiences of gender variance being positioned as '[not] legitimate enough' is connected with the change in an individual's sense of their own gender over time. This allows for the potential claim that transgender communities that (inadvertently or not) reproduce or reify the gender binary as 'more' real, legitimate, or accepted, may impact how individuals negotiate identity. This is not to be confused with the additional possibility of individuals 'passing as binary trans' (whilst not identifying as such) to avoid de-legitimation. Rather, a sincere renegotiation of identity, which may be rooted in the additional difficulties of hierarchies of transness and lack of intelligibility as non-binary. As Plummer articulates in his analysis of sexual stories (1995), the possibilities of identity are modified by the social environments in which they are negotiated. Further, this is not to imply that resultant binary identification arrived at by Jen and others is *inevitably* related to conscious or unconscious forms of social pressure. This is evidenced by individuals negotiating the reverse; where a binary identity (adopted through limited access to trans narratives, or through social pressure) is dis-identified with in favour of a non-binary identity.

There is a commonality between discourses of people coming out as 'non-binary before binary' as V (indirectly, giving accounts of friends), Frankie, and Jen all articulate, and expressing identity as 'binary before non-binary', as Ash, Mark, and V (directly, discussing himself) did. This is the development of greater awareness of selfhood and gendered possibilities over time. This is potentially through accessing community support, or awareness of new terms and language, gaining the confidence to re-declare one's identity, or resist anxieties of being viewed as illegitimate. Such anxieties may be through not feeling trans enough to be binary, or through non-binary identification being positioned as unstable. As Alex (20) put it in their interview, "I think

people sort of view [non-binary] as a fake identity? You know, like a ‘teenagers on Tumblr want to be different’ identity”. The liminal instability of non-binary is here connected to the liminal instability of adolescence, whereby both are positioned as immature, in development, and a (temporary) phase (Turner, 1969). This iterates how the gender binary can be positioned as so fundamental as to be unassailable, such that claims which destabilise it are relegated to ridiculousness, or motivated by adolescent ‘attention-seeking’.

Alex expressed the view that a person’s identity should be respected regardless of whether one believes it to be fundamentally untenable, with the conversation drawing comparison to Otherkin⁵¹, and ‘adult babies’⁵² within kink⁵³ communities. Alex added:

It’s a form of self-expression, and I feel like those people have that need for self-expression and this wouldn’t be an issue if we would just recognise everybody’s right to be who they are in every way, then we wouldn’t be having this ‘oh well that’s taking away from trans people’ thing. Because you know, people need to express themselves in different ways. (Alex, 20, interview)

Alex was explicit in their view that the question of ‘reality’ is irrelevant when compared with the necessity of respect for identification (regardless of how transient). It was their view that with acceptance as a default position rather than needing to be earned or proven by minorities, hierarchies of ‘realness’ would no longer exist.

Building on the idea of respect for temporary identification as no ‘less’ than identities positioned as permanent, Frankie also specifically recognised the possibility of shifting back to a more non-binary identity in the future. Like Ash, this illustrates that some individuals maintain openness to fluidic change throughout life with regards to gender. This is not necessarily only the case for those individuals who experience a shift in identity conceptualisation, as individuals who feel fixed and static in their non-binary (or binary) identity may recognise potentiality to feel differently in the future.

⁵¹ Otherkin are individuals who identify as partially or entirely non-human. This may be as either animals (e.g. ‘foxkin’), or even as mythical creatures (e.g. ‘dragonkin’).

⁵² Recognised as a sexual fetish and clinically referred to as ‘paraphilic infantilism’, this practice involves role-playing a regression to the state of a baby or young child. This may be accompanied by nappy-use, bottle-feeding, or other infantilised behaviour.

⁵³ Generally understood as any ‘unconventional’ sexual practices, in the context of ‘kink communities’, this refers to a shared interest in BDSM – Bondage and Discipline, Dominance and Submission, Sadism and Masochism. This may encompass a wide range of sexual or erotic fantasy and practice, often accompanied by a sense of ‘taboo’.

Some individuals may come out as having a binary identity rather than (or prior to) a non-binary identity because of perceiving greater difficulty being accepted, or in navigating gendered interactions. Although Jamie came out as non-binary, he did express some regret of having done this:

The thing is, partly with me, it was a stepping stone. If I was coming out at work again now, I think I was really naive to think anyone would understand me when I said I'm non-binary and would actually treat me like I deserved any of the protections of the equality act. If I was coming out to people now I'd say 'I'm transgender' and only if they asked would I say I'm non-binary, and I would let people just assume I'm just the 'opposite' of what I was assigned at birth. But I very much needed to go through a stage almost of saying 'I'm not trans, I'm non-binary' because I didn't feel allowed to identify as trans, to get to the point where people identifying me as male socially is fine and makes me quite happy. (Jamie, 24, interview)

There can consequently be a space between how one wishes to (or does) identify in particular spaces, and how one identifies personally, or with people or in other spaces deemed to be more safe and supportive. This differs from strategic essentialism (Spivak, 1985) in that an epistemological primacy is not being utilised, though what Jamie wishes he had done may be conceived as 'strategic simplification'. In presenting themselves not as explicitly non-binary but as transgender in an umbrella sense (Currah, 2006), Jamie would have desired to strategically rely on individuals they interact with to interpret 'transgender' in binary terms, for the sake of social legitimacy and respect.

The experiences of identity negotiation over time in liminal terms can all be situated within the proposed model (figure 5), where individuals can be situated within heterogeneous categories, and potentially move within/between them. This speaks to (the potential for) changes over time, but not how interactions in different spaces can have particular significance for individuals, which will now be examined.

Heterogeneity in Community Involvement

The relationship between being non-binary and the value of queer communities is neatly introducible through David's discussion of how queer interaction affects their feelings about their identity. David articulated how the comfort queer spaces gave them affected their perception of what was 'normal':

I've got a group of university friends who are currently having a WhatsApp conversation about us getting together, there are 7 of us and I've just realised they're all straight! Everybody's going to be married very soon, and a couple of them have kids, and I'm like... I'm not sure what to do with this, really! You're all so... conventional! (David, 31, interview)

Queer time and queer space are conceptualised by Halberstam (2005) as a framework for understanding queer experiences of difference, in relation to heteronormative practices of reproduction, marriage, and how they are timed and expected in relation to the life-course. David's sense of disconnect from the pressures and expectations that a queer life course can give from heteronormative family construction supports Halberstam's model of queer time, and highlights the importance of queer communities. However, David also added that "you can't trust the LGB community to not be transphobic, because they quite blatantly are", highlighting the inevitable tensions that also exist in queer spaces, and how their accessibility is partially dependent on the specifics of an individual's gender and sexuality⁵⁴. Yet this does not eliminate the possibility of identifying trends in community behaviours and the experiences of them by non-binary people.

As discussed in the previous chapter, tensions could arise within transgender communities through experiences of the boundaries of transness being indirectly policed, such that some non-binary individuals could feel excluded through a sense of not being trans enough. LGBTQ community behaviours could also serve to alienate non-binary participants through more general problematic behaviours. After articulating discomfort with an LGBTQ society, Alex explained this was due to some members:

Just having very strong views which are not flexible, and you know, how I feel is that pretty much everyone's gender identity is unique, you can't say 'this is how gender works' and then if people do say that, it annoys the heck out of me. And it also invalidates me when I'm different. (Alex, 20, interview)

Alex expressed frustration with individuals who had understandings of gender that essentialised gender norms, or risked erasing the breadth of gendered possibility

⁵⁴ This also raises the point that many LGBT spaces, such as clubs, bars, or saunas, may be very (cis) male dominated, and not particularly welcoming for cis lesbians or bisexual women, in addition to the dimensionality of transgender awareness.

associated with postmodern, queer deconstructions of gender. Leon found that some trans-focussed spaces could be particularly binarised, which they found alienating:

I'd been to *FTM*⁵⁵ *London* and I hated it, it didn't have any space for non-binary identities at all. I remember going to one meeting, and they had some people from Charing Cross talking, and it was packed out. A psychiatrist and an endocrinologist - and the endocrinologist was basically saying 'you're all just men without testicles' and I was like 'this is just *wrong*' and I left half way though and never went there again. (Leon, 34, interview)

Leon's feelings about FTM London were not isolated. David, who had also independently attended the group, had recognised, as a non-binary person not seeking medical transition, how the group presented information in a way that assumed the interests and identifications of members in a homogenising manner:

I worry that there might be people in the room going 'oh my god, I'm not interested in chest surgery, I'm not interested in hormones, why are you pushing me towards this?' (David, 31, interview)

Further to specific concerns related to non-binary identification, Leon and David also discussed experiences with queer communities which did not recognise inclusion of any trans people, within or outside of the gender binary. Leon explained how when trying to work with an 'LGBT' swimming group, they were told 'we don't have any trans people'. David discussed in detail negotiations with the LGB group at their place of work, highlighting how the conspicuous absence of the 'T' positioned them as both out of touch and failing to offer an inclusive space. The fact that the swimming group positioned itself as *LGBT*, yet within both their interactions and club information only discussed the possibility of gay men and lesbian women, illustrates how presence of the 'T' cannot be taken to assume awareness and inclusion of transgender people⁵⁶. Dean Spade has dubbed this exclusion through the collapse of *LGBT* to 'sexuality only' as "LGB fake-T" (Spade, 2004, p. 53). Despite not necessarily requiring specific

⁵⁵ Female to Male.

⁵⁶ As a non-binary sexuality, in that it disrupts a binary of 'gay/straight', bisexuality can similarly be erased. Inclusion of the 'B' within an LGB or *LGBT* acronym associated with a queer community or organisation is not enough in and of itself to signify definitive conscientiousness towards bi-specific issues.

policies in the same way as trans people, the collapse of LGBT to gay men and lesbian women is also an example of bi-erasure (Barker and Langdrige, 2008; Yoshino, 2000).

David recognised the problem of interactions being derailed by basic issues of transgender (though particularly non-binary) respect, through a fictional conversation recorded in their diary which they used to illustrate the point:

“Isn’t it a beautiful day today? I hope X enjoys it, she is always saying how much she loves the sunshine”

“Actually, X uses the pronouns “they/them/their”. But it is a very beautiful...

“Oh God I am so sorry, it’s just so difficult for me. But now that we are talking about this, can I ask you about gendered pronouns? What’s a pronoun anyway? How can ‘they’ be singular? [...]

Etc. etc. ad nauseam and, in the meanwhile, the beautiful day has been forgotten and the day is all about pronouns now. (David, 31, diary)

This allegory by David can be used to understand the potential educational and emotional labour (Martínez-Iñigo et al., 2007) that may be expected as a direct response to being openly non-binary. This is most acutely felt within mundane social navigations (interactions with non-queer people and the micro-interactions associated with, for example, shopping). However it is significant that during spaces and times when a non-binary person might hope to be able to presume their intelligibility and respect, this cannot be taken for granted in the contexts of many queer communities either.

There were multiple participants who specifically mentioned cisgender gay men as a particular source of tension or intolerance in their experiences of queer communities. Hal said:

With the queer community, gay men, they can be really dismissive. You go from straight guys who are just being ‘oh that’s queer’ to those who say ‘oh that queen is giving us all a bad name. Why can’t you keep it together and be normal like the rest of us?’...I get it most from guys who call themselves straight acting, their masculinity is very important, and they don’t like people saying deviation is perceived as part of the same group. (Hal, 42, interview)

The pressure to 'be normal like the rest of us' speaks to a respectability politics produced through an assimilatory homonormativity that may be found amongst some queer people, to the detriment of those positioned as most (visibly) transgressive (Hines, 2009; Duggan, 2002). Charlie and Frankie give further particular examples of behaviours they have associated with cis gay men, and responses to their gender identities:

Ben: Do you see much of that within the context of queer communities, queer people policing other queer people?

Charlie: I see some of it, especially in the university LGBTQIAA+ society. I don't especially like to be a part of that group of people because whilst some of them are really great, with such a wide and varied group of people there will be people with some negative opinions of non-binary people, or people that if they're non-binary they're not subverting the binary enough they feel.

B: Do you see that sort of negativity coming from particular demographics at all?

C: Yeah. It's often... some of it's been a lot of cisgender white gay men. But also there are transgender people who are more binary in the group who say things like that, and yeah. (Charlie, 21, interview)

Ben: so have you ever had experiences where your identity is being challenged or invalidated by other queer people?

Frankie: Yeah. I think assumptions have definitely been made, I think in the past when I used queer as a term to describe myself, the assumption was made that I was a cis gay male. And people thought I was talking about being interested in men, and it very much came from a sexuality assumption, looking through a very cisnormative lens.

B: What sorts of people were making that assumption?

F: Mostly cis gay men? (Laughs). To be honest, but occasionally others as well. Usually always... I say usually always cis people, but some trans people as well. (Frankie, 25, interview)

In these examples, different responses to non-binary people within queer spaces could function to cause tensions. For Hal, who discussed experiencing being mistaken as a gay man exhibiting femininity, gay men whose sensibilities are informed by homonormative values could stigmatise them. This is explained through Stryker's

analysis that gay and lesbian assimilation may be threatened by non-normative transgender articulations and needs (Stryker, 2008b).

The cultural dominance of gay men within many LGBTQ spaces may also help explain why despite its deliberate and subversive ambiguity, the subtext of certain queer spaces may assume a 'sexuality exclusive' reading of queer. This runs contrary to an active recognition and inclusion of gender-variant people, even whilst drag artistry is often embraced. We also see from Charlie that through a lack of cultural intelligibility or through transphobia, cisgender members of queer communities are by no means necessarily recognising or supportive of non-binary people. Charlie also raised the possibility of non-binary people being challenged for 'not subverting the binary enough'. This relates to Mark and V's discussions in the previous chapter, where it was recognised how some individuals could challenge the authenticity of others in order to gain a hierarchical sense of self-validation. With non-binary positioned sometimes as particularly 'subversive', it is worth recognising how non-binary people may engage in such negative practices to other non-binary people also.

Whilst cis men were highlighted more frequently than any other demographic, Ricky particularly discussed coming out as non-binary in the context of a lesbian community:

There was a lot of... 'How are you different from me?' with lesbian friends. A lot of competitive stuff as well, of like, you know 'well I identify as a woman, but I'm way more masculine than you, so how dare you identify as something nearer male than I do!' (Ricky, 43, interview)

This illustrates that some queer individuals (such as the butch lesbians Ricky is referencing) may problematically construct their sense of validity of masculinity or femininity in a comparative, competitive, and oppositional manner to other community members. Additionally, 'masculinity' and 'maleness' may be conflated, such that claiming of a non-binary identity from AFAB⁵⁷ individuals who are not particularly masculine may anger or offend masculine, butch women who are not alienated from being assigned female. Members of lesbian communities have articulated that not only may lesbian identity formation be disrupted by queer and trans discourses, but so may the ability of lesbian communities to produce effective social activism (Shugar, 1999). Such tensions along boundaries of identification may feed into a sense of insecurity over being trans enough, or in the context Ricky raises, not masculine enough to 'enter

⁵⁷ Assigned Female at Birth.

into' transness (Halberstam, 1998). The affronted response of some butch lesbians was a result of their perception of dissonance between Ricky's identity, and the butch lesbian's expectations of masculinity and femininity in relation to gender identity. With butch lesbians articulating masculinity but without rejecting femaleness, there was a sense that non-binary people (as 'less female' than them) 'need' to be correspondingly more masculine. Ricky was considered negatively for failing to be adequately masculine to claim non-binary, from the butch lesbians' position. This also continues to situate non-binary identity (particularly in the context of AFAB individuals) as an incomplete, partial, or lesser trans masculinity, rather than as a state of being that does not exist in a hierarchical relationship with binary trans identification.

It is, however, important to emphasise that this collection of experiences does not reflect a universal dissatisfaction with LGBTQ spaces for non-binary people. Rather, they highlight that navigating non-binary in queer communities can cause difficulty or alienation, through the cultural unintelligibility of non-binary extending well into some queer spaces – rendering them uncomfortable, or creating obstacles for feeling included, understood, or respected. Further, the manifestation of tension can depend upon the specific context, such as whether it is a generalised LGBTQ group, or with a more specific target demographic (be that age, such as a student group, or gender/sexuality intersection, such as a lesbian group). Multiple participants used the potential broadness of the term 'queer' in discussing their experiences of queer communities to go beyond typical understandings of LGBTQ – queering spaces that are not inherently focussed on gender and sexuality minority identification. This also raised the significance of additional community groups for non-binary identity negotiation.

Within kink communities, the importance of consent both in and beyond sexual activity is such that it is positioned as an essential community norm beyond the individual (Barker, 2013a). Alex illustrated how consent culture⁵⁸ (Barker, 2013b) had positive ramifications for their feelings of validation and respect with regards to gender:

When I was kind of struggling with my gender identity a bit, someone referred to me as a lady at a kink event, and I said 'I'm not a lady, I'm a barbarian'. And there were some people, who, because they didn't

⁵⁸ Whereby consent does not exclusively operate at the level of the individual, interpersonal interaction, but is embedded across the community such that responsibility for ethical practices and avoidance of harm is shared.

know if I was serious or not, they referred to me as a barbarian ever since. [...] They were willing to do that, even though I was just kind of being stupid... That's amazing. I love getting that sort of thing from people. People are obviously much less questioning of things like clothing choices in that community. (Alex, 20, interview)

Despite speaking favourably of the kink community, Alex also told the anecdote of everyone at a particular event being asked to write their names down on a piece of paper with 'male/female' columns, and that "a bunch of us wrote our names down the middle, and then they stopped doing it". Alex also drew attention to the kink events taking no action in relation to male and female toilets being the only available options (such as creating temporary labels to indicate gender neutral bathrooms). Further, Alex articulated that they felt the dress code of the kink group they engaged with was transphobic "because it's got to be kink wear, and kink wear is very different for female or male bodies". Despite it being entirely permissible for an assigned male at birth individual to wear fishnets and heels as an example, they explain:

Alex: The men have to wear formal clothing. But then I just wander around in tracksuit bottoms and I can get away with it because I get my tits out. And I don't think that's okay. I don't mind because I want to wear suit trousers but I don't think that should be a rule.

Ben: So for example, a trans woman couldn't wear the bottoms that you'd want because of how they'd be read?

A: Yeah. (Alex, 20, interview)

The point Alex is making is that whilst the group has rules that a particular level of formality is required, those individuals with breasts can easily ignore such rules for the clothing on the lower half of their bodies, precisely because of their breasts, which Alex positions as unfair. Thus the symbolic reading of the bodies of trans people may result in being treated differently (in a manner that delegitimises their genders) from cis individual's bodies. This would likely be dependent on transition or point of transition – the trans woman without breasts having her experience differentiated from the trans woman (or cis woman, or pre or non-operative trans man) who has. The non-binary or transmasculine body with breasts is thus also positioned as female by the community's cisnormative perceptions of bodies in clothing associated with kink. This links back to how trans bodies which have received medical interventions are more likely to allow for identity to be respected and positioned as '(more) real'.

Relatedly, Bobby discussed their involvement with the Lolita community⁵⁹, and how the openness of the space towards different gender identities allowed individuals to explore their relationship with femininity through a hyperfeminine oriented style and subculture. Bobby illustrated this style in figure 8:



Figure 8: Sketch showing Lolita fashion, from Bobby's diary.

There's a load of 'Brolitas' which is like cis male Lolitas that have all of the dress and the bows and fells and usually have a wig. I think a lot of people go through the stages of working out where they are on the [gender] spectrum, by going out one stage at a time like 'I am a cis person, but I am just going to wear this item of clothing' and 'oh I'm not sure anymore, maybe I am a non-binary person or whatever'. (Bobby, 23, interview)

Bobby's drawing was included in their diary in part as a conscious effort to ensure that the researcher/reader would comprehend the community being discussed. This raises the consideration that participants, to greater or lesser extents, may have constrained

⁵⁹ In this context, a Lolita is an individual involved with the Lolita fashion subculture, which originated in Japan. The community is centred on the construction of modest, hyperfeminine, identifiably stylised garments to create a 'Lolita look'.

or structured their diary entries on the basis of their perceptions or assumptions of my knowledge of views. Bobby's Lolita community differed from an LGBT-specific community in that involvement in the former did not imply any particular relationship with sexuality or gender identity, yet still provided a space for gendered exploration – indeed, a form of exploration not specifically possible in an LGBTQ setting, due to the differences between constructing a 'Lolita look', and wearing drag. In being structured exclusively around style, the Lolita group produces different discourses than 'crossdressing' in specifically LGBT community contexts.

Both Ricky and Ash highlighted their positive experiences with bi communities. Ash shared the view that “most, if not all” people in bisexual communities were aware of and friendly towards trans and non-binary people. In explaining what it was about the bi community that made it more “ambiguity positive”, Ricky explained:

I think for a start that once if you recognise that you're attracted to more than one gender then I guess you're possibly more open to the idea that there isn't this 'there are two genders and they're the complete opposite of each other and never the twain shall meet' – I think that's part of it. I think the bisexual community is much more open to the idea of fluidity and flexibility and ambiguity, whereas hetero and gay spaces tend to be, you're either one thing or the other. (Ricky, 43, interview)

Bisexual identification has experienced a history both within and outside queer communities as being relegated to a temporary ('you are just not sure') or immoral ('you are being greedy', 'bisexual people will cheat') state (Monro, 2015a; Alarie and Gaudet, 2013; Hemmings, 1999). It is intuitive then, that a sense of recognition and solidarity would be seen between individuals breaching the gay/straight binary of sexuality and the male/female binary of gender. A valuable point is that community spaces are also changing over time in direct response to voices and forms of resistance within them. Ash gave the example of how the intersection between gender identity, race, and sexuality has been addressed at an annual bisexuality convention:

An example was at bi-con. I went to one of the workshops... there was exclusive spaces for trans people of colour, and those people came together... and they started to talk about the ways they experienced racism in bi-con specifically. And then they started to send somebody out to liaise with the organisers, talking about ways to make it better.

Trying to educate some people about how to be better and more respectful, and actually what they were talking about this year was the great extent to which that's been achieved now, and people are coming into the space not with an awful lot of grievances that need correcting but generally quite happy with the space. So just talking how that's good, and how useful it was to have that exclusive space and come together with people who understand, talk about the problems, and when they've got something coherent they want to ask for, come to the rest of bi-con and ask for it. So that's an example how that space was rubbish but has improved. (Ash, 33, interview)

This exemplifies that within a time/space for queer community, a demarcated area amplifying more marginalised voices and engaging with intersectionality served to address wider issues of awareness. The similarities and differences between the struggles of the civil rights movement and of LGBT liberation have been compared in a legal context, in terms of what the latter can learn from the former (Neal, 1995). One of the central points of import in this analysis was how LGBT rights must “take care not to exclude, either by acts of commission or omission, people at the fringes of the movement” (p. 681). Whilst it would be a mistake to assume that non-binary people are, by necessity of their relatively recent increase in recognition ‘at the fringes’ of queer communities, Ash’s example does serve to show how sincere and significant efforts by organisers to create space for more marginalised voices can serve to improve the community’s reputation more generally. Community practices in particular spaces, or at particular times, can thus bring greater particularity to member’s needs (Hines, 2006).

Conclusion

In this chapter I have focussed on recognising how binary and non-binary transgender identities can each function to lead to the other, and how this may be catalysed through personal embodied desires connected to medical transition. This was related to negotiations of the self over time, such that the experience of being binary or non-binary can be understood as liminal – that is, either existing on two sides of a boundary at once, or occupying a fluid, evolving, transitional middle point in a social process. Whilst in older literature being trans could generally be conceived as liminal due to binary medical and social transition being all but compulsory, the nuances of non-binary may mean that a continually fluidic sense of self may mean some individuals are ‘permanently liminal’, or that community spaces are regarded as such as people enter

and drop out of them continually over time, or use them at particular times or in particular ways.

I moved on to explore how participants viewed non-binary identities as a stepping stone to binary identities, and vice versa. Participants gave varied accounts and explanations showing both scenarios occurring amongst the trans population, as well as demonstrating the possibility of identifying simultaneously with and outside the gender binary. I constructed a model in order to visually illustrate how the motion of identity over time is an important dimension in gaining a nuanced understanding of individuals. This also emphasises how 'trans' can be a transition not only of the body as emphasised in medical literature, but of identity through and over time, and of how one is socially interpreted and interacted with. Transgender negotiations of the self in relation to gendered expectations is a story that has historically been told in a manner focussing on embodiment and surgery, which had notable and tangible effects even for those not attempting to access medical intervention, but simply social recognition, validation, and equal treatment. Exploration of non-binary identity with reference to the theme of liminality has highlighted the potential benefits for medical practice in more explicitly recognising how an individual's relationship with embodiment may change over the life course, and that not all individuals are static in their sense of identity or desired embodiment.

Likewise, changes over time in the needs communities have of their spaces have also been apparent in this chapter. The binarised or medicalised focus of some trans communities, and potential for off-putting, un-inclusive views among some members, or names, official information, or practices that erase trans or non-binary lives can create difficulties or tensions. However, community groups that are not trans focused, or even necessarily LGBTQ focused can be of great importance and benefit to non-binary people, and demonstrate reflexive and intersectional practices of inclusion.

I conclude that regardless as to whether individuals experience non-binary identity as liminal, fluid, or static, it is useful and accurate to consider identity formation as a temporal process which has no fixed end. Many of the positive and negative experiences that different participants reported were linked to particularities of space, and who occupies the space – often informing the levels of sensitivity and knowledge that could be expected during interactions. Further, as time passes, individuals are able to adjust, explore, and become comfortable with these important factors relating to non-binary. This chapter has served as a foundation for the consideration of non-binary clinical interactions, as experiences occurring over significant lengths of time, and with

community interplay, are deeply significant for understanding trans healthcare. In the following chapter, I thus move on to consider how interactions within the context of primary care relate to non-binary identity negotiation.

Chapter 6 – Views of the Clinic: Non-Binary Perceptions of Primary (and Non-Transition Related Secondary) Care Services

Those who identify ‘beside’ the gender binary will still be situated within it by others whose worldviews are bounded by the discourse of binary gender, such that it is impossible to escape this discursive framework altogether.

(Sanger, 2008, p. 50)

Introduction

This and the following chapter will focus upon non-binary perceptions of healthcare in the UK. This includes primary⁶⁰, secondary⁶¹, and tertiary⁶² (specifically gender related) care. In this chapter I address primary care services for the most part (with some mention of secondary care), focusing on the experiences and views participants reported of interactions with doctors and other staff – such as nurses, and administrators.

Primary care is exclusively addressed in this chapter, whilst Tertiary (GIC-oriented) care is the subject of chapter seven. GPs are responsible for referring patients to GICs before gender affirming medicine can be accessed, centralising this process as bridging primary and tertiary care. Secondary care practitioners whose fields are unrelated to gender transition will have, on average, similar knowledge of transgender healthcare needs as primary care practitioners. Such discussions are addressed within this chapter. Further, the motivation for a non-binary service user to access such secondary care may be very broad, and comparable to cisgender service users. This is not the case when a secondary care service has been accessed, for example, on the advice or referral from a GIC. Secondary care services that are routinely used as a consequence of GIC access (such as some endocrinologists and psychiatrists) will have experience and approaches in closer alignment to tertiary care gender specialists. Therefore, these medical experiences are addressed in chapter seven.

I begin this chapter by considering how participants judged the non-binary community’s overall view of care when going to a GP. This is followed by specific accounts and

⁶⁰ Frontline, day-to-day healthcare provision, typified by GPs and nurse practitioners.

⁶¹ Specialist services, such as dermatologists, or cardiologists. Patients are typically seen by referral.

⁶² Specialised healthcare which is consultative, but with specialised facilities.

examples of individual's experiences of primary care, for appointments not related to gender transition. This begins with experiences of 'gendered medicine' – healthcare which is differentiated in gendered terms, such as smear tests. This is followed by generalizable healthcare experiences, such as arm pain. Some experiences resonate strongly with binary transgender experiences of primary care (Dewey, 2008; Feldman and Goldberg, 2006). Responses from doctors to patients that may be ideal for a binary trans person have the potential to be appropriate, or instead, deeply uncomfortable for a non-binary patient. Some participants did discuss positive views of general medical practice, whilst simultaneously reporting an overall negative and guarded sense regarding medical practice in the community.

This leads to an important sub-group of non-binary clinical experiences, those who experience chronic illness and disability, and the interplay that has with individual's experiences of gender. Finally, this chapter addresses how clerical administration in medical institutions may affect non-binary patients. This includes discussion of how names and pronouns are used and recorded, and medical forms specifically discussed by participants – including feedback forms and documentation related to tertiary care. Whilst this chapter is structured around primary care, the cross-practice nature of administration renders a general discussion that cuts across all forms of care appropriate. Discussion of the key administrative process of referral brings this chapter to a close. This section also serves to link to the following chapter on GIC care, much as the referral acts to bridge from the GP to GICs within practices of care.

Non-Binary Views of Primary Care

In addition to considering the discrete examples of interactions non-binary participants had experienced in primary care, more general views of the non-binary community's perceptions of primary care were also expressed. Participants communicated views of primary care that were not connected to a single discrete clinical interaction they had experienced. Some participants made it clear that positive (but unspecified) experiences shaped their view:

My experience has been overarchingly positive in terms of the NHS. Medical staff seem concerned with functionality, and unconcerned with social labels. True, not so long ago medical systems couldn't cope with assigned a male pronoun to a patient owning a vagina. However, this is different now. (V, 28, diary)

V was keen to highlight how differences could be seen between the present and the recent past, emphasising the importance of how changes over time in medical practice influence individual's views, which links to the discussions of temporality in the previous chapter. Frankie had positive and negative feedback to share, but reported her belief that other people's experiences tended to be negative:

[Trans peoples' experiences of medical practice is] not good! Generally not good. That said, you don't normally hear people being particularly vocal about the good experiences they've had. The ones you do hear about tend to be the negative ones, especially in my line of work. Yeah, just a lot of misunderstanding, a lot of barriers put up to medical assistance. Accessing things that need to be accessed, or that have been accessed for a long time but because someone's changed their circumstances, moved GP or something; they have to go through a whole lengthy process again just to get their prescription moved, and this that and the other. So yeah, generally not good, but then that might be kind of slightly tainted by the fact that I work in wellbeing, work with trans people, generally have to deal with difficulties rather than positive experiences. (Frankie, 25, interview)

Frankie recognises the possibility of being exposed to a particularly negative view of medical care through working with transgender people accessing support. This recognition may have potentially been nucleated due to the negative accounts that comprised the majority of the views Frankie had heard, clashing with her own broadly positive experiences. When asked their thoughts on the medical establishment's interactions with non-binary people, Alex said:

I think it's very bad at recognising them. There's a lot of misgendering. I've had quite good experiences with that personally, but I know there is a lot of people who report being misgendered, who report having poor interactions, with the medical establishment based on that. (Alex, 20, interview)

This reiterates the theme that even when having positive experiences personally, participants did not then dismiss or play down what they heard through community networks of other people's negative experiences. Therefore the relative impact of negative experiences on an individual's conception of medical service provision is higher. Relatedly, it has been found that those individuals who associated or

experienced stigmatising behaviour coming from healthcare practitioners would anticipate this more generally (Earnshaw and Quinn, 2012), implying that negative experiences will have a deeper impact on views within a community than positive experiences. This will be considered in more detail with regards to gender transition-oriented care in chapter seven.

One specific critical view of primary care practitioners that was aired by multiple participants was the tendency for other medical conditions or diagnoses to be ignored in transgender individuals, instead connecting unrelated complaints to gender identity. Some participants highlighted this through a comedic yet exasperated tone:

Got acne? It's because you're trans*
 Aching muscles? It's because you're trans*
 Headaches? It's because you're trans*
 Bruised toe? Because you're trans*
 Stress? Trans*
 Trans*
 Trans*
 Trans* (Mark, 43, diary)

I didn't have good experiences with doctors at uni at all. They don't ever believe anything's wrong with you, they just think you're stressed. Or at least my doctor it was always 'are you feeling stressed, are you getting enough sleep, are you eating enough', it's what people say about being trans; you've got a trans broken leg! (Jamie, 24, interview)

Further, Jess gave evidence to the Women and Equalities Committee⁶³ held by the government on 8th September 2015. She stated:

We call it the trans cold. If you go to your doctors with a cold it will be a trans cold. Quite literally, my housemate has had a throat problem for

⁶³ On 27th July 2015, the Conservative UK government launched a new select committee to examine the issue of transgender equality. A formal government response was published July 2016 which recognised various forms of inequality, but was extensively critiqued by a collaboration of transgender organisations. See Andry, K. et al. 2016. *No Excuses: Inclusion and Equality for all. Our critique of the Government Response to the Women and Equalities Committee Report on Transgender Equality*. [Online]. [Accessed 16/10/2016]. Available from: <http://nonbinary.co.uk/wp-content/uploads/2016/07/No-Excuses.pdf>.

the last year or so and has been taken to Ear Nose and Throat, and the doctor diagnosed her with 'transgender problems', that's literally the words he wrote on the piece of paper.

(Women and Equalities Committee, 2015, quotation at time mark 11.52.08).

These incidences serve to highlight the sense within the transgender community that primary care practitioners may articulate an inappropriate fascination with an individual's transgender status, which may negatively impact the ability of transgender people to access medical services as easily for medical issues unrelated to trans status. The potential fear of voyeurism from primary care practitioners regarding transgender status risks alienating some individuals from accessing healthcare in a timely manner (King, 2016).

In addition to descriptions and discussions of how experiences of primary care related to their genders, some participants talked about how they felt alienated from their GPs because of the impression they received of them more generally. Participants could extrapolate their concerns; such that they felt there was an unacceptable level of risk regarding communicating being non-binary with their GPs. Hal went into detail when relating how they felt they should make an appointment to discuss ADHD⁶⁴ medication, but had misgivings:

I realised it's not just the stress and workload that is keeping me from booking an appointment with my doctor. It is also the fact that he is very conservative... His nurses and staff also make me uneasy. Uneasy enough that I have to prepare myself mentally before I go to the clinic; make sure that there are no traces of nail polish or mascara visible on me and dress carefully in what I call my "office drag". It doesn't make me feel good. It actually feels awful to be so afraid of these people judging me at a moment when I feel pretty vulnerable already. I should get another GP. (Hal, 42, diary)

By 'office drag', Hal is referring to a normative, masculine appearance in order to 'pass' as cisgender. Articulating this as drag indicates Hal's sense that this presentation is affected and performed, as a protection against potential stigma in this context. Hal connected the Conservative political affiliation of his physician with a morality and worldview that made them "afraid of these people judging me". Fear of stigma when

⁶⁴ Attention Deficit Hyperactivity Disorder.

already feeling vulnerable significantly impacted Hal's willingness to attend the doctors at all, which compounded with the stress and workload they initially mentioned, to render primary care considerably less accessible. Frankie had a similar experience:

My GP made a big point of being like 'we don't know anything about this, we're a very conservative community' as if that somehow meant that they didn't need to know about it. (Frankie, 25, interview)

Frankie's GP also made demands of her to "explain what being a trans person is", emphasising the unrecognised educational and emotional labour that can be demanded of trans patients. Jess expressed the same anxiety as Hal, having not seen a "doctor, or a dentist, or a medical health professional of any kind" in the nine years since she came out as non-binary. Jess explained this in relation to multiple overlapping loci of negative medical associations. Firstly, she explained how she felt if she went to the doctors she would "have to start that conversation about gender" which could "rope [me] into a binary transition pathway which I'm not sure I want". This concern expresses an anxiety with potential lack of agency in the doctor/patient interaction (Newman and Vidler, 2006; McKinstry, 1992). Jess and Hal's feelings illustrate a sensitivity both to the views that doctors (may) hold, as well as the view, or clinical gaze (Singer, 2006) that the clinician exerts over the non-binary body⁶⁵. Discussion of the hegemony of the gender binary within transition pathways will be developed in the following chapter.

Secondly, Jess's activist work training doctors around transgender healthcare means that they "see it behind the scenes", and are apprehensive to receive insensitive or substandard care on the basis of being non-binary. Like Frankie, Jess is exposed to a great deal of negative narrative, but without the mitigating positive personal experience Frankie recounted. Finally, Jess alluded to negative experiences as a disabled child accessing medical care for their impairment, highlighting how intersections with chronic health and disability concerns must be recognised when considering transgender health.

As Jess and Frankie's accounts have alluded, it is important to recognise that not all perceptions of primary care that non-binary people experience will be from the position of being a patient. Whilst the cohort of participants did not contain any medical doctors,

⁶⁵ Not to be confused with the intersex body – the non-binary body is non-binary by virtue of being the body of a non-binary identified individual, rather than a reflection of the specific physiology an individual does or does not have.

Alex (20) discussed their experiences as a student nurse, and working in healthcare as a non-binary person in their diary. In particular, they discussed that a department they worked in made an accusation of problematic relations with others, which was sent to their academic tutor. These were not acted upon, but Alex articulated how they were positioned as being uncommunicative, and not engaging in their departmental handover process. Alex explained their belief that this was due to how they interacted with their nursing colleagues/instructors socially, rather than professionally. It was Alex's view that due to being positioned as/assumed to be female, they were accordingly held to gendered social norms. When not offering expected cues in response to "conversation about celebrities, when they all talked about 'being good' and watching what they ate", this was from Alex's perspective the reason they were judged accordingly negatively, despite holding that "by male standards I was fine; it's just unusual for 'women' to not conform to certain behaviours".

This experience highlights the gendered nature of the workplace (Holmes and Stubbe, 2003), and how negative experiences on the basis of gender identity can be connected to an older feminist literature that problematizes the differential and unequal treatment of men and women in places of work (Heilman, 1995; Williams, 1989). Alex was also able to provide a view of medical practitioner language and behaviour in a context without a patient present:

We had on one placement I was on... there was someone who, certainly on records was a man, and who was presenting male, but who had somewhat effeminate mannerisms and a little bit of a high pitched feminine tone of voice and pattern of speech. Which – so what? And as soon as they [the patient] were gone out the room [nursing colleagues said] – "do you think that's a woman? I bet that's a woman! I bet it's a woman that's just like – being a man, or it's a tranny!" And I was like "No, if it was someone who was transitioned and was on hormones as you're suggesting then their voice would be lower, surely?" I was trying to like, logic it, because telling your boss that they're a bigot doesn't work. And they were like "oh maybe they forgot to take their medication this morning" I was like, you can't change someone's voice box in a day by missing your medication! (Alex, 20, interview)

This demonstrates that whilst power dynamics position patients as more vulnerable, practitioners also need to be mindful regarding the assumptions and gendered practices that can manifest when interacting with colleagues. In addition, even if successfully performing a professional persona and negotiating a positive interaction with a transgender service user, cultural practices that allow for the normalisation of slurs (such as 'tranny') and voyeuristic, overt speculation regarding patients' genders are deeply problematic. Such delegitimising practices must be challenged, and their cultural normalisation dismantled, in order for NHS practice to be able to be responsive and sincerely trans-sensitive.

The most consistent view among participants was a sense that primary care practitioners were unlikely to understand or be confident over what 'transgender' means, and even less likely to be specifically aware of the existence of non-binary gender identities. Even in the context of studying to become a health professional, Alex said that the general attitude amongst healthcare staff is:

As a whole, the attitude is that it's [non-binary identification] not something that's particularly real, it's not something that's particularly important as well. You know, 'we don't need to worry about that'. People that are trying to maintain their non-binary identity, I feel, are viewed as often sort of causing trouble, trying to get attention, that it's not an okay thing for them to do. Even with doctors who are really understanding, one once said to me 'don't you think you're letting your identity define you a bit'? It's like well, yeah... it's my identity! But obviously a cis person wouldn't get that. Because they wouldn't have to constantly defend their identity. But the medical establishment seeing it as we are wrong to be trying to defend them all the time – that we're overreacting. (Alex, 20, interview)

Alex emphasises the differential attitudes of healthcare practitioners to the gender identifications of trans patients, compared to cis patients. Whilst gender when cis is unquestioned, the act of working to claim a gender different from that assigned at birth serves to emphasise gender. From a cisnormative position where no emphasis on gender is needed, this correspondingly may seem to be an 'overemphasis', to explain the physician's failure to appreciate why Alex raised the topic of gender in order to be accurately recognised and respected.

Whilst binary transgender narratives have an established medical aetiology (through the constructed sexological discourse of transsexualism), non-binary articulations do not, despite current guidelines being worded in such a way that non-binary inclusivity is at least technically possible. Jess has experience of training medical practitioners through activist work, and so, whilst having not attended personal medical appointments, stated:

I think that probably 99% of clinicians, of doctors, of nurses whatever, don't know what a non-binary person is, so is therefore very much more likely to get things wrong, to make mistakes, to force somebody into a binary gender and generally behave in a way that is not conducive to the patient's welfare, but is also pretty shitty in other ways. Of the people who know about non-binary, then a lot of people think it might be a phase. (Jess, 26, interview)

Jess's view that many of the practitioners aware of non-binary identities view them as a 'phase' links with discussion in the previous chapter – how transgression of binaries can position one as 'unstable' which undermines the status of one's gender as real. The medical framework for considering gender essentialises the property of 'being static' to gender, which troubles equal status for those with fluid experiences of gender. Those individuals whose experiences of (trans)gender fit with the paradigm legitimised by the medical gaze are correspondingly more likely to be afforded belief in their stability and realness. Transgender support networks are well-recognised to not only provide emotional support, solidarity, and advice, but to highlight negative medical experiences within the community (particularly in relation to transition-oriented care) so that others may navigate clinics with as little issue as possible, or so as to avoid practitioners who gain a negative reputation (Kosenko et al., 2013; Hines, 2007b).

Beyond the Gender Identity Clinic: Specific Experiences of Primary and Secondary Healthcare for Non-Binary People

Some participants recorded particular experiences of accessing primary healthcare during the diary-keeping period. I will begin by considering examples of primary care that involve what I term 'gendered medicine' – those procedures or experiences which are explicitly gendered in and of themselves as a result of the gendering of bodies and their parts, such as the examination of genitals or breasts. Such healthcare, in this context, is not specifically connected to medical transition. This will be followed by discussion of clinical experiences which are not so explicitly connected to gender –

even though perceptions of gender or transgender status still influence the doctor-patient interaction (Bertakis, 2009).

Jamie illustrated the extreme discomfort of being a non-binary person undergoing a cervical smear test without a trans-sensitive medical practice, and showed how potentially harmful the gendering of medical processes can be. In his diary, Jamie said “it took a lot of strength to ring a friend when I got home instead of just taking a knife to my wrists” following from this experience with his primary care practice.

Jamie gave a thorough account of his medical experience, which began with his interaction with a member of reception staff. After being addressed by his previous name (a destabilising and unpleasant experience, and triggering of dysphoria) he produced his deed poll to attempt the record change, for the fourth time. Previous attempts by Jamie to formally have his name changed on medical records were not acted upon, despite possession of a deed poll, and allowing the practice several months to enact the change. The interaction then involved the receptionist having a telephone call with patient central, during which (despite the context of a first name change and gendered title change to ‘Mr’) they referred to Jamie as “a lady”, “she” and “her”. Whilst a more detailed consideration of the role of administrative processes in medical care will be considered later in this chapter, this context is important because of the emotional impact this interaction had on Jamie before entering the space of the examination room, and the gendered negotiations with the nurse performing the cervical smear.

Jamie made a point of telling the nurse in the examination room that he is transgender. However, the nurse gave no clear indication of having registered or understood the relevance of this for the interaction. Instead she simply continued by replying “Okay. Have you ever used sex toys? It [the speculum used during screenings] is no bigger than a dildo...” This gave Jamie considerable anxiety, uncertain whether the nurse “thinks I was assigned male at birth and have had lower surgery and am worried about my neovagina being hurt or something?”. Whilst the nurse did express sympathy in response to perceiving anxiety, Jamie characterised her response as very general in nature and did not suggest awareness that Jamie’s specific, (dysphoric) anxiety was informed by transgender identification, being misgendered, and the lack of practitioner awareness.

Further, the symbolic use of sex toys to make a point about the speculum is noteworthy. It is unlikely that this comparison would be used by the nurse for all individuals

attending a smear test because of the possibility of offense, due to the potential for sex toys to be symbolically connected to deviancy by patients (Kay, 1992). In terms of making the point about size, the nurse could have easily shown the speculum, or made a comparison that did not involve the asking of an intimate question. Whilst this has been recognised in women's healthcare (Moore et al., 2000), the specific context of transgender carries different requirements for sensitive practice that have lacked specificity and discussions of interactions within existing literature (Unger, 2014). There is also the potential that the nurse made the speculum-dildo comparison due to discursively connecting sex toys and transgender as sexually deviant. Most problematically is how Jamie recounted the exchange during physical examination:

Nurse: So how do you cope with your period?

Me (thinking, WHAT THE FUCK?! Why do you think this is a) appropriate or b) at all likely to calm me down?! Are you seriously trying to dispel my anxiety by bringing up the precise dysphoria I'm currently desperately trying to dispel?!?!?!): Badly. (Jamie, 24, diary, capitalisation original)

This illustrates unambiguously how lack of awareness regarding transgender experiences means that practitioners risk causing extreme discomfort for transgender patients through inappropriate interactions. The phrasing of the question, and the fact that the nurse did not ask for any more information following Jamie's response of "badly" shows that this question was not asked out of medical necessity. The inaccurate collapse of 'people with cervixes' to the social category of 'woman' results in a blanket-style approach to particular healthcare interactions that have the potential to be delegitimising and upsetting for binary and non-binary transgender individuals.

Mark's discussion of his (gendered, but not GIC-related) secondary care experiences with a gynaecologist provides another perspective:

On paper, I'm very scary apparently, I'm told. [According to] the gynaecologist that was checking me out... I'm having trouble with my digestive system actually, but when it first came up it was assumed to be an ovary. So that meant a trip to the gynaecologist. And he apparently, somebody really hadn't felt very comfortable dealing with me... and I thought 'what's wrong with me?' but I think when I get in there and they realise that I'm first of all quite personable, I'm not kind of going in grunting. I don't have the testosterone sweats or anything

like that! And also that I'm happy within the contexts of what they're doing to be open about being transgender. I had another ultrasound recently; they're trying to tick off what's not wrong with me at the moment, anyway. But of course, the lady doing the ultrasound wanted to know what the background was, had I been for one recently, yes, I went for one before Christmas, but that was specifically just to check my ovaries. Because I'm transgender, and that was fine. That was the only conversation that went on about it. But I think if they realised that I go in and I don't have two heads, that hopefully there's a weird sort of educational process going on! That just because someone called Mark is coming in to have their ovaries looked at doesn't mean I'm going to be a monster. (Mark, 43, interview)

Mark is keen to emphasise that through being personable, he is able to dispel much of the anxiety that he articulated practitioners expressing in relation to him. It is important to recognise the significance of a doctor telling their patient that they found them 'very scary on paper'. Through Mark's possession and embodiment of a transgender history, this is enough in and of itself to cause a fear response in the clinician. One possible interpretation of this fear is that of discomfort with Mark, on the basis of 'transness as scary'. This has been explored through feelings of transgender rage at being positioned as an artificial creation and monstrously different (Barad, 2015; Stryker, 1994). The doctor's fear instead (or in addition) may not have been located in relation to Mark in and of himself, but the fear of failing to provide adequately for Mark – the fear of failing as a physician (McLeod, 2003; Caplan, 1994).

Mark's initial response of 'what's wrong with me?' highlights how he felt a sense of being viewed as 'wrong' by the doctor's reaction. The doctor's fear may be more likely a fear of the unknown, and fear of making mistakes or being ill-equipped as a practitioner despite (or perhaps because of) being in the position of power, and thus expected to possess relevant expertise. The doctor's candidness with Mark of his feelings may have been ill-advised rather than ill-intentioned. Mark's response illustrates the potential for this to be problematic for a transgender person, even though Mark did not place emphasis on the experience as being especially upsetting. This example illustrates not only the lack of normalisation that trans bodies can have within the healthcare system, but how this process of othering is not recognised as potentially damaging to declare. This exists in tandem with the doctor 'confessing' his vulnerability, and fostering potential for mutual reassurance. This interaction also reminds of the

humanity of practitioners, and how their emotions (such as anxiety and stress at the prospect of inadvertently causing distress) also have interplay with clinical interactions. Mark emphasises that “just because someone called Mark is coming in to have their ovaries looked at doesn’t mean I’m going to be a monster”. There is a discursive connection between ‘being scary’ and ‘monstrosity’, which has been specifically recognised and explored by transgender scholars in relation to their own experiences of being socially othered (Nordmarken, 2014; Stryker, 1994).

These two examples from Mark and Jamie illustrate significant narrative differences, in that Mark did not express being upset by how his treatment was conducted or the nature of the practitioner’s communication, whilst Jamie did. This may be connected to the previous chapter’s theme of time, in that Jamie was in the early stages of negotiating his identity whilst Mark articulated considerably more experience and security. Further, Mark’s doctor did explicitly recognise him as trans, and engage in a discursive act of rapport building (however problematic). The response of Jamie’s nurse to Jamie’s act of coming out in the clinical space was symbolic erasure (Namaste, 2000), through lack of nuanced reaction and subsequent upsetting questions.

In having his name already registered and used consistently at the doctors (and with ‘Mark’ being read unambiguously as male), this is a clear indicator that medical staff were able to follow up on. The difference also meant that Mark did not share Jamie’s experience of trying to have the correct name and title arranged (yet again) before the appointment, which functioned to prime Jamie into a vulnerable state. Further, due to having already accessed gender affirming medical services, Mark was read socially as male more consistently than Jamie – making it considerably easier for Mark to avoid being assumed to be female, even within the setting of a gynaecological examination. Mark evidenced that earlier in his transition, he was more easily upset and destabilised by the behaviours of clinicians:

A couple of times I have made complaints to practice managers, but that was generally in the very early days. And the trouble is of course, back when... you have so little to hang on to. You have no testosterone, no surgery, you are basically told to get out there and be a man. (Mark, 43, interview)

This adds to the temporally and materially dependent discourse of ‘not being trans enough’ as discussed in chapter four. There is potential insecurity in not feeling (or being viewed as) trans enough, when an individual has not yet accessed (or does not

intend to access) transition related treatment. Further, individuals may feel they lacked the catalysis of embodied change, which would not only stimulate confidence in one's transness, but also allow for less problematic negotiation of (gendered) services. Unless a trans person who is accessing gendered medicine exhibits unambiguous social markers of cross-gender identification or embodiment, their identity, and correspondingly their particular socio-medical needs may be rendered invisible if nuanced trans-sensitive policy is not in place.

When not (or not yet) accessing gender affirming medical treatments, it may be considerably more difficult, and correspondingly dangerous, to attempt to 'pass' socially as a gender other than that assigned at birth. Whilst 'passing' is unavoidably a navigation performed in binary terms, many participants expressed how being read as 'the other binary gender' is considerably preferable to being positioned as they were assigned at birth. Avoiding being positioned as the gender one was assigned without medical intervention can be difficult for some, and impossible for others. Thus, presenting oneself in accordance with one's assigned gender can be a survival mechanism for navigating the world with fewer practical difficulties. In such cases, the individual's gendered appearance is taken at face value, due to medicine operating within cisnormative society whereby appearance functions as 'cultural genitals' (Kessler and McKenna, 1978). Which of these two far from ideal options may be pursued is often dependent on the severity of dysphoria, and thus may also fluctuate over time (as dysphoria is not necessary constantly the same intensity, if present).

This also highlights an important difference between some non-binary transgender articulations in contrast to binary trans identification. Genderqueer or gender-subversive presentation often relies upon the blending of categories, however many non-binary people do not present in such a manner (certainly not constantly), and additionally such presentation does not guarantee recognition of a non-binary gender identity. The closer a non-binary person's gender presentation and social cues are to that which they were *not* assigned at birth, the more likely their transgender status is to be recognised (should they either not 'pass', or disclose their trans status). That is, non-binary gender identities struggle for legitimacy unless following binary transgender discourses (Vaid-Menon, 2015), which also remain subject to significant ignorance within primary care.

Only when the medical record of 'M' or 'F', and gendered appearance are 'misaligned enough' does an individual have a chance of being regularly recognised as trans within medical contexts, although it is also possible that staff may instead presume the

gender marker on records to be a 'mistake'. The potential confusion that trans embodiment can cause is also supported by Frankie's account of receiving an ultrasound, after experiencing abdominal pain since starting HRT:

The clinician was nice enough, just kinda did his thing and then I left. I got the impression he might have been slightly flustered about how to treat me, looking 'male' but with 'female' details – think there were a couple of questions where he really thought about the wording before asking, which was cool. (Frankie, 25, diary)

The symbolic disjuncture between appearance and records (as with Mark) acted as a social cue which the doctor was able to recognise, and modify his interaction accordingly. Frankie's account also illustrates how recognising the act of the doctor thinking about how to word his questions may help trans individuals feel more at ease, as recognising such an action is evidence of concern for the patient in terms of their trans status. It provides evidence of a practitioner with some awareness of gender sensitivity and, importantly, an active desire to be respectful and create an affirming environment.

To compare this interaction with Jamie's smear test, Jamie may have avoided some elements of distress had his earlier attempts to change his records been successful, but his interaction with the nurse was partly due to her assumption that he was female. However, her inappropriate question about how Jamie 'copes with [his] periods', asked in the context of *knowing* Jamie's trans status, was not rooted in medical necessity (but rather, curiosity), and did not recognise the potential sensitivity of the situation as Frankie's clinician did. This illustrates how transgender clinical experience may have a significantly unpredictable element to it based in the personality and style of a given practitioner. Whilst this may also be true from a practitioner perspective (in that trans service users are very heterogeneous and therefore not predictable), there is a great sense of concordance from the trans community regarding modes of practice that are viewed as sensitive, collaborative, and preferable (Ellis et al., 2015; 2014; Dewey, 2013; 2008)

In relation to uterine and sexual healthcare experiences, Ash (33) drew an image of their internal reproductive structures (figure 9) in order to clarify 'what they had':

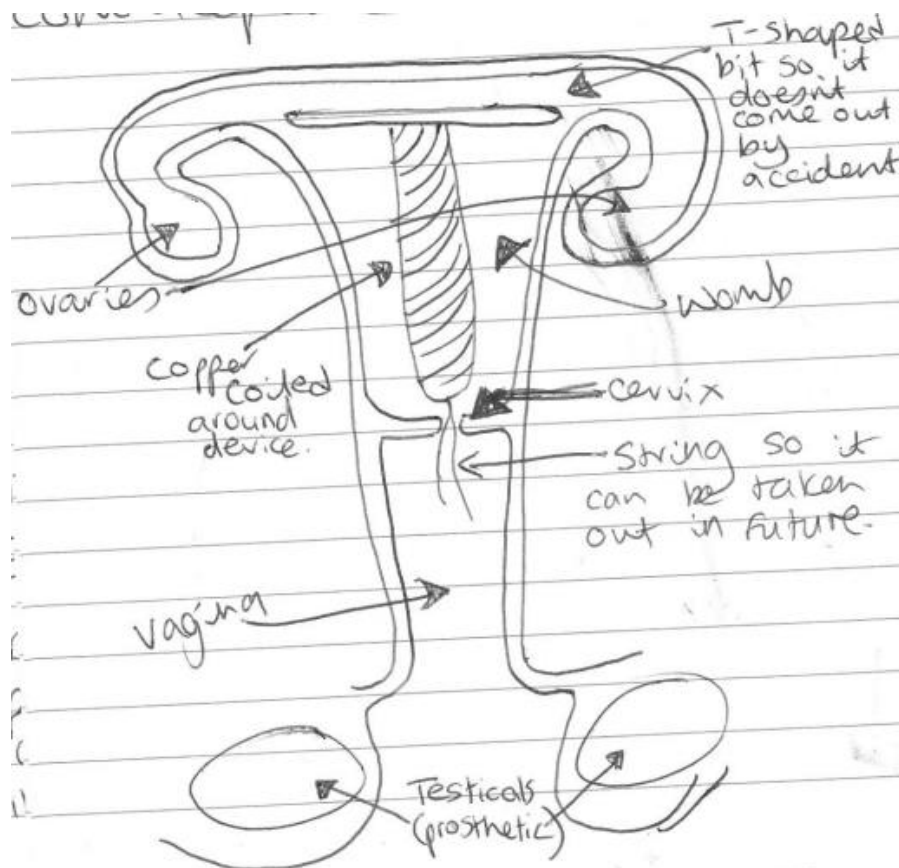


Figure 9: Illustration of non-binary vagina with prosthetic testicles and intrauterine device, from Ash's diary.

This image literally illustrates non-binary embodiment, and the results of negotiation both with oneself and with the providers of medical care. The image shows at least two independent medical procedures – prosthetic testicular implants, and an intrauterine device. In gendered terms, such procedures would typically be assumed as mutually exclusive. Therefore this highlights both the introspective work done in reaching the decision of wanting a non-binary physiology, and the effort required to successfully access this through appeals to both identification (Baril and Trevenen, 2014) and sexual responsibility. The image also reminds how an individual's process of negotiation can be inscribed upon the body through medical procedures, indicating, at least partially, the nature of some of the negotiations experienced.

In addition to the impact of clinician awareness, sensitivity, and demeanour, explanations related to health and diagnoses given by doctors have interplay with gender identity. Within their diary, Ash talked about sometimes feeling that their reproductive system might be “broken, not as good as that of cisgender people”. Ash here illustrates internalisation of the stigma of a body that does not fulfil idealised

(cis)gendered expectations. The rendering of the physiological in moral terms ('not as good') fuses two of Goffman's (1997) types of stigma. According to Goffman there are "abominations of the body" and "blemishes of individual character" (Goffman, 1997, p. 205), both of which are relatable to trans embodiment.

Ash's feelings of being damaged or lesser related to their experience of sexual healthcare, as well as their history of receiving HRT. Ash discussed having the contraceptive coil fitted and explained how the copper coil tends to make menstrual flow heavier, meaning they were bleeding more than they had for years. Contrary to experiencing dysphoria in relation to this (as would be expected of a historical or hegemonic transgender narrative for someone AFAB), Ash explained they were happy about this, because of making them feel less 'broken'. The coil served to reduce anxiety Ash had over a perceived increased risk of cancer:

When I went to see an endocrinologist and they put me on female hormones I asked why I have to do 3 weeks on, 1 week off cycle when lots of people (trans women) I know take oestrogen every day of every month. The endocrinologist said if you have a womb it is different. You should take time off oestrogen to let your womb bleed. If your womb does not shed its lining regularly this is bad for you, and you are at greater risk of cancer. So after they said that I have often looked at the tiny red smear in my knickers each month and felt anxious that it's not enough and I will get cancer. (Ash, 33, diary)

The act of menstruating, rather than being a simple cause of dysphoria (as it may or may not have been in Ash's past) reassured Ash that their physiology was 'working', and so it felt to them less likely that they were at risk of uterus-related pathology. There is potential for the explanation of the endocrinologist to have been an oversimplification, as whilst oestrogen-only HRT may increase the risk of womb cancer (Grady et al., 1995), combined HRT of oestrogen and progesterone *reduces* cancer risk (Hill et al., 2000). Modern contraceptive pills for example decrease womb cancer risk whilst also preventing menstruation (Cancer Research UK, 2014), thus flow rate is not in and of itself a reliable predictor of cancer risk, and yet Ash was rendered anxious by their endocrinologist's explanation.

These examples of gendered medicine have illustrated how experiences of gendered primary and secondary care may result in non-binary trans people experiencing problematic responses, even when not individually dissatisfied with the medical

interaction. The following examples are not rooted in gendered physiology per se, yet illustrate how social interactions in clinical contexts can be gendered problematically, or for transition-related healthcare to be connected to other healthcare experiences.

Gender could be unnecessarily brought to bear even in very mundane medical interactions. Alex illustrated this by explaining in their diary how when expressing discomfort at a local anaesthetic injection for the removal of an ingrown toenail, the nurse practitioner said “once women have babies they don’t complain anymore”. Whilst the nurse’s response implied that she was being glib, one could argue that regardless of the patient’s gender this response may be interpreted as dismissive. When Alex responded by saying they were never going to have children, the nurse responded with “the usual patronising line about how I’m young and I’d change my mind one day”. Alex expressed that they found this response annoying to the nurse. Although the nurse did not verbally respond, Alex reported feeling a sense of “judgement and disapproval”. It is important to note that such an interaction may have been equally offensive to many cisgender women, due to the stereotypical assumption of those read as women inevitably being positioned as (future) mothers. However, the way in which such an interaction also can heighten dysphoria and delegitimise an individual’s gender identity entirely, means this has particular significance in the context of transgender interactions.

As a student nurse, Alex was particularly critical of this interaction, because of having first-hand experience of how medical professionals are taught and expected to put themselves across in a ‘neutral’ manner. This instance not only reinforces how gender norms and expectations can be clinically reified, but the significant difficulty of being respected as neither male nor female in contexts where that is not the focus of attention.

The following example from Mark runs counter to the example concerned with taking oestrogen and bleeding from Ash. In Ash’s case, non-binary contextualisation may have iterated the need for a more nuanced, particular response. On the contrary, in Mark’s case, his health concern (a sore arm) was demonstrably conflated with his gender related medical treatment and dismissed. Binary and non-binary trans people who access gender affirming medicine can thus find unrelated health experiences being consigned to ‘side effects’ of for example, hormone treatment:

I have had a sore arm for around 4 years. It actually started before I first took T. I went to see a doctor about the pain after a couple of

years (you can't accuse me of over-extending the NHS!) and was told that the muscles in my arm were growing, due to the T, and that these were essentially 'growing pains'. "But why just in one arm?" I queried. The reply was that as I am right handed, I was using the 'new' muscles more frequently, so wasn't experiencing pain. In my poor, slovenly left arm, I had pain due to my body not being used to the muscle growth. At that point I gave up. (Mark, 43, diary)

Mark specifies that his arm pain began before he ever took testosterone, yet the explanation he received relied upon this prescription as causation. Further, the explanation is clearly unsatisfactory for Mark, yet he chose to 'give up', due to the sense that attempting to challenge the doctor's position further would be too demanding, and likely produce no results. There are parallels here with how other stigmatised bodies receive inappropriate medical scrutiny and blame, such as when a patient is overweight (Puhl and Heuer, 2010; Foster et al., 2003).

Mark can be understood to be negotiating his relationship with his doctors so as to fulfil the role of the 'good patient' (Lorber, 1975), reducing the possibility of conflict. This was seen in how Mark navigated the gynaecologist, working to perform a particularly amenable persona in order to counteract and diffuse any apprehensions a physician may have over trans patients being 'difficult'. This could be both in terms of how to treat, and in terms of patient behaviour as challenging or disrupting the doctor's presumed superiority in the context of the clinic. Mark also previously mentioned his hope that "there's a weird sort of educational process going on", illustrating how by performing the role of an agreeable patient he hopes to further normalise transgender people to his clinicians.

A very different account of gender transition intersecting with additional health concerns was described by Ash:

A couple of years ago I kept pointing out to my doctor that I had the symptoms of severe malnutrition and the doctor wasn't helpful at all – just kept saying "eat xyz", which I was already eating. I was really ill. The only thing that made it stop was the GP being confused by my gender, and saying he wasn't willing to prescribe HRT until I'd seen an endocrinologist and they had said it was appropriate... I am so lucky that being transgender got me diagnosed and treated appropriately in this indirect way. I am pissed off that they didn't take me seriously

earlier and I had to feel ill for a couple of years for no good reason... During this time I actually went into hospital and had a blood transfusion because I had so few red blood cells (anaemia) on two separate occasions. They were saying “you must’ve been bleeding heavily, how did this happen?” and they didn’t believe me when I said I hadn’t. (Ash, 33, diary)

Ash iterates that they felt lucky that their gender transition meant that they were treated appropriately for the nutrient deficiencies they had, however it is problematic for this condition to have not been followed up in its own right. Thus this example does not suggest it is appropriate practice for secondary care referrals (rather than a simple blood test) to be universally required prior to HRT prescription. Ash needed to be seen by an endocrinologist, but not because of wishing to start HRT. The assumptions within medicine that bodies gendered a particular way perform similarly (in this case that people with wombs must bleed) meant that Ash felt medical staff distrusted them, rather than entertaining the possibility of another explanation. The importance of practitioners trusting patients has been explored (Peter and Watt-Watson, 2002; Rogers, 2002), which is particularly valuable in cases with relatively frequent, ongoing contact such as with cases of chronic illness (Thorne et al., 2000). The following section acknowledges participant experiences of chronic conditions and disability, and how this intersects with their gender identities and treatment access.

Disability, Chronic Illness, and Being Non-Binary

The last example with Ash highlights how a patient’s condition(s) – in that case, a history of mental health diagnoses – can potentially impact interactions with medical practitioners. Intersections between experiences of disability and chronic illness were raised by multiple participants, and how this impacted their negotiations of non-binary gender identity. Further, the impact of medical interactions was multifaceted. Mark explained in his diary how he experiences multiple chronic conditions:

Of my medical files...

Bipolar (Type 2 – I take lithium)

Hypothyroidism (caused by lithium. Crap)

OCD (The diagnosed sort, not the trendy one)

Gout (bloody painful)

IBS (maybe – the doctor isn’t sure)

GENDER DYSPHORIA (well, duh) (Mark, 43, diary)

Mark explained how this meant he had a lot of experience with doctors, as well as being “well known” at his local surgery. This was to such an extent that “the pharmacist just hands over my drugs without asking my name”. Mark further contextualises how his mother was a nurse, so he is “not scared” of medics.

Contrary to this, Ricky’s chronic health problems alienated them to doctors, rather than acclimatised them. Ricky detailed how they were diagnosed with ME⁶⁶ in 1998, and how their experiences in relation to this badly soured them towards the medical profession. Their determination to access hormones despite this aversion (and the symptomatic fatigue of their condition) helped Ricky realise to themselves how serious they were, and thus how significant gendered medical intervention was for them. They went on to explain how:

We’re really lucky where we are, because we live in this tiny little old mining village. And it’s got a tiny little GP practice which they’ve never managed to find a GP to take it over, so it’s been locums for years. We’ve got a guy there now who’s been the locum there for a really long time. But he’s one of those doctors that you just go in, you tell him what you want and he gives it to you. He’s not really that interested, he’s just got his feet up, he’s very laid back, and you just go in and go ‘I’m trans, refer me to the gender clinic’ and he goes ‘okay’ and he writes a letter, and you tell him what to write – I can live with that level of interaction. If I actually needed a GP that was going to help me and talk stuff through with me and investigate something or put their own thoughts into what was going on for me, I think I’d be really stuffed. But as long as I know what I need, then I can get it. (Ricky, 43, interview)

Ricky’s account here demonstrates how earlier medical interactions firmly shaped how they wished to interact with medical practitioners – both in relation to chronic illness, and gender identity. They recognise how their GP’s apparent apathy can be problematized, though Ricky does discuss themselves as ‘lucky’ – because of the fit between their doctor’s approach and their individual needs and preferences. Ricky’s experiences as chronically ill prepared them for assuming the role of the expert patient (Taylor and Bury, 2007; Fox et al., 2005; Donaldson, 2003), so as to claim power in accessing what they felt they needed:

⁶⁶Myalgic Encephalomyelitis, which, depending upon the medical definitions used, may be used synonymously with CFS – Chronic Fatigue Syndrome.

There's no point going to them and saying 'I'm feeling this, can you help me' I have to go 'I need this from you'. I think in some ways that's also a process of empowerment really, and has certainly helped with being trans, I didn't go along to the doctor and go 'you know I think I might be' or 'I think this is going on' I just went and said 'you need to refer me to the gender clinic please', and I think that's quite empowering from that point of view. With my ME I had to take it into my own hands, I realised the medical profession just didn't have answers for me. (Ricky, 43, interview)

The way Ricky represented themselves through their language as confident and certain of their needs discursively aligns with stability and validity – and thus greater chance of validation by the medical gaze. As previously mentioned in chapter four, diagnosis with gender dysphoria is dependent upon trans individuals self-reporting, such that clinical interactions that lack confidence (for whatever reason) may allow clinical doubt in the service-user, in primary care or GIC contexts.

Jess explained how her experience of being disabled shapes how she is symbolically read, and thus how she is interacted with. Initially, Jess contextualised how her impairment affects her speech and gait, such that she went through both speech therapy and physiotherapy during childhood. Jess articulates that these aspects of her expression that are positioned as “markers of [her] queerness” – their ‘mincing walk’ and ‘gay voice’ – are for her, markers of disability:

I feel like my identity as a disabled person is quite often subsumed into my queerness, and kind of consumed by it. It means that a lot of the time I'm not seen as disabled at all, which can be quite difficult when I need to access disability specific things or talk about disabled people. People see it as being about my queerness. And that's probably because it makes me look physically queer. Which obviously puts me in danger, and allows me easier access to queer spaces... I think that partially it's the disability, those disability markers are being read as femininity, this means that I'm kind of often misgendered as being a femme when what they mean is you're a femme boy, rather than a kind of butch woman. I've also noticed that as another interesting intersection between disability and transness is that I get a significantly less amount of harassment when I'm walking with my walking stick

than when I'm not. So I often feel like sometimes even if I don't need it, I might take my walking stick out. Because it feels a bit like a foil, people see the stick and don't look at you. You've already been classified as a disabled person rather than as a trans person or a gender freak or whatever. It's like people can only see you as one thing. It means that in general I get an easier time of it. So especially if I'm going on long journeys on public transport I'll take my stick, even if I don't need it, because public transport seems to be where most of my misgendering and harassment and sexual assaults and violence happens against me but seems to happen less often if I'm walking with my stick. (Jess, 26, interview)

Whilst Jess's body being symbolically positioned as 'male' by social actors is significant in their walk and speech being read as queer more so than disabled (Whitney, 2006; Sandahl, 2003), by encouraging a disability reading through her use of the stick, Jess can feel protected against transphobic abuse (Schmidt, 2013).

Rachel (28) included material in their diary (figures 10, 11, and 12) raising intersections with their experiences as a disabled person:



Figure 10: Image of disabled individuals in wheelchairs, from Rachel's diary.

Jess may mitigate experiences of harassment through socially positioning herself in a manner which results in her gendered presentation being explained away, rather than punished, which resonates with Rachel's sense that social actors symbolically ascribe

disability as the explanation for 'gender inappropriate' presentation. That disabled people are often socially positioned as either not experiencing or not understanding sexual desire is an ableist trope that is well recognised (Esmail et al., 2010; Di Giulio, 2003). The text overlay in Rachel's image highlights their insecurity in relation to a genderqueer identification. As Rachel did not highlight experiencing any cognitive impairment, this question is likely rhetorical as individuals who are physically disabled often experience being patronised (Stevens, 2014), and treated as if mentally impaired and unable to make 'appropriate' choices by themselves (Aiden and McCarthy, 2014). There is an important intersectional consideration in Rachel's account, as whilst disabled people may struggle to find clothes that are comfortable, accessible, and stylish, a trans identity adds additional constraints to clothing choice. For example, a gendered clothing cut may cause pain due to tightness, or gendered clothing may differ in the difficulty to take on and off relative to the individual's body.

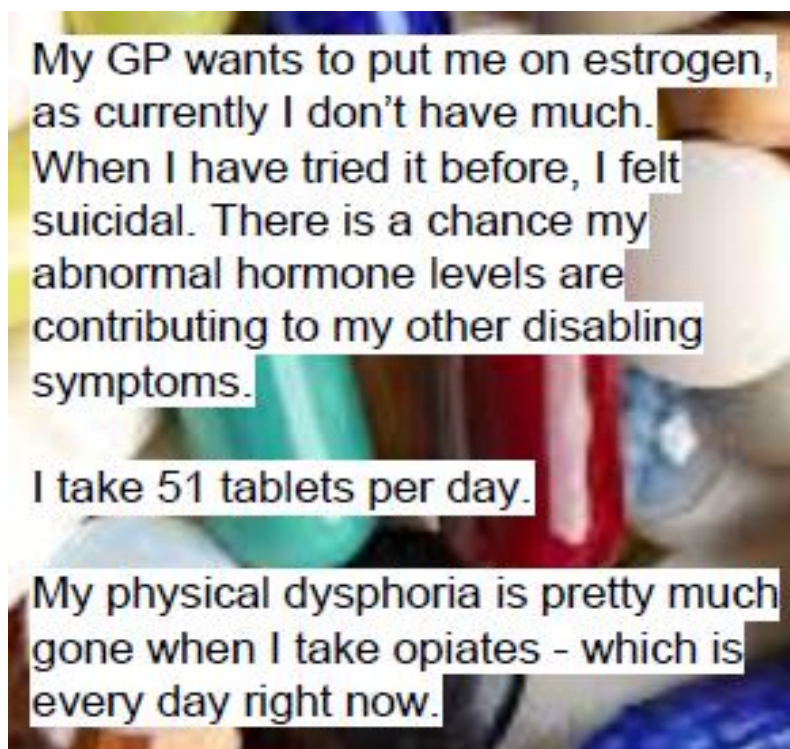


Figure 11: Image of pills, from Rachel's diary.

This excerpt shows how Rachel's experiences of chronic illness and their experiences of gender cannot be disentangled, in terms of medical treatment as well as social interactions. The opiates which Rachel was taking during the diary-keeping period served to relieve their gender dysphoria, though were not prescribed in relation to this. Rachel explained how they did not wish to discuss gender with their doctors because of the potential to disrupt their other carefully managed and highly necessary healthcare

interventions. This was also Bobby's approach to navigating their chronic (mental) healthcare:

Naturally I have not told [the mental health team] any gender stuff... they would almost certainly latch onto any hint of gender identity and DECIDE that everything I'm going through, all of the mental health issues, all of it is entirely based in gender... They will think of my gender identity as either the cause or result or both of this crisis. (Bobby, 23, diary, capitalisation original)

This highlights how comorbidities may synergise with perceptions of healthcare providers to create additional healthcare barriers for disabled trans people. It is recognised that access to mental health care can be limited because of expectations of stigmatisation from those with mental health conditions (Thornicroft, 2008), which is likely to be exacerbated by intersectional fear and expectation of stigma in relation to trans status. Rachel said that "If I can put up with them seeing me as female and using those pronouns and stuff it seems like a better option", because of both the risks and the associated labour (in explaining their feelings to non-gender specialists, for potentially no gain). Rachel's healthcare management can also be linked back to how experiences of non-binary gender is temporally dependent – as Rachel's experience of gender-related distress is significantly different depending upon the medication they are or are not taking at a given time.

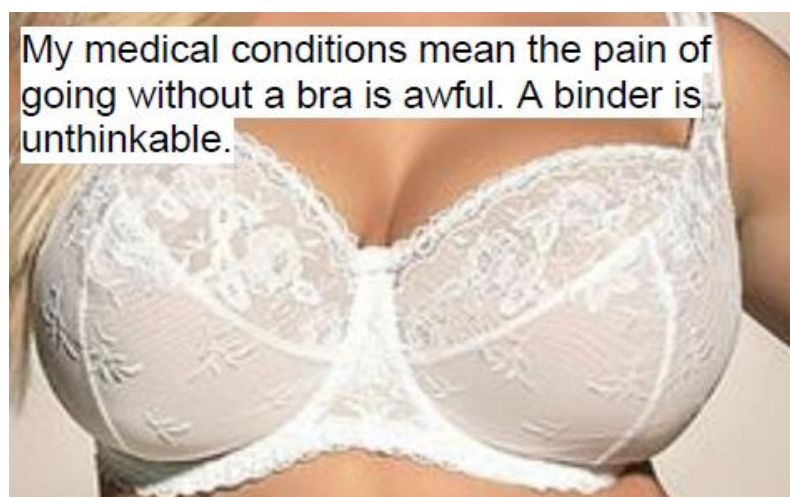


Figure 12: Image of breasts in bra, from Rachel's diary.

This image illustrates how chronic illness and disability can constrain not only access to discussing gender or medical transition with doctors, but also gender presentation, and therefore social interactions. Relating back to figure 3, where Rachel stated "I feel like a

man trapped inside a woman's body. Except the body is comfy and pretty and safe" shows that there are multiple, somewhat contradictory aspects to their experiences of embodiment in particular. Contradiction does not undermine the validity of Rachel's identity, but serves to illustrate how different facets can hold greater or lesser significance in a manner dependent on context and time. Rachel iterates that changing the way they dress to better match their identity actually makes them feel worse, as the disjunction between their physicality and gendered presentation serves to emphasise that they are "trapped inside a woman's body". This serves to disrupt hegemonic narratives of transgender embodiment, which can lack space for experiences such as those who are AFAB, who do not bind, with feminine presentation. Such traits, as well as experience of chronic illness (ME, as with Ricky) were shared by Charlie.

Chronic health conditions and disability thus influence the relationships individuals have with the medical profession overall. Treatments themselves may also significantly impact the experiences of gender dysphoria and/or gendered identity, which feeds into negotiations of the social world. Both Ricky and Rachel showed very different relationships between chronic health and (not) being referred to a GIC. This important administrative process at the primary care level together with the impact of other clerical interactions will now be considered.

Medical Administration – Being Referred, Being Frustrated

In primary care, experiences with non-medical staff and with administrative systems themselves can pose specific difficulties for non-binary people. Jamie's difficulty procuring a name and title change highlighted the potential difficulties and distress that can be encountered when negotiating administrative processes within one's medical practice. Following a six month wait, Jamie gave the practice an ultimatum, threatening to report them to the Patient Advice and Liaison Service (PALS – which supports formal complaint proceedings within the NHS):

They rang me on the last day of my ultimatum to say 'I don't know if you know, but it's very complicated what we have to do, we have to get a new NHS number' I know! I gave you the guidance of what to do! Don't tell me what you have to do as if I don't understand how complicated it was. (Jamie, 24, diary)

The nature of this interaction follows a parallel narrative to that of the 'expert patient' (Taylor and Bury, 2007), which subverts power dynamics through challenging and

resisting the supposed expertise of the clinician. In this case however, patient expertise is demonstrated in healthcare administrative policy, thus challenging the administrator. This expands the role and knowledge of the expert patient beyond healthcare decision-making, such that an individual becomes a 'manager patient'. I use this term to refer to contexts where rather than (only) demonstrating significant familiarity with medical literature and expert status in relation to transgender healthcare, the patient performs managerial labour in guiding and instructing medical staff in processes of medical administration. Thus, 'expert status' can extend beyond the doctor-patient interaction, due to the significance of gender in record-keeping that does not intersect with other examples of expert patients. However, the patient still lacks the power to enforce their knowledge of institutional policy, and remains dependent on staff following their instruction – which, Jamie's circumstance demonstrates, cannot be depended upon.

This altercation highlights the inadequacy of the current system in allowing for record changes. This is not only due to the (arguably unnecessary) complexity of the task itself, but the lack of appreciation by administration that the delay in affecting the change could result in anything more than mild inconvenience rather than significant distress. Leon also experienced problems, specifically stating in their diary that "The practice won't seem to let me go by my preferred name". This could suggest a lack of transparency around name change protocol making it difficult for Leon to access, or inconsistency between the policies of different clinics. It also raises the question of clinic policy on recording preferred names (for waiting room announcements and interactions), and whether administrative systems are built to be able to accommodate this universally. The potential impact of dysphoria and stress through administrative delays and the excessive patient labour this can demand is emphasised through Jamie's statement that "It's been really stressful and horrible, because it definitely puts me off going to the doctor. It nearly put me off going for a mole which has now been diagnosed as possibly melanoma".

Conversely, Mark indicated he was impressed with the clinic's sensitivity of communication (from the position of having had his gender marker and name successfully changed on his medical records):

The letter was addressed to Mr. [surname], and used impeccable language, which I suspect took someone some time to formulate, given that I am a Mr. with a uterus and ovaries. (Mark, 43, diary)

Mark praises the nameless staff member who wrote the letter for respecting his title and pronouns in a context of writing about his uterus and ovaries, stressing the awareness of how the social possibility of 'a Mr with a uterus and ovaries' is rarely recognised. Mark's satisfaction may also potentially be influenced by the extensive misgendering that practically all transgender people have experienced. Contexts such as this, where the respect, and, by proxy, social legitimacy of gender identity is threatened (in this case through the explicit juxtaposition with physiology) may result in relief when avoiding being misgendered. In a sense, Mark may be grateful for a level of nuance rarely found outside of transgender communities, which contrasts with the frustration that other participants articulate when expecting and experiencing administrative misgendering. This example also demonstrates how a non-binary identity is not a reliable predictor of title (or pronoun) usage, with Mark using 'he' and 'Mr', rather than 'they', and 'Mx'.

The fact that Mark's administrative markers of name, pronouns, and title are all socially coded as 'male' likely assists in consistent and aware administration, than if potentially using the title 'Mx' or singular they as a pronoun. Mark also further evidences performing the role of a 'good patient' in an administrative as well as clinical setting, through deliberately articulating a presentation that is more feminine or camp than he generally would. This affectation serves not only to position him as non-threatening to reception staff "Trying Very Hard to be nonchalant" (note the deliberate capitalisation for emphasis from the diary entry), but also to assist in the negotiation of his own comfort levels within the setting of gendered medicine. In performing himself as a feminine (rather than masculine) male, Mark aims to ease the symbolic dissonance staff may view between his identity and embodiment.

Despite being broadly comfortable with being socially read and positioned as male in navigating day-to-day life, Mark explicitly states feeling uncomfortable as male in the gynaecologist's office, alluding potentially to how the space is socially constructed as 'for women'. Whilst an explanation in terms of dysphoria is also possible, it is problematic to assume this as a/the source of Mark's discomfort, and would risk further reinforcing the clinically constructed, hegemonic, binarised narrative of gender dysphoria.

Frankie (25) used her diary to share her thoughts and feelings concerning primary and secondary care administration, particularly her engagement with feedback forms. Frankie shared photographs she had taken of feedback forms she had filled in after attending particular secondary and tertiary care appointments:

No personal information will be shared.

Please mark your answer with a cross (x) in the box.

About you

Are you? Male Female **NON-BINARY**

Age group? 0-14 15-24 25-34 35-44
 45-54 55-64 65-75 75+

What was the purpose of your visit today?

MRI CT PET/CT Ultrasound
 Audiology ENT DXA X-Ray
 Echocardiogram Cardiology Endoscopy Blood Pressure
 ECG Breast Imaging Other

Please rate your overall satisfaction with the service

Excellent Very Good Good Fair Poor

Figure 13: Scan of secondary care clinical feedback form, from Frankie's diary.

| | | | | | |
|--|-----------------------|--------------|----------------------------|-----------------|-------------------|
| 1. The administrative staff were pleasant and respectful. | Strongly Agree | Agree | Neither Agree Nor Disagree | <u>Disagree</u> | Strongly Disagree |
| 2. The clinician was pleasant and respectful. | Strongly Agree | <u>Agree</u> | Neither Agree Nor Disagree | Disagree | Strongly Disagree |
| 3. I feel listened to. | Strongly Agree | <u>Agree</u> | Neither Agree Nor Disagree | Disagree | Strongly Disagree |
| 4. I feel involved in my treatment. | <u>Strongly Agree</u> | Agree | Neither Agree Nor Disagree | Disagree | Strongly Disagree |
| 5. I have confidence in the abilities of the clinician. | <u>Strongly Agree</u> | Agree | Neither Agree Nor Disagree | Disagree | Strongly Disagree |
| 6. I am likely to recommend this service/team to friends or family if they need similar care or treatment. | <u>Strongly Agree</u> | Agree | Neither Agree Nor Disagree | Disagree | Strongly Disagree |
| 7. The information was provided in a way that was understandable. | <u>Strongly Agree</u> | Agree | Neither Agree Nor Disagree | Disagree | Strongly Disagree |
| 8. Any questions I had were answered. | <u>Strongly Agree</u> | Agree | Neither Agree Nor Disagree | Disagree | Strongly Disagree |

Figure 14: Scan of GIC feedback form, from Frankie's diary.

As the first image shows, Frankie rated her overall satisfaction with the experience of receiving an ultrasound scan 'excellent', although she did also point out in the additional comments section how the binary tick boxes for gender did not provide her with an acceptable option for her identity at that time. The second image was taken of a feedback form following a secondary care appointment with a Gender Identity Clinic. Whilst Frankie's views on secondary care will be further explored in the next chapter, this feedback form illustrates how the only aspect of Frankie's experience that was particularly problematic was that of administrative staff. Whilst Frankie felt involved in her treatment and confident of her clinician(s), there remained aspects of their respectfulness and ability to listen that could be improved upon, despite offering overall very positive feedback.

Secondary and tertiary care contexts produce forms for the collection of healthcare-related information that is more specific than primary clinical needs. However, Jamie's (24) discussion of one such form highlighted significant problems with its construction and resultant impact, as discussed in chapter four. The length of the form meant a larger burden was placed on patients who were required to complete it, and the ambiguous or uncertain purpose of some questions inspired anxiety. Jamie highlights how the psychopathological construction of gender dysphoria has led to clinical assumptions that feelings about parts of the body can be articulated in simple positive or negative terms, that can be essentialised to thirty-three specific body parts (Nottinghamshire Healthcare NHS Foundation Trust, 2016b, p. 9). Jamie demonstrated in his diary how flaws in the form's design render it vulnerable to deconstruction and ambiguous interpretation.

Jamie's discussion within his diary showed he was scrutinising the questions to assess the purpose for which they were being asked, but experienced anxiety due to lack of transparency from the Gender Identity Clinic concerning how such information might be used by medical practitioners. For example, on reading questions asking whether the individual felt their buttocks were too big, Jamie interpreted this as potentially screening for the presence of an eating disorder, which could then jeopardise being seen as 'really trans'. This provides an example of a phenomenon already observed within binary trans navigations of Gender Identity Clinics – significant anxiety concerning how clinicians make their assessments, and a desire to fulfil expectations (by performing the role of 'good patient') as accurately as possible, so as to successfully access desired outcomes. For non-binary people this is particularly difficult, as non-binary identification in and of itself defies current historical medical precedent.

The presentation within the form inspired feelings from Jamie in the diary that “they seem like terrifying unknowns designed to trip you up, to trick you into revealing that you’re not trans at all”. This resonates with how Jess described her sense of GIC care provision processes:

It is incredibly pathologising and essentially assumes that the person being referred to them is a cis person who is having some sort of delusions. The kind of process isn’t a process of affirming people’s genders but is a process of trying to ‘catch out’ the secret cis people who are deluded enough to go through this process. And in that way obviously the trans healthcare system is actually entirely built around cis people, and ‘saving’ cis people from becoming trans. Which is one of the reasons why it’s particularly bad for non-binary people, because people have a particularly binary focussed way of understanding what trans is, and so if you show any deviation from a binary transition pathway or a binary life then you’re likely to be seen as a deluded cis person. (Jess, 26, interview)

That Jamie recounted how his transgender community group engaged in a particular discussion of the Gender Identity Clinic’s form illustrates how members of queer communities can function to assist each other in navigating healthcare. This can influence which clinics trans people choose to access. Finn described:

I’ve got a [GP] who is more trans friendly/actually knows what to do. So I’m going to ask them to refer me to [GIC], because I recently made a trans friend who has had a really good experience there. They were seen in a lot shorter time, one of his clinicians is trans and I was like ‘wow that sounds so much better’. And I have a friend in [city] who I’d be able to stay with if I needed to. (Finn, 22, interview)

Thus, Finn’s decision to access a particular clinic was directly informed by the sharing of experience from another trans individual. The reputations of clinics (and individual clinicians) spread within transgender networks so as to influence patterns of access.

The remainder of the excerpts addressed in this chapter will relate to experiences and views of the referral process from primary to secondary care. As presented within this chapter’s introduction, it is not necessary for GPs to make any form of assessment before referring individuals to Gender Identity Clinics who make such a request.

Guidelines simply state “those who need gender identity services for the first time should be referred by the GP” (Wylie et al., 2014, p. 17). However, there was a sense amongst participants that getting referred could be an unnecessarily arduous process. Jamie stated that his GP felt that “it was important [for him to ask questions], ‘I’m only going to refer you if you tell me that you’ve felt like this for years and years’ so I lied”. In this context, ‘it’ was the sense that there was a perceived need to ask questions, that by the GP’s understanding, the GP’s role is that of gatekeeper. When considering referral to secondary or tertiary medical services more generally this is rooted in a UK-specific historical context of demand management (Loudon, 2008). The ethics around gatekeeping practices have been considered, with the potential for under-referral to save medical resources, or over-referral in private ‘for-profit’ care being particularly problematized (Pellegrino, 1986). The complete absence of pathology in the specific case of binary and non-binary transgender identification fundamentally differentiates gender identity-related medical interventions from other healthcare referrals. Increasing recognition of this through education and trans service user demands is bringing the role of the GP into debate (Singh and Burnes, 2010). There was a sense that when GPs are asked to provide referral, they can be unfamiliar with what this means:

They generally don’t have any idea about trans stuff. You know, they’re reluctant to do stuff like referring you to GICs, to monitor you once they get you back, to even treat you for other medical stuff because they get side-tracked by trans stuff. (Rachel, 28, interview)

So then I went to the GP here, who was utterly clueless about... she said outright ‘I’ve never had a trans patient’, in some convoluted way, like ‘I have never had a transgender’! (Leon, 34, interview)

The potentiality of a wide range of GP responses from experience and reassurance to ignorance, stigmatisation or rejection may present a significant barrier; as with Hal’s or Jess’s more general reluctance to see their GPs (as discussed earlier in this chapter), non-binary people are primed to expect an environment within the clinic which does not understand them. In Jamie’s case, his GP showed their lack of knowledge of this particular care pathway:

The GP was like ‘I’m so pleased to see you, how many appointments have you had’ meaning [Gender Identity Clinic], and I looked at him

and said 'I'm on a 6-8 month waiting list which is one of the shortest in the country' and he didn't have a clue. (Jamie, 24, interview)

The extensive waiting lists for GICs are well known within transgender communities. From Jamie's position then, not being aware of a piece of information discursively coded as 'common knowledge' serves to further undermine trust in the GP's ability to occupy the position of expert in relation to (transgender) healthcare, which the doctor-patient relationship initialises and assumes. This example further emphasises the common need for transgender patients to explain their healthcare requirements and experiences to under-equipped practitioners. Finn said:

My appointment with my GP where I asked for a referral was painful but ok – I had to do what felt like a tutorial in gender 101 with her, explain my identity, define different terms, and detail why I want hormone replacement therapy. I got asked a lot of questions that I don't at all see the relevance of – things about my sexuality, my relationships, my sex life. I answered them because I wanted to seem cooperative, but all the time I kept wanting to yell "THERE SHOULD BE TRAINING FOR THIS, WHY DO YOU NEED TO KNOW THIS, JUST REFER ME!" (Finn, 22, diary, capitalisation original)

This can render the most vulnerable members (who may be significantly distressed by such an interaction due to mental health difficulties, and who may thus be unable to educate their GP) of the non-binary population even less likely to be referred easily. Finn is clearly frustrated by a lack of adequate training on the topic of gender identity, such that the labour of educating practitioners can often fall upon transgender patients. This is problematic because whether or not such labour is (able to be) performed by the trans patient may change the outcome of the clinical interaction. In addition, the potential refusal of an uncertain GP to make a referral immediately serves to extend the length of time until a GIC appointment can be accessed. This may be a particular source of patient anxiety given the extensive waiting lists. Further, wide recognition of the potential for problematic interactions may result in trans people lowering their standards and expectations of healthcare – such that Finn still describes a "painful" appointment as "ok". The significantly higher rate of attempted suicide in trans people with negative experiences of medical care (Haas et al., 2014), and how well-recognised significant distress is (through medical interactions or other sources) in the trans

community may mean that individuals potentially downplay their negative health experiences when they feel that it 'could have been worse'.

In making such observations I do not infer that GPs actively demand training from their patients. However due to members of the trans community reporting smoother outcomes to each other when arriving prepared with NHS guidelines, or prepared to perform an educative role, there exists a sense within the trans and non-binary community that such actions are advisable, if not necessary. David said:

We hear lots of really great stories about really excited GPs, people come into the group with stories, 'I told my GP I want a referral to the gender clinic, and they were like this is so cool! I don't know what to do about this, I'm going to read all the books, can I google you?!' Sometimes you need to talk them off the ledge! It's quite bad, and the unintentional ignorance, and well-meaning ignorance within the medical community towards trans issues unless they are specifically working within gender identity that trying to bring in gender identity issues on top of that would probably make their heads explode. (David, 31, interview)

This unpacks the important point that lack of experience or knowledge of transgender healthcare does not necessarily mean that GPs are unwilling or insensitive towards binary and non-binary health. A practitioner's expression of desiring further information will have different ramifications, based upon the symbolic interpretation of this by the patient. A pattern could be seen in the language used by participants who had positive experiences of being referred. Individuals repeatedly emphasised that their experience of the system had been 'lucky', or 'fortunate':

I have been incredibly lucky, I don't know why, I've had a really easy run, I've literally got... from the day I went to my doctor to saying can you refer me to the gender clinic to the day I took testosterone was less than a year, which is astonishing. And I do not know how I've been so lucky. Just lead a charmed life, clearly. But that is so atypical. (Ricky, 43, interview)

This implies that whilst such participants had personally positive experiences, in regarding themselves as lucky, they reveal belief that the majority of trans service users have unsatisfactory or problematic experiences of referral. There is a striking

parallel with Frankie's earlier discussion of clinical experience, whereby the positive personal experience is subsumed within the acceptance that the community consensus is very negative.

There is the possibility of confirmation bias – that is, negative narratives receiving more space and attention due to transgender anxieties over avoiding negative healthcare experiences, through learning from those who have come before. However the direct recounting of negative experiences together with (an albeit often binarised) precedent within research on transgender health experiences (Ellis et al., 2015; Quinn et al., 2015; Ellis et al., 2014; Hagen and Galupo, 2014; Bauer et al., 2009; Bockting et al., 2004) means that assertions of negative conditions from those who report positive experiences must not be dismissed.

Mark's experience of seeking referral supports a general consensus that primary care practitioners are uncertain how to respond to patients outing themselves as trans and requesting referral. It is notable that rarely do these experiences involve specific mention of non-binary identity, likely due to appreciation by non-binary people that this could serve to result in a greater burden of education or further trouble their access to tertiary care. This would demonstrate the concept of 'strategic simplification' introduced in the previous chapter. Mark's account highlights his expectations regarding the presence of trans community, which was not met:

The very first doctor I went to see... well put it this way, my expectations going to see a doctor to speak about gender were... I would talk about it, and I don't know, maybe they'd give me a leaflet or something, then perhaps they'd give me the details of a local support group and off I'd toddle with all my bits of paper, thinking 'ee, I've done something!'. Didn't quite work out like that. Went to see a lovely doctor who freely admitted that she didn't have a clue. But having googled a few things, in front of me! Said she would find out. And actually somebody finding out about stuff from an honest starting point I had no problem with. And actually she was really good, and did get me my first referral. I didn't get my leaflet for a support group, because there wasn't one. (Mark, 43, interview)

Mark went on to explain how this motivated him to create a local support group. This instance still illustrates that interactions with medical care can catalyse involvement with community. This may be because Mark felt ready, having taken the (medicalising)

step that is discursively linked with legitimacy. This also highlights the additional problem that primary care practitioners may be ill-equipped to direct trans patients to additional support.

Lack of education on transgender identities among clinicians, together with unfamiliarity with NHS guidelines, and standards of care, is responsible for commonality in (binary and non-binary) transgender patients perceiving excessive policing from GPs when attempting to be referred to a GIC. It is common for GPs to practice gatekeeping, only sending a referral letter if and when the trans patient has adequately performed their trans identity. Jamie experienced this directly “he didn’t need to ask me any questions but was asking ‘how long have you felt like this’ when I asked to be referred to the GIC”. Thus in order to negotiate (undertrained) primary care practitioners, non-binary people can utilise a binary narrative, explaining Jess’s assertion that non-binary people can be ‘forced into a binary gender’.

Participants could make points about perceptions of practitioners that cut across primary and specialist care:

Everyone who I know who’s trans has had really bad experiences with the medical community, both with trans specific healthcare and general healthcare. (Rachel, 28, interview)

This is a significant difference from other patients with specialist needs, who whilst frustrated by gatekeeping practices or lack of ability to provide specialised care, are more satisfied with interactions with specialists (Lewis et al., 2000; Harrold et al., 1999; Kerr et al., 1999; Owen et al., 1997). ‘Coercive binarisation’ and other causes of tension between GIC practitioners and non-binary service users will be further discussed in the next chapter.

Conclusion

The potential for non-binary identification to influence primary care experiences is multifaceted and extensive. Of particular note were the erasure of health complaints due to overemphasis of trans status, avoidance of clinical checks by participants due to negative experiences, or their anticipation, and concerns that raising gender with practitioners could negatively influence access to or experiences of other important healthcare, particularly in relation to chronic illness. Whilst experiences were both positive and negative, participants expressed a universal sense that the non-binary population overall felt negatively about medical care, and broadly experienced that care

negatively. This was particularly related to lack of awareness amongst staff (albeit with the caveat from some participants that staff could be well-intentioned), leading to additional burdens of education and emotional labour for non-binary patients. Participants discussed important trends, such as the inappropriate over-emphasis of gender in medical contexts. Views of medical practice from participants situated differently than 'patient' (such as fellow staff member, or trainer) provided additional insights into medical staff's attitudes and knowledge, when not performing the role of expert within the doctor/patient interaction.

The second section of this chapter engaged with examples of participant experiences of primary care. Whilst positive and negative encounters were articulated, the intersection of particular social phenomena highlighted serious problems with primary care experiences for non-binary people overall. Social processes of gendering are internalised uncritically within medical practice, and lack of specific or consistent training could leave medical and administrative staff unprepared and unaware of important and specific sensitivities relevant to both binary and non-binary transgender identification.

Being recognised by primary care practitioners as transgender can depend upon being read as such, which can be particularly difficult prior to, or without accessing gender affirming medical treatment. In cases where trans status is recognised, this is uniformly within the gender binary, with no evidence shown of specific non-binary awareness. Indeed, those participants who were recognised as trans in primary care contexts did not press for a non-binary distinction, because of the difficulties with negotiating the situation as it already stood – producing feelings of vulnerability as the doctor/patient interactions were being managed.

The intersection of chronic health conditions and disability highlighted the importance of intersectional analyses. Experiences spanning the life course could significantly impact participant's feelings regarding accessing medical care. Further, treatment for unrelated medical conditions could alter the relationship had with dysphoria, or with gender itself. This could then feed back into social interactions that permeate all aspects of lived experience, raising many highly specific questions about transgender healthcare intersections that have yet to receive any detailed academic attention.

Finally, administrative systems (including detail changes, feedback forms, and secondary care information forms) all demonstrated important problems that impacted how non-binary identified individuals went about or could negotiate existing medical

practice. It is imperative to note that the heterogeneity of experiences in primary medical care will depend upon factors such as whether an individual is 'passing' deliberately as the gender they were assigned at birth, whether they are regularly misgendered and how this affects them, whether they wish to access a GIC, and how much experience an individual has with negotiating interactions with the clinic since articulating a transgender identity. Such factors also play an undeniable role in the negotiation of secondary/tertiary care at GICs, as the next chapter will explore.

Chapter 7 – Ticking the Legitimising Boxes? Non-Binary Perceptions of Gender Identity Clinics

“I did once express how I was feeling confused about my gender... and they promptly withdrew my diagnosis,” “any sign of ambivalence is used as an excuse to delay your transition,” “the fact that I confidently voiced uncertainty about my gender with the doctor meant that he didn’t take my trans-ness seriously.” This particular issue was even more acute for those who did not define unequivocally as male or female.

(Ellis et al., 2015, pp. 12-13)

Introduction

There exists a wide body of literature addressing access to medical services for gender transition (Dewey, 2013; 2008; Obedin-Maliver et al., 2011; Feldman and Goldberg, 2006; Keller, 1999). Whilst much of this literature was reviewed across chapters one and two, there is a significant lack of empirical sociological consideration of *non-binary* experiences of GICs, which this chapter addresses through attention to participant perceptions.

Echoing the opening of chapter six, this chapter first reports participant views of secondary and tertiary care. This includes the perceptions of those non-binary participants who have yet to, or do not intend to access such services, as well as individual’s views on how non-binary communities as a whole perceive secondary and tertiary gender-related care in the UK. I follow by considering experiences had by non-binary people under the care of NHS-run UK GICs, and private medical care. These experiences relate to accessing gender affirming medical services, such as HRT and surgeries that are desired in relation to gender.

Non-Binary Views of Medical Practice Related to Gender Transition

There was a strong sense of agreement among participants that avoiding any mention of non-binary, or claiming a binary identification, would be their best tactical option for obtaining access to gender affirming treatments as quickly and easily as possible. This is supported in chapter four by Frankie’s (25) discussion of her primary physician explicitly positioning binary transgender people as ‘easier to treat’ than non-binary trans people. In considering how he would communicate at his first GIC appointment, Jamie

(24) noted in his diary that “I’m just gonna tell them I’m not female; that’s not a lie”. He went on to say that:

I haven’t learned anything about their attitudes to non-binary people that would convince me to do differently than bend the truth to the max.
(Jamie, 24, diary)

That Jamie ‘hadn’t learned anything different’ reminds of the common behaviour among trans people looking to access GICs to seek out as much information as possible, in relation to what to expect from their practitioners – from both NHS and community sources. The reasons why participants felt that even GIC specialist physicians were poorly equipped to address their needs sensitively were most often rooted in what individuals had gathered from the wider community, broadly similar to views participants had of physician trans sensitivity in chapter six:

I have had it expressed that some doctors are completely blind in this area, especially for transitioning, whilst others are more open to it, because they’re just... for some reason, especially with doctors who are in an area of transitioning, they don’t even know anything about that. They always give the wrong gender, say the wrong things... but they work in that area. (Zesty, 22, interview)

Zesty indicates the concern that when specialist doctors working with gender make language-based mistakes concerning names and pronouns, trans people accessing GICs generally are disheartened and doubt the clinician’s expert status. This is because of how validating and respectful use of language is positioned as both fundamental and not particularly difficult by the trans community. The importance of such social interaction is a significant difference from other examples of tertiary care, where the doctor’s expert status would be unlikely to be undermined by the language they use. Due to the now heavily interconnected nature of the trans community, many accounts of GICs are within intimate interpersonal networks, rather than from anonymous or unknown sources, which may be deemed less reliable. Reports from trusted friends of inadequate experiences of healthcare are more likely to be taken seriously, and negatively impact the reputation of GICs. Community solidarity thus means scepticism of positive practice is more likely than scepticism of negative reports of doctors from other transgender people, as with negative experiences of primary care discussed in the previous chapter.

Because of the sense within trans communities of both ignorance and insufficient nuance in the medical practice at GICs, the desire to perform the role of the good patient (Lorber, 1975) is explicit; the good patient in this context being the individual who unproblematically matches prior precedent for treatment, which fits within the gender binary and clinician expectations. Further, as in other medical contexts, patients must perform the sick role (in this case, fulfilling the practitioner's view of 'trans'), as introduced in chapter one.

Stewart and Sullivan (1982) explain how in the context of many chronic illnesses "the entire illness behavior process appears to be characterized by definitional and role clarity, consensus and harmony. It is proposed that, in contrast, when physicians have difficulties diagnosing and treating an illness, as is the case in multiple sclerosis and many other chronic illnesses, the entire process is more problematic. The situation is less normatively controlled and as a result, social dissensus and disharmony are likely to occur" (Stewart and Sullivan, 1982, p. 1397). Therefore, it is not simply *good patient* behaviour that individuals feel compelled to perform, but narratives that allow them to *be* positioned as patients. As already established, binary and non-binary trans identities are not chronic illnesses; the value in conceptual comparisons lie in how medical treatment pathways model and address them similarly.

Mark (43) highlighted in his diary how this can lead to internal negotiations and performance of gender which can lean towards gender stereotypes:

The trouble is we soon learn how to jump through hoops. To be accepted as a trans man, one is expected (and not just by the medical/psychological people) to be a man. Be A Man. And it isn't just the outside world, either. Our internal censor tells us that if we aren't women, then there's only one alternative...



Figure 15: Stylised drawing of the word 'man', from Mark's diary.

By switching from his typical handwriting to draw out the large, angular, capitalised and monolithic 'MAN', Mark is highlighting his view that to most successfully 'jump through hoops', that is, successfully fulfil the expectations of the GIC to be found to be in need of gender affirming medical services, simply proclaiming one's gender identity with confidence and certainty is not enough. The stylisation highlights the difference between being a 'man' and being a 'MAN', the implication being that the latter embodies a desire to fulfil hegemonic masculinity (Connell, 1995). Such reflections from Mark resonate with Foucault's 'technologies of power' (Deetz, 1997; Foucault, 1988), whereby individuals submit their conduct to a particular end, on the basis of an unequal dynamic with others. In other health contexts, such as the diagnosis of CFS (Chronic Fatigue Syndrome), "a diagnosis is a legitimacy awarded to those who are easily medicalized" (Clarke and James, 2003, p. 1389). In the context of gender, attaining such validation may be thought to be (or found to be) more likely if one positions oneself as undeniable as possible through hegemonic behaviour reproduction, producing a 'supernormal self' (Rinken, 2000) by exceeding the gendered demands made of cis people. The epistemological primacy afforded to genitals at birth in situating gender means that greater deviation from norms can be seen in cis people's presentation and behaviour without the 'truth' of their genders being brought into question.

It is also clear that Mark recognises such gendered policing as problematic. His method of highlighting his view (that hegemonic masculine presentation and attitudes are somewhat expected from individuals assigned female at birth) is presented humorously, with the literal 'GRRRRR!!' parodying and ridiculing rigid gender expectations of manhood. Importantly this is not simply directed at clinical practitioners, but also at "our internal sensor". Mark is here expressing his view that the synergy between not wanting to be read as how one was assigned at birth, together with doubt or refusal of acceptance from others, and the corresponding insecurity and instability this can produce, can lead to over-compensation in order to legitimise oneself as trans.

Finally, even whilst Mark's non-binary identification is such that he felt the desire for inclusion within this project, his view of accessing the GIC makes no mention of this, and was entirely in binary terms – supporting the notion that binarised gender enactment in the clinic is common, and frequently viewed as necessary among non-binary people. An alternative possibility for some (as earlier discussion of the 'stepping stone process' intimated in chapter five) is that non-binary identification may be self-conceptualised after medical transition has already been successfully accessed. Jamie

immediately made reference to 'what one heard' from the trans community, in reference to their view of non-binary experiences of GICs in comparison to binary trans people:

From what you hear, and this is internet communities now, more disbelief, more suspicion, more concern over trans regret. There seems to be the assumption that non-binary people just aren't sure, that being non-binary means an unstable identity. (Jamie, 24, interview)

As discussed in the previous chapter, the positionality of non-binary as unstable, liminal, or 'in-between' male and female (Wilson, 2002; Herdt, 1993) means that the societal pressure to fit within the gender binary is an important differentiating point between binary and non-binary transgender identity negotiation. Binary trans people can, in particular ways, still experience this, for example, those who have difficulty 'passing' in their identified gender and are stigmatised as a result. However, the desire to be viewed as a man or a woman is inherently more intelligible, even as any trans status at all can still be problematically positioned by some as outside of being 'really' male or female (Roen, 2002; Billings and Urban, 1982).

Jess builds on the suggestions that Mark makes regarding expectations (and evidence) of the clinic responding better to more normative articulations of gender:

In order to get access to these medical treatments, you have to conform to cisnormative standards of beauty, you have to conform to cisnormative standards of masculinity and femininity. It often becomes a competition of who can fulfil these roles in the quickest and most attractive way. Even if you're a binary trans person that's how it works. Even if you're non-binary it becomes like a mini version of that. Who can perform these roles in those ways, but be with a kind of slightly sense of edginess which is actually just like a very small socially acceptable dissent from that. But actually there's no real dissent. Within the non-binary community, these kind of norms, these kind of individualising competitive nature of the trans community which really does... which comes from above obviously, but really does undermine our community, our sense of solidarity, our ability to provide mutual aid and mutual support for each other. (Jess, 26, interview)

The current medical system relies upon the clinical judgement and assessment of secondary and tertiary care physicians, whereby a diagnosis of gender dysphoria must be ascertained before an individual can access hormones or surgeries. Jess's account emphasises her view that this system cannot and does not take account of the socially constructed manner in which physicians can harbour gender expectations and (conscious or unconscious) biases towards ratifying some experiences of gender over others. This can also be seen in the context of CFS, where the material evidence of the condition may be disputed. Subsequently, the culturally and temporally specific meanings of illness are reflected in practice, so as to discredit lived experiences, and disconfirm the possibility of diagnosis (Ware, 1992). Evidence of this can be seen, as an example, in the published account of non-binary patients by Dr. James Barrett, a lead clinician and consultant psychiatrist at the Charing Cross Gender Identity Clinic in London. Barrett summarises non-binary individuals seeking gender affirming medical services by saying:

These patients are very uncommon, and accordingly remain mysterious. They seem mostly to be female, and to have either a poor ability at (or perhaps a low interest in) interpersonal relationships. Certainly, there seems not to be any sexual motivation in what they seek. Patients of this sort nearly all had rather cold, schizoid, personalities. They have tended to lack humour. Two have been fluent in psychological-sounding jargon, yet were unable to draw abstract meaning from a common proverb. It is unclear whether there is benefit in acquiescing to these patients' requests. Certainly, the numbers are so small that there is not even a clinical impression of prognosis. It might perhaps be best to comply with the wishes of a group of four or five such patients (on the strict understanding that they accept that a good outcome can be in no way guaranteed), and then to declare a moratorium on all others until the first four or five have been followed up for at least 5 years (Barrett, 2007, p. 43).

It is of course important to note that such views may have evolved, as the visibility of non-binary people has increased extensively in the nine years since this stance was published. However, the availability of such an assessment of non-binary identification, easily accessible through the internet, means that non-binary people may judge this as supporting negative accounts reported by other members of the trans community.

Barrett here illustrates a pathologising and othering approach through the language used to describe his non-binary patients. There has also been historical precedent by which attempts have been made to subcategorise (in hierarchical terms) transgender people, such as the demarcation of 'primary' and 'secondary' transsexuality (Person and Ovesey, 1974a; Person and Ovesey, 1974b), and differentiation on the basis of sexuality, such as with the conceptualisation of autogynephilia (Blanchard, 1993; 1989b). Even in the contemporary landscape, it is likely that clinical attempts to estimate the proportion of patients who are non-binary will be too low, given the likelihood that some of the non-binary population completely obscure or otherwise resist divulging their non-binary gender identities.

Such conceptualisation of trans identification has been extensively critiqued and dismantled (Baril and Trevenen, 2014; Serano, 2010; Ware, 2010; Campbell and l'Anson, 2007; Eber, 1982). No recognition is given to the potentiality of such theorisations ('transsexualism as 'primary' or 'secondary', or autogynephilia) as problematic within Barrett's work. Joy Diane Shaffer positions such work centred around demarcation and explanation as illustrative of how "academic physicians and psychologists were often more interested in validating their own theories of the aetiology of transsexualism than in helping transsexuals to live happier lives" (Shaffer, in Israel and Tarver II, 1997, p. xi).

Jess's point is that, for as long as roles must be performed in order to access gender affirming medical services, a hierarchy will favour those able to fulfil the expectations and desires of physicians. Whilst normative roles are performed by patients generally seeking all kinds of treatments, a non-binary identity inherently positions an individual as non-normative. The medical culture of normalisation therefore inherently and fundamentally disadvantage anyone with a non-binary identity seeking transition services. Whilst changes in social and clinical norms regarding how trans people are conceptualised shows that "boundaries of normality can be fluid" (Tishelman and Sachs, 1998, p. 48), the lack of clear diagnoses for non-binary people at this time troubles the ability to source legitimising discourse from medical professionals. Conversely, the increasing challenge non-binary people pose to existing medical models encourages professional shifts, such as the revisions to diagnostic manuals.

Connection between Jess's views of trans people needing to conform to "cisnormative standards of masculinity and femininity" together with Dr. Barrett's disdain at his patients being "fluent in psychological-sounding jargon" can be made with an experience that Jamie recounted:

So for example I read a horror story really, recently about someone online who'd seen a private gender clinic and been told 'oh you seem very feminine, (someone who identifies as male) I think people have way too much access to information about being trans now, it confuses people...' this is all the stuff that I'm scared about [a doctor saying]. Pretty much every time I think about it, try to sleep actually, I start thinking 'god what will they ask me', how will I strike a balance between telling the truth and making sure they think I'm trans enough to get treatment? So that involves lying about when I realised it. Overemphasising some aspects of my past which I wouldn't emphasise that much, unless I knew that they kind of ticked legitimating boxes. (Jamie, 24, interview)

Here we anecdotally see a physician specialising in gender identity services (though working privately) voicing the opinion that "people have way too much access to information about being trans now". This is indicative of the view by some doctors that it is (and should be) the role of the physician to diagnose an individual's 'gender condition', and that their judgement is more reliable and authoritative than the patient's. This can be understood as a response from doctors to symptoms that are unverifiable, and depend entirely upon patient self-reporting. Such a reliance challenges the ubiquity of medical control, and inspires mistrust – as seen in the self-reporting of pain by patients in prison diagnosed with cancer, and physician suspicion of exaggeration of pain as part of drug-seeking behavior (Lin and Mathew, 2005). Whilst illustrating the conundrum for practitioners of how to trust self-reporting from patients, the unique example of transgender identification can be fundamentally demarcated due to being a question of agency over desired embodied change being legitimised, rather than treatment of pathology (or the subversion of medical resources under such a claim).

NHS England adopted the current interim protocol from NHS Scotland in 2013. This interim has yet to be updated after over three years, demonstrating how the development of protocol and best practice guidelines is, as it stands, too slow, as well as problematic in attempting to view gender identity in an essentialised and reductionist manner. The physician's view amounts to a desire for greater passivity in patients, and greater deference to physicians' decision making rather than having to address complaints and challenges from expert patient (Taylor and Bury, 2007; Fox et al., 2005; Donaldson, 2003; Prior, 2003) members of the trans community.

A physician-dominated power dynamic is also implied by the view that there is a lack of transparency in GIC practices toward the trans community. Jamie expressed that:

Jamie: Well nobody knows what the medical community thinks, and that's one of the major problems. We have no idea what they think of us.

Ben: Do you think that scares people?

Jamie: Yes, very much. There's no transparency, we said before about waiting lists, there's no transparency about that, about what happens at appointments, or the attitudes of different clinics. (Jamie, 24, interview)

This lack of transparency may be linked to notions in the medical community that such information would make it even easier for trans people to perform an expected gender role. When Dr. Montgomery, former Clinic Director of Charing Cross GIC, was asked at the Third International Gender Dysphoria Conference his view on patients prepared to “do virtually anything” to access treatment, his response was “if you are prepared to lie to get it, then you can't expect the co-operation of psychiatrists” (Montgomery, 1994, no pagination). The age of this quotation means that it is important to recognise significant developments in practitioner attitudes over the past twenty-two years. However, this quotation does further contextualise the historical tension between transgender patients and gatekeeping practitioners – that access to services must be ‘earned by good behaviour’. Further, it illustrates how practitioners can deem it appropriate to essentially ‘punish’ ‘dishonest’ patients through the denial of service, rather than appreciating the social factors that yield patients who feel unable to be entirely candid. Once again, this is the employment of gatekeeping practices in retaliation for breach of one of Parson's (1951) sick role criteria – that one is expected to cooperate passively with medical professionals to be granted sick role status.

Pig was very clear that whilst they would ideally like to access a GIC, they were unwilling so long as the system continued in its current form:

With gender services, I would totally be up for talking to people about how I feel because I want it to be on record that I exist, however I don't wanna have to pay for the privilege of it, or have to be patronised by some middle aged heterosexual wanker with a massive ego. (Pig, 30, diary)

This also raises a further element of GIC appointments – that non-binary individuals have the extra dimension of potentially feeling validated through ‘being on record that they exist’. This could be experienced as exciting, or conversely as a burden or pressure. This is in addition to the potential to be disheartened by non-binary erasure within medical practice. Jess agreed with Pig’s implication that GIC appointments do not necessarily centralise the non-binary service user’s experience under current practices:

I’m not really convinced that medical practitioners have non-binary peoples’ interests at heart. And again that’s why people end up getting spewed out of the NHS system and de-transitioning, because they’re forced into binary pathways. I think private doctors are much better at non-binary issues. (Jess, 26, interview)

Whilst private physicians are still bound to ethical practices of care, the interplay that may occur between NHS doctors and protocol (be that refusal to act outside of protocol guidelines, or the potential for patients to challenge for going outside of guideline recommendations) is not present. As appointments are paid for, it is possible for private consultations to be considerably faster as there are no waiting lists as there are for NHS clinic appointments⁶⁷. Thus Jess indicates a view that there is a discrepancy between private and NHS transition oriented care, indicating how in her view, NHS guidelines may be more problematic than beneficial. This may be connected to the conceptual shift of patients to consumers (Hall and Schneider, 2008; Hardey, 2001), and doctors as facilitators of choice rather than gatekeepers to resources (Tummers et al., 2013).

Private medical practice generally (rather than specifically in the context of transgender care) has been criticised in terms of potentially engaging in excessive diagnoses and investigations in order to drive up costs, to the practitioner’s benefit (Bhat, 1999). This does not translate well into the context of transgender care however, as patients are not ‘told what they need’ by clinicians, but either make the requests directly, or undertake a process of negotiating what they feel they need (such as through a course of psychotherapy). Whilst private healthcare is costly, it does have the benefit of avoiding the extensive GIC waiting times that are a central point of criticism and

⁶⁷ Anecdotal accounts of private gender clinic appointments indicate that a first meeting can be accessed within several weeks of first contact, with follow-up appointments occurring at intervals of several months.

frustration within trans communities. More specifically to non-binary individuals, Jess's sense that private doctors are much better than NHS doctors may be due to feeling that binarised gendered performance is not (as) necessary in such contexts, as self-funding re-contextualises the power relationship between service-user and clinician. The growth of private healthcare further underscores the discursive shift towards patients as consumers and doctors as facilitators of choice.

Whilst NHS guidelines require that gender dysphoria be "persistent and well-documented" (NHS England, 2013, p. 15) for hormones to be prescribed, Jamie expressed anxiety at the idea of interacting with clinicians who may ask for information to determine the legitimacy of his desire for gender affirming medical interventions. Jamie expounded on this in their diary:

There is such a trust issue between the trans community and the medical community. No love lost. Everything I read tells me they're out to trip me up, to prove I don't really want it and haven't thought it through; that they start from a position of disbelief. (Jamie, 24, diary, underline original)

This trust issue that Jamie mentions can be conceptualised 'both ways', in that the transgender community are very wary of being pathologised or denied by medical gatekeepers, whilst doctors (such as the physician discussed by Jamie who expressed their belief that too much knowledge is available) can be concerned that individuals, who may think they are trans but may later have regrets, will use available discourses to 'trick' doctors into providing inappropriate treatments.

One of the reasons why NHS doctors are not very good on non-binary issues is because they're worried basically that non-binary people are confused, might de-transition, might come back and sue, or that they don't understand these issues enough. So often it's a sense of covering their own backs really. (Jess, 26, interview)

Jess's view here can be connected to how, through the hegemonic nature of cisnormativity, there is a sense among some practitioners that the purpose of gatekeeping is to protect individuals from inappropriate treatment. This positions 'not requiring treatment' as the baseline for patient scrutiny and, in doing so, makes the assumption that denial of treatment is the 'safer' route. Further, under such a system, experiences of regret from trans people may be manifested in malpractice cases, such

that it is in the doctor's personal interest to be conservative with treatment recommendation. This helps contextualise why there is a modicum of consensus among participants that adjusting one's narrative to more neatly align with narratives of trans people who have already successfully navigated treatment access through a GIC. In Alex's diary, they discussed their potential plans for the future regarding GIC access, and in the process articulated some of their views:

I'm thinking I might look into if I can earn enough to use some [money] on seeing a private gender clinic. The waiting list for NHS is currently 3 years on Leeds, and from what I've read online they don't have a great reputation for being helpful or easy to work with, especially if you're not someone who strongly and constantly projects the gender norms that they want. Which I probably won't – because even though I'd like to access testosterone, I do have a lot of 'feminine' interests... and sometimes I still cross my legs when I sit – it's pretty comfortable.
(Alex, 20, diary)

Alex here explicitly demonstrates their agreement with Jess's view that treatment access depends upon the ability and willingness to fulfil expectations rooted in normativity rather than clinical necessity. They also illustrate a sense of being disciplined into the production of a supernormal self, seen through how Alex positions 'feminine interests' and 'crossing legs' when sitting as factors which, they feel, could place clinical doubt onto their claim of not being female. There was also the sense, as from Jess, that private treatment is preferable. The extent of Alex's sense that they would struggle to find the clinic "helpful or easy to work with" may have extended into hypercorrection, as they indicate they feel even crossing their legs might affect a GIC appointment. Whilst such scrutiny did demonstrably take place to this extent in the past (Stoller, 1964), clinics are keen to explicitly state that judgements will not be made on factors such as clothing or sexuality (Nottinghamshire Healthcare NHS Foundation Trust, 2016a).

There have been a large number of claims of improper practice towards trans service users in relation to gender, at the GIC level as well as primary care. This was encapsulated to some extent by the creation of a 'Trans Doc Fail' hashtag on Twitter in January 2013, where over 1000 individuals posted to highlight negative experiences. A follow-up survey was then created, prompting many of these individuals to formally report their experiences to the General Medical Council (GMC). This was summarised

in a report by Helen Belcher, one of the transgender activists most centrally involved (Belcher, 2014). The GMC indicated that they wished to investigate 39 of the 98 survey cases anonymously presented to them, with it particularly noteworthy that 63% of complainants had not voiced dissatisfaction through any route before – implying that clinical feedback may fail to reflect the number and extent of negative experiences. The reasons given for this included fear of treatment being withheld or withdrawn, lack of emotional resources to complain, and feeling intimidated.

This evidence suggests that transgender people not only adjust their behaviour to fit with the perceived expectations of GICs, but will also avoid challenging or disrupting physician behaviour they find unsatisfactory. Lack of clinical precedence of non-binary-specific narratives, and overarching cultural unintelligibility are additional potential barriers to clinical access for non-binary services users that do not impact binary transgender people. Therefore, whilst non-binary and binary transgender people experience great overlap in their reasons for negative GIC experiences, there are challenges sourced in the particularity of how non-binary is symbolically interpreted by clinicians. When asking Alex about their actions and intentions in the follow-up interview, they went into greater detail:

I've been trying to see the gender identity service, and I am basically preparing to lie to them, because I know that they have certain criteria. You know, you have to have 'socially transitioned' and changed your name, and all that nonsense, so I'm preparing to almost lie to get access to what I need to [...] I know from talking to people and reading people's experiences that doesn't tend to go down as well with the gender identity services. So I've said I'm probably going to just be like 'yeah, no, I'm just a man, just a man, just give me hormones' because I think that's honestly going to be the easiest way to do it. (Alex, 20, interview)

The most recent criteria that Alex could be referencing are the Interim NHS England Gender Dysphoria Protocol and Service Guidelines 2013/14 (NHS England, 2013). However, the criteria for the prescription of hormone therapy do not formally require name change, or social transition. Indeed, the guidelines specifically state “there is no requirement for the patient to have commenced a social role transition before a recommendation is made for hormone therapy” (NHS England, 2013, p. 15). Social role transition is required prior to accessing genital reassignment surgery. There is a

significant lack of formal research regarding whether NHS physicians place demands on patients in addition to those within NHS protocols, prior to provision of treatment. Berg (1998) discusses how because protocols function as tools which restrict the autonomy of doctors' decision making in practice, they may be resisted as 'bureaucratic' or 'political'. Therefore the existence of protocols and good practice guidelines do not necessarily guarantee the standardisation of medical practice.

This is significant in relation to non-binary gender identity, because of the lack of meaning behind "living in the gender role that is congruent with the individual's gender identity" (NHS England, 2013, p. 19) when one considers non-binary people. Whilst deconstruction of the concept of gender roles can allow this policy to be problematized even when applied to binary trans men and women, there is no obvious way it can be implemented in relation to non-binary people, as no 'non-binary gender role' is socially conceived. Further, current criteria indicate that GICs send a letter of recommendation to the service user's GP, who is ultimately responsible for the prescription of hormones. As the prescribing physician is ultimately held responsible, the potential for misgivings in primary physicians is likely greater when confronted with any individual (whether binary or non-binary identified) if they present in a manner that challenges transgender narratives that have been positioned as typical.

Frankie's personal development highlights how the demands made of trans people to fulfil gender roles may make it more difficult for individuals with particular gender (transgressive) expressions to access some treatments. She says that:

I was never comfortable expressing masculinity from a male-bodied perspective. But since there have been changes going on, with my body, with my psychology and my frame of mind I've found it really, really comfortable to start exploring my masculinity. (Frankie, 25, interview)

The vagueness around what a 'gender role' is in a clinical context, or how different practitioners may subjectively interpret this aspect of protocol, leaves open the potential ambiguity for feminine trans men (or AFAB non-binary people) or masculine trans women (or AMAB non-binary people) to be found to be lacking the clinical criteria for genital surgery in particular, if desired. There is little available evidence that suggests clinics are explicitly aware of, and sensitive to, trans people whose desired presentation, expression, and identity exploration are not rooted in the 'opposite' position to the gender they were assigned at birth.

Minimisation or erasure of non-binary identification was not the only mode of resistance expressed, however. In Jamie's diary, he made mention of:

[Friend], who's been given a three-year wait at [clinic], is basically attempting to blackmail the NHS into giving him hormones sooner by writing a letter that says "I am going to start taking random hormones I've bought off the internet which will be super risky for me, so I am asking for a bridging prescription in accordance with your harm reduction protocol". If it works, he's going to put the text online for trans people everywhere to use, and we will break the NHS together or something... (Jamie, 24, diary)

This illustrates how many members of the trans community have expert knowledge of the relevant guidelines and protocols, as this strategy utilises aspects of the Good Practice Guidelines for the assessment and treatment of adults with gender dysphoria (Wylie et al., 2014). The guidelines indicate the necessity of medical practitioners to consider risks of harm in not prescribing hormones; highlighting the suggestion made by the World Professional Association for Transgender Health's (WPATH) standards of care (Coleman et al., 2012) of a 'bridging' hormone prescription whilst awaiting further assessment. The importance of community is also illustrated by the fact that the individual proposing this resistance to gatekeeping wishes to share the tactic with others, in order to challenge what is viewed as a problematic access restriction. Jamie's facetious positioning of this "break[ing] the NHS" is not hostile to the NHS itself (on which the trans population is largely dependent). Rather, this phrasing can be interpreted as 'breaking' the problematic removal of trans agency regarding embodiment.

It is important to also note that views of GICs were not exclusively negative, which will be seen more extensively in accounts from those participants who have first-hand experience of gender identity clinics in the next section. However, positive comments were given, with caveats of the concerns already discussed.

Some doctors are really quite good in championing the cause, I can think of John Dean, the head of NHS England's gender services, and he's pretty good really for non-binary stuff. He runs the Laurels, which is probably the best gender identity clinic for non-binary people. But he's definitely one extreme, and the vast majority of gender identity clinicians are either ambivalent or actively antagonistic towards non-

binary people, in terms of either seeing it as a phase, or not really understanding it. I think there are huge problems with non-binary people who need to access healthcare who don't conform to people's binary ideas of what gender should be. So as a non-binary person, I would be still more likely to get healthcare if I presented wearing a dress, if I changed my name to a girl's name... I do have a girl's name, but if I did a whole bunch of stuff which is essentially conforming to a binary gender. I think what they're looking for is they're okay with you maybe presenting as non-binary if you essentially tick their boxes of what a binary trans person looks like with maybe a little bit of acceptable 'edginess'. But if you aren't interested in changing your name, if you aren't interested in adopting clothes associated with the 'opposite' gender I think you undergo quite a lot of heavy policing. (Jess, 26, interview)

In comparison to Alex's earlier discussion of lived experience and name change, Jess articulates the view that heavy policing can be expected. This was on the basis of her experiences of providing trans sensitivity training to medical staff, familiarity with medical policy, and, as with many of the participants of this research, extensive networks with many other members of the non-binary trans community. Whilst some of the participants whose general views have been discussed have personal experience of accessing secondary and tertiary care in relation to gender, many do not (as also highlighted by some individual's discussions of their future intentions). The following section will focus on individual accounts, allowing for comparison and contrast with these more general articulations. Such a demarcation allows for difference to be identified between those who have interacted with tertiary care services directly, and those who have interacted only with the discourses around services that exist within trans communities.

Non-Binary Service Users' Experiences of Gender Affirming Medical Practice

Some of the participants in this study had a history of hormone prescriptions and/or having accessed gender affirming surgical interventions. Because of the significant lengths of time accessing such medical services takes and the relatively small size of the sample, none of the participants accessed surgeries or hormones for the first time during the diary-keeping period. Even when access has proceeded smoothly for individuals, there was a recurrence of emphasis on having been 'lucky' or 'particularly

fortunate' that this was the case. When asked his thoughts on the medical communities' interactions with the transgender community, Mark said:

They're terribly scared of us! In my experience, which I appreciate isn't universal, I haven't had any horrendous... you hear really awful stories, like, oh god... but that hasn't happened to me, I've been fortunate.
(Mark, 43, interview)

Personal positive experiences, or at least absence of significantly negative experiences, did not mean that individuals saw GICs as working unproblematically for the trans population overall. Ricky also highlights their awareness of disability intersection, as discussed in detail in the previous chapter. Whilst unable to explain the relative rapidity of their treatment access (which further emphasises the lack of transparency in GIC access as raised by Jamie in the previous section), Ricky did go into more detail about their case as being 'simplistic' from a clinical perspective, as explained in chapter four. The explanation which Ricky gave of their experience being "surprisingly easy" was the ease with which their requests, from a physician's standpoint, could be conceived within the gender binary (matching that of a binary transgender man).

That the clinic was very respectful of Ricky's pronouns, both in interpersonal interactions and when making notes on identity in writing, demonstrates both the capacity and precedent for clinical sensitivity in response to non-binary referrals. This runs contrary to the concerns of participants who had yet to attend, or did not wish to attend the GIC. This does not, however, allow an assessment to be made as to the consistency across different clinics, or between the relative attitudes and approaches of individual clinicians. Indeed, clinical inconsistency is demonstrable, with Northamptonshire GIC having previously stated:

At present this service is not commissioned to provide treatment for persons not identifying as male or female... We would not decline a referral, as assessment and formulation of an individual's gender disorder may be more complicated than it appears to the referrer or indeed the service user. We may still be able to signpost an individual to another service. (Northamptonshire Healthcare NHS Foundation Trust, 2014, no pagination)

However, this was brought to the attention of the NHS England Gender Task and Finish Group, who took this up with the trust as incorrect, resulting in removal of this

text from the GIC website (Huxter, 2016). As Ricky emphasises, their treatment needs were met in a manner indistinguishable from some binary trans men. Given that there is a lack of empirical difference between the services offered to and accessed by binary and non-binary transgender people, this raises the question of what is meant when the service positioned itself as ‘not commissioned to treat non-binary people’. One potential explanation is that due to the ubiquity of the gender binary in the vast majority of discourses, commissioning documentation is likely to make no specific reference to the possibility of identification outside of the framework of male and female. That clinical exclusion may be based in policy, given that it is not based in medical possibility, is particularly emphasised by the willingness of other Gender Identity Clinics to provide treatment for explicitly non-binary people.

Frankie has this dimension to add:

My experience so far with gender identity clinics has been absolutely fine – other than the hideously long wait for appointments. (Frankie, 25, diary)

The significance of waiting times for GICs is an issue that impacts both binary and non-binary transgender people. NHS England confirmed in January 2015 that “NHS England agrees that people accessing gender identity services have a legal right under the NHS Constitution to be seen within 18 weeks of referral” (Jeavons, 2015, p. 3). Freedom of information requests have been made to the seven adult and one youth GIC services in England, four adult and one youth services in Scotland, and one adult and one youth services in Northern Ireland in order to establish how many patients have been referred to each, and their respective waiting times. For the period of August to October 2015 (the most recent available), the average waiting times for a first appointment in England, Scotland, and Northern Ireland were 44 weeks, 40 weeks, and 11 weeks respectively, with a 38 week average (UK Trans Info, 2016, p. 4). In addition, there has also been a UK-wide increase in adult waiting lists by 12% (UK Trans Info, 2016, p. 6) and a 19% increase in patients waiting longer than 18 weeks for a first appointment (UK Trans Info, 2016, p. 7). This clearly demonstrates how the perceptions of long waiting times are empirically verified and not a simple case of an unfortunate minority, but the systemic inability of GICs in their current state to operate within the NHS constitution. Whilst this is a problem across different medical services, it is particularly normalised, expected, and occurrent within the context of GICs.

The examples in the previous section of participant concerns and plans of how to interact within the GIC are vindicated by the descriptions given of interactions by those who have already achieved access. Whilst not highlighting problems with GIC staff, Mark did say:

I get my treatment on the NHS, so there is a strong motivation to tick the boxes, say what I 'need' to say, and then bugger off to be who I wanna be. (Mark, 43, diary)

Mark clearly demarcates 'who he wants to be' from how he puts himself across in a clinical context – and given that, as a non-binary person, he has negotiated his healthcare without major incident, furthers the precedent to other non-binary people that engaging similarly can work. This, however, does not take into account the heterogeneity of the non-binary population. Whilst obscuring or erasing non-binary identification for the sake of access is a viable tactic for some individuals, for others this may potentially cause similar distress as other experiences of being misgendered. Whilst some participants (who used singular they as their pronoun) explicitly made mention that being misgendered with the gender they were assigned at birth is considerably more distressing, and that being misgendered as the 'opposite' to their assignation could even potentially feel positive, this cannot be generalised.

Frankie discussed her experiences of being out as non-binary within the GIC context, and how that was responded to in some detail:

I've been reasonably open about my non-binary-ness from day 1 I think, though always used to talk about it within a binary framework. (Frankie, 25, diary)

This statement can be compared to Jess's critique that GICs will accept non-binary people "if you essentially tick their boxes of what a binary trans person looks like with maybe a little bit of acceptable edginess". By utilising a 'binary framework' to articulate gender (such as through saying 'I feel more female than male') the doctor-patient interaction is managed, as Frankie has predicted that such an articulation will be more readily accepted. Whilst Frankie's self-conceptualisation shifted to feeling more binary than non-binary over the course of the research, Frankie wrote explanations of her more personal preferences for gender label use:

I'm quite happy with the term 'non-binary', though not with 'genderqueer'. I'm not sure why this is, I'm just one of those anomalies

who occupy a place in 'queer' communities but doesn't like the word 'queer' as a self-descriptor. For me I think it says both too much and not enough about my sexuality, regardless of whether it has the 'gender' prefix. Other I.D. descriptors I've used in the past and occasionally return to are 'androgynous' (too binary in foundation), 'transfeminine' (too feminine), 'demigirl' (sounds kind of inferior or 'less than'), and very rarely 'woman' (WAY too complicated!). Recently I enjoy 'tomboy', 'bemme' (butch who's occasionally femme), 'hard femme', and 'riotgrrrrl', and am finding progressively more solace weirdly in 'lesbian' and 'dyke'. (Frankie, 25, diary, underline and capitalisation original)

Such flexible and thorough explanation of feelings in relation to identity labels was not expressed as something any participants felt comfortable to vocalise in the context of the GIC. In relation to some participant narratives this could be thought to result from anxieties in delays to or denial of treatment. However it is also important that whilst many binary and non-binary trans service users are confident of which services they need, others are not:

When I first got to the GIC I didn't necessarily want to access hormones straight away, I didn't really know exactly what I wanted, I didn't identify as male and that was a problem. So yeah it [a course of therapy] was kind of suggested by one of the therapists and I was like 'yeah cool that sounds great, try that' and to be honest I feel like that was a really beneficial, positive experience. Compartmentalising a little bit, everything felt very muddled for a long time, and for a long time very hazy, it was very difficult to pinpoint what was going on, it helped me clarify things, compartmentalise, and work out how to move forward, it was brilliant. I can't thank [name] enough in a lot of ways. He was a really great person to do that with, just a really good counsellor. (Frankie, 25, interview)

Frankie's account here points out how despite the general consensus of trans community voices highlighting the need for a reduction in gatekeeping practices and the need to challenge practitioners who operate from a position of 'trying to identify if the patient needs protecting from an inappropriate intervention', trans people also cannot be generalised to be expert patients, or necessarily self-assured of their needs.

Correspondingly, this does not justify clinical behaviour that disempowers or disenfranchises non-binary people of their identities. Frankie noted that of one of her physicians (rather than her counsellor):

The thing I've noticed most is pronouns. He uses the pronouns he thinks are appropriate not that I think are appropriate. He originally used 'he', which was pretty uncomfortable. And I didn't really realise this actually until I went abroad, when I go abroad, because I've got an F on my passport I usually take a couple of GIC letters just in case. Just anxiety really, just in case anyone stops me and questions it. When I recently went abroad I rifled through some of my GIC letters and noticed this, I hadn't really noticed this before. (Frankie, 25, interview)

This can be related back to Zesty's earlier point, that despite not having been to a clinic themselves, they felt "they always give the wrong gender, say the wrong things... but they work in that area". Despite how Frankie said that her clinical experience had been "absolutely fine", she also said that "no-one wants to be at that fucking clinic any more than they need to be". This shows that rather than universal clinical mistreatment, the alienation that trans people experience from the GIC, in practice, can be better understood and discussed in terms of the power dynamic between doctors and patients, which is structured by cisnormativity in practice – a lack of transparency, and inconsistency between different practitioners.

Leon provided information that demonstrated that, despite existing protocol being argued for in terms of patient protection and the prevention of regrets, circumstances could arise where an individual with a history of hormone access could still be denied continued treatment. Leon explained how they first sought out treatment when living in America. Accessing a low dose of testosterone within the American healthcare system proved to be straightforward for them, however the prescription was recorded as being in relation to suffering from fatigue, which was also accurate. In advance of returning to the UK, and with a pre-existing awareness of the extensive waiting times to access a GIC, Leon's American physician provided them with a nine month supply of testosterone. On explaining this situation at the primary care level, the GP refused to refill the testosterone prescription, with the justification that testosterone is unlicensed for the treatment of fatigue in the UK.

I've realised that my rationing of T (which is the prescription I brought over from the USA in September and I won't get an appointment with the GIC until at least May) is leading me back into muscle fatigue and exhaustion every month. Not sure what to do about that because I really don't want to talk to my GP about it and I can't speed up my appointment. (Leon, 34, diary)

There is a lack of recognition among the medical community that hormone prescriptions given to transgender patients may also assist with symptoms of conditions separate from gender dysphoria (or a more general, unpathologised desire for hormonal transition). This is a reflection of the scenario recognised in the previous chapter, where medication for conditions unrelated to gender impacted experience of dysphoria, such as Rachel's opiate prescription. As it currently stands, due to lack of awareness, trans-specific training, and insufficient nuance within practice guidelines, the majority of GPs are unwilling to prescribe hormones without direct and explicit recommendation from a GIC.

Some practitioners will give an NHS prescription on the basis of a private clinical assessment (which can save trans service users significant amounts of money through NHS prescription costs rather than private costs, on top of assessment appointment fees). Leon needed to begin the process of GIC referral and access from the very beginning, despite two and a half years of taking testosterone, and only experiencing a negative impact upon running out. This indicates the necessity for healthcare practitioners (at the primary and secondary/tertiary care levels) to provide continued access to hormones when initially accessed internationally. Leon stated in their diary that "I need the T to keep hold of a sense of legitimacy and strength". The notion of legitimacy links back to the discourse of not feeling trans/legitimate enough without medical access. This in itself is a source of strength (impacting emotional and mental health and wellbeing) but may also be interpreted as in reference to the physiological relief of fatigue that the testosterone grants Leon – or even the literal 'source of strength', as testosterone stimulates muscular growth.

The same argument for hormone prescription, without, or prior to, GIC access may be applied in cases where individuals self-medicate through ordering hormones via the internet, though none of the participants in this study reported self-medicating. Primary care hormone access would allow for hormone levels to be properly monitored over time. Indeed, the 2013 good practice guidelines specify that "A harm-reduction approach should be taken. Accordingly, hormones should not be stopped. A bridging

prescription may be appropriate, and blood tests and health checks are undertaken to screen for contraindications” (Wylie et al., 2014, p. 28).

Such recommendations are reasonable because of the markedly low regret statistics associated with accessing hormones or gender affirming surgical interventions. It has previously been estimated that 1-2% of trans women accessing surgery experienced regret (Lawrence, 2003). This has been then generalised to be a reasonable estimate for all trans people (Wylie et al., 2014; Gooren, 2011). It is also worth noting that at least one major meta-analysis study of trans patient satisfaction, whilst recognising the low regret rate, also states that available evidence is very low quality (Murad et al., 2010). One participant did however give an important and nuanced account of regret, which was Ash:

I do regret the phalloplasty. I can't orgasm anymore and I constantly smell of piss. It wasn't worth it. (Ash, 33, diary)

In considering Ash's experience, it is vital that this not be over-simplified, which requires contextualisation over Ash's life course:

When I went on the waiting list for breast surgery, I imagined that I wasn't actually going to have it. I did it because it was expected of me, and if I did everything that was expected of me, I'd get a prescription for testosterone. And I imagined I'd probably just go 'oh I changed my mind' and not having it done, and stop taking the testosterone, I thought a couple of years might be enough. But actually I found it so interesting becoming more butch, and I was, my curiosity about what it would be like to actually pass as male just totally got the better of me, and I decided when they said 'here's a date' that I'd accept it. (Ash, 33, interview)

From this account it can be seen that Ash's original intention was to never access mastectomy, but only a prescription for testosterone. That Ash changed their mind in direct relation to their experience of navigating the clinic and experiencing the changes that hormones produced can be compared with Frankie's account. Frankie found herself feeling more binary after accessing hormones and made this link directly. Ash's identification remains non-binary; however at the time of accessing mastectomy, Ash was embodying a masculine presentation and identification. They explained how through extensive exercise they experienced a large increase in muscle mass to the

extent that their chest measurement was larger than pre-mastectomy. Ash articulated experiencing enjoyment in “embodying something completely different, watching the way the world reacted to me differently”.

It is often assumed by doctors and the general public alike that gender identity (and corresponding embodiment) remains relatively static across the life course, as discussed in detail in chapter five. However for Ash, after a 10 year period they decided they wished to return to more feminine embodiment, though without a sense of regret in relation to their masculine time and embodiment. Initially they attempted further chest surgery to embody a ‘non-binary chest’, with an ambiguous structure that could be potentially read as pectorals or breasts dependent on clothing choice. However, after negotiating this with their surgeon, the result was unsatisfactory. Ash did not articulate this experience as particularly harmful however:

But... it wasn't very effective. It just looked kind of like a lump which didn't look properly one way or another, it just looked like a fake lump thing in my chest, and I thought, 'okay if you're going to do it, do it properly' and I went back and said 'look, let's just do breasts', I've decided which way I want to go, and it took me a little while to feel comfortable with it, but the reaction of [sex work] clients just instantly changed. That suddenly they were happy with my chest, and I got more business, it paid for itself in a matter of weeks, honestly. And because it had made this huge positive difference to my life, I felt happier about it than I thought, and I really learned to like it in the end.
(Ash, 33, interview)

The intersection with Ash's profession as a sex worker is also significant here, as Ash experienced a significant economic improvement which synergised with their improved life quality overall, allowing them to “learn to like it in the end”. This is a significantly different narrative to the earlier, NHS-accessed phalloplasty:

I went in there going 'okay, I keep being offered this phalloplasty and you know maybe it would be nice, but I really have concerns about being able to enjoy sex, this is meant to make my sex life even better, and it's pretty bloody good to start with'. So I took some diagrams and said 'could we position things here', so from being the insertive partner I can really feel it, and we went through and it was a little more standard and he said yes. Then when I woke up he said 'we couldn't

do exactly what you said anyway, so I did this instead'. And it involved... mutilating quite a lot. I was very unhappy, and he did his best to rectify the situation... when I woke up he'd not done what we agreed. And there's no way I could have known that in advance. There's no way I could have known, but if I had I wouldn't have done it. (Ash, 33, interview)

From Ash's account, they were quite clear that they had not been coerced or manipulated. However, when asked if they thought there were ethical or legal ramifications to their surgeon's action, Ash explained that "it's a fairly specialist field of surgery, and if the guy who's the biggest specialist said 'I made a judgement call at the time, and that was correct' everyone else believes that it's correct because he's the guy that knows". Further, Ash went on to say how the surgeon had clarified that "under normal circumstances the reports you get is this doesn't ruin things for people... statistically I was unlucky". In comparing to earlier narratives of luckiness, this inspires a discourse of powerlessness – that whether one has a positive or negative outcome is difficult to have influence over. Here, Ash is internalising and accepting the surgeon's explanation that they were not 'normal circumstances', which discursively aligns with how non-binary clinical presentations are positioned as 'not the normal case'.

Ash did not say that they accept their surgeon made the best decision he could. Rather, they instead feel that attempting to challenge his authority would be fruitless because of his standing as 'expert'. Ultimately, trans patients (binary and non-binary) are dependent upon the views and decision-making of their clinicians, which is problematic given the lack of nuanced understanding that trans communities feel (and evidence) clinicians have of transgender particularity. Despite their self-assuredness in their genderqueer identification, it is particularly poignant that Ash said:

If I hadn't had to present myself as a binary trans man in order to get some medical help, I wouldn't have then been repeatedly offered and guided in the direction of a phalloplasty. And the worst thing that's really happened to me ever wouldn't have happened to me, and that would've had a positive impact on my mental health if that hadn't happened. (Ash, 33, interview)

This illustrates that discourses of inaccessibility and unequal treatment between non-binary and binary transgender service users have a significant ethical impact in medical practice. These necessitate policy revision and revitalised training programmes in order

to mitigate. The details of such potential recommendations will be expanded upon in the following concluding chapter. That Ash had even turned surgery down multiple times but kept being offered it, meant Ash “kept thinking maybe I am missing out on something, maybe my life would be better”. There was also a critical queer community interaction to this experience, as Ash explained that at this time they were trying to date gay men, but experienced rejection – which may have been due to a phallogentricity among those Ash interacted with – “I thought it was that I hadn’t had the surgery, and didn’t have what they were looking for”. This demonstrates how the immutability of gender as a binary, within queer community and medical discourses can lead to multiple directions of pressure upon non-binary individuals to force themselves to pursue or perform embodiment and identity in undesirable (binarised) ways.

Conclusion

The chapter voiced that current guidelines force trans people (binary and non-binary) to fulfil practitioner expectations, and to invariably compete with each other for limited NHS resources – as those deemed most in alignment with physician expectations of what being transgender means will be conflated with possessing the greatest need. Further, keeping desired treatment within existing frameworks (such as only accessing surgery *following* hormones) also positions a non-binary service user as analogous with binary transgender treatment access, and correspondingly straightforward to treat. Ease of experience in the clinic was often positioned as ‘lucky’ by participants, further reiterating the sense that GICs caused difficulty or distress more often than not.

Participants also raised the issues of lack of transparency in GIC decision making and processes, and a lack of trust between practitioners and service users. This was due to a sense that practitioners were concerned with maintaining a hierarchical power dynamic in relation to patients, and to protect themselves from potential malpractice lawsuits in the case of individuals regretting accessing treatments. The perceived bureaucracy of the NHS in the form of protocols, and most critically, long waiting lists, also meant that private healthcare could be, or could be viewed as, considerably easier to navigate, where affordable.

Among those who had already accessed gender affirming medical services, there was an overall sense that their experiences had been positive. However, the fact that these participants still remained critical of GICs’ service for the trans population overall was illustrative of additional complexity. There was a sense that experiences were made considerably easier by performing or emphasising (more) binary identification and/or

expression. It was also made apparent that in resisting medical disempowerment of trans people, it is important not to then homogenise service users and risk universalising all those desiring treatment as expert patients.

This does not however mean that top-down power dynamics (that can involve direct disrespect of non-binary identification) cannot be addressed in practice. Leon's experiences of being denied testosterone in the UK following years of access in the USA illustrated a lack of pragmatic ability to incorporate international synergy into NHS practice. Finally, Ash's case highlights how rare cases of post-treatment regret might be better understood as resulting from a complex interplay of social factors, rather than lack of understanding or rash decision-making. Regretful outcomes may be further minimised, not by tightening the access to gender affirming treatments, but by recognising a wider range of gendered possibilities as valid, such that gendered medical discourses are less likely to impact patient choices.

In reflecting on this chapter, it is interesting to note differences between the views participants had of GICs depending on whether they had direct experience with them, or not. Overall, participants communicated that there is a great deal of distrust and fear within the non-binary population of practice within GICs. This was explained with reference to a wide variety of points, including how practitioners' understanding of gender remains heavily biased towards the gender binary. This is a product not only of how fundamentally socially engrained the gender binary remains, but how lack of precedence/visibility of non-binary patients discursively positions such individuals as 'non-standard'. In order to appease physician expectations, patients can feel the need to obscure or entirely erase their non-binary status through the construction of a supernormal binarised self, or through strategic omission so as to feel they are maximising their chances of accessing gender affirming medical treatments. The conclusion of this work will address the themes in chapters four to seven so as to suggest recommendations in the light of this research.

Conclusion

I certainly believe that we can move toward de-regulating gender and still engage in important corrective practices like gender-based affirmative action. I am not arguing for a gender-blind society in which all people are similarly androgynous, but instead for a world in which diverse gender expressions and identities occur, but none are punished and membership in these categories is used less and less to distribute rights and privileges.

(Spade, 2003, p. 29)

Summarising the Narrative

This thesis has sought to address how non-binary gender identities are negotiated, within the contexts of queer communities and medical encounters. Whilst doing so through an empirical sociology that utilises symbolic interactionism as a theoretical framework, the academic foundations for this research have been found in both the sociology of health and illness, and transgender studies (most notably, an empirical sociology of transgender).

Throughout this work, sociological conceptualisations used to understand illness (such as the sick role) have been redeployed within the context of non-binary transgender identities. It has been important throughout that such theoretical usage does not imply that trans identities are modelled as pathologies. The nuances present, particularly in contexts where non-binary people seek access to gender affirming medical services through GICs, highlight differences in how transgender health interactions function when compared to healthcare relating to conditions unproblematized as illness.

I began the theoretical contextualisation of this work in chapter one by examining the history of medical sociology, and how it developed into the sociology of health and illness. This saw the expansion in the social roles of physicians, from not just curing disease, but in helping individuals maintain 'good health' and 'good health practices'. This was significant because of how narratives of the socially constructed 'normal' are tied into judgements of health, as doctors both influence and are influenced by the social world. This chapter recognised the relevance of the sick role, biographical disruption, and expert patienthood in pertaining to transgender health interactions. Further, I contextualised how many studies of trans people and their genders have been rooted in a pathologising history of medical scientific interest. Much of the

research *in* medicine which scrutinised transgender identities has been significantly problematized and rejected; such as autogynephilia, primary and secondary transsexualism, and discourses that position gender variance as disordered in and of itself. Research *of* medicine, and its intersections with trans lives, has been of central concern in much of the (more recent) literature that collectively forms an empirical sociology of transgender health. In distinguishing between research *in* medicine (of transgender), and research *of* medicine (and transgender), I paralleled Straus' (1957) distinction between sociology in/of medicine.

It was important to recognise the limitations of considering transgender narratives exclusively in terms of interplay with gender affirming medical services, and processes of medical transition. In chapter two, I further contextualised the study of and interactions with the trans population over the last 50 years, by addressing the contributions of ethnomethodology, and tensions and synergies with feminist discourses. Consideration of transgender communities included reflecting on activist and legal scholarship, and recognition of (intersectional) social stigma and inequalities. In considering this very broad and multi-faceted range of literature pertaining to transgender lives, I have highlighted elements hinting at non-binary identities or potentiality. The explicit literature on non-binary or genderqueer identities and experiences however, remains very small. This thesis aims to significantly contribute to filling this gap, so as to also draw attention to and disrupt assumptions of a ubiquitous and unproblematized gender binary – in both transgender studies and wider social contexts.

The research questions that were centralised within this study asked how non-binary people are involved with, and integrated into queer communities. In accessing such narratives over time through participant diaries, and also further reflections within semi-structured interviews, the research allows for broad consideration of how the increasing visibility of non-binary people within queer communities is accommodated (or not). From this, changes, or necessary developments may be implied for the organisation of communities and activism that is centralised within and around such communities. Further, this project's research questions examined how non-binary people negotiate access to and use of medical services, at both the level of general, primary care for any ailment, and in the context of medical gender transition via a GIC. Concerns and social meaning ascribed to such interactions were considered broadly, such that discourses within the non-binary population were engaged with whether currently seeking or accessing particular forms of medical care or not. The experiences and perceptions of

the non-binary participants allowed for assessment of how current healthcare provisions for the non-binary population are viewed or experienced, and what implications this has for future provisions and potential methods of improvement.

Chapter three began by explaining the epistemological logic that underpinned this project, and how the framework of symbolic interactionism was adapted for the study of non-binary gender identities (inspired by its previous use in the study of sexuality). The practical details of fieldwork deployment were explained, together with the methodological justifications for multi-method research comprised of mixed media diaries, and semi-structured interviews. I entered into a discussion of the importance of reflexive practice within research, which strengthened both ethical practice and processes of rapport development during fieldwork. Participant demographics and the limitations of elements such as recruitment methods were discussed prior to engaging in analysis of research data.

Some participants discussed their gender identities in terms of being static articulations of a third gender category. Others emphasised the fluidic nature of non-binary identification. Some participants were keen to acknowledge that, whilst they were happy in how they conceptualised their genders in the present moment, they accepted the possibility of having different feelings in the future (regarding making changes to embodiment, social presentation, or more personal conceptualisation).

Medical transition services had been accessed by some participants. Others wanted to and were attempting to navigate such processes. Yet others wished to, but had not approached any service providers, whilst some did not desire to access medical services and instead negotiated their non-binary identities in relation to their embodiment as it stands. Explicit cases were identified of participants whose self-conceptualisation had changed from binary trans to non-binary trans, or vice-versa. It was also seen that participants could embrace a non-binary identity whilst at the same time preferring to use titles, pronouns, and presentation that positioned them as being socially interpreted within the gender binary. This is amongst the first work which highlights particularity and demarcates differences between members of the non-binary population.

A wide range of themes were identified throughout participant diaries and interviews, so as to create knowledge that establishes a framework for understanding negotiations and navigation of being non-binary. As 'non-binary' functions as an umbrella term, including many individuals with disparate feelings about embodiment, presentation, and

what interactions function to distress or validate, any essentialising answers to these research questions would be significantly limited. However, trends were identifiable that allow for original recognition of discursive influences, connecting interaction with medical service providers and queer communities.

Chapter four was constructed around the theme of participants 'not feeling trans enough', which allowed for exploration of feelings of insecurity, or instability in gender identity. How this manifested could vary, in some individuals being indicative of internal self-doubt about the reality of one's status, or potentially more in relation to how one is viewed by other people (including other trans community members, medical practitioners, or more general social actors). A strong link could be seen between the discursive dominance of medical interventions in hegemonic transgender narratives, and struggling for self-acceptance when not performing such narratives *even if* consciously recognising this as problematic. Whilst participants frequently doubted themselves as 'not trans enough' by their own standards, or the standards they feared may be imposed upon them, self-definition was sufficient for participants to accept others, thus highlighting a disjunction between how binarised norms of gender affected judgement of the self versus others.

Historically constructed (particularly medicalised) narratives of transgender could be resisted in how participants articulated their relationship with embodiment, such that diagnostic criteria and language (such as gender dysphoria) could still be fulfilled in order to justify being trans enough, both to the individual and to others. The social difficulties in having to claim a gendered position that resists the proclamation of gender assigned at birth can fuel problematic hierarchies of realness within trans communities (among both binary and non-binary trans people). Lack of intelligibility or awareness of non-binary identification within some trans communities could also lead to practices or organisation that served to be uncomfortable or inaccessible for some non-binary people. Such accounts served to address how non-binary people are involved with and integrated into some queer communities; however these experiences only represented some of the highly heterogeneous examples of community organisation.

Chapter five engaged with themes that were collected under the broad idea of time. It was recognised how the passage of time, and the gradual process of identity reformulation – with particularly significant events (especially GIC interactions) correlating with adjustments to the relationship with gender identity. I proposed a visual model by which coming out processes, and renegotiation of identity from binary to non-

binary and vice versa may be visualised. The theme of identity as a stepping stone process was related to the resources that participants may have access to in naming and processing their feelings around gender (that could be age or community-dependent). The theme of liminality provided a framework for conceptualising the potential fluidity or 'inbetweenness' of some non-binary articulations. This served to accommodate personal identity conceptualisations that demonstrated binary and non-binary overlap, which could be temporally or spatially situated, in terms of how identity was emphasised or expressed. It also re-renders medical transition as not necessarily having a 'fixed end point' (as binary gender transitions regularly assume), as gender cannot be assumed to be universally experienced as static over the life course simply because desirous or deeply necessary medical interventions have been accessed. This allows for reconceptualization of narratives and concerns around 'transgender regret' that may be potentially used to legitimise transgender access to gender affirming medical services.

Further, particular barriers were expressed for non-binary people with chronic health conditions or disabilities. In some cases, extensive interaction with health services unrelated to gender identity primed individuals to expect problematic interactions when seeking assistance. Participants could be concerned that raising a discussion of gender identity could disrupt treatment for their other conditions, positioning such an action as unacceptably hazardous for them. Highly specific interactions also recognised the potential for interaction between conditions and transness – through medical interventions (such as Rachel's experience of taking opiates and their incidental impact in mitigating dysphoria) or social navigations (such as Jess's sometimes-strategic use of her walking stick).

Finally, in chapter five, the heterogeneity of non-binary involvement in queer communities was explored, showing how a particular focus on transgender people was not necessarily indicative of a politics of non-binary inclusion. Communities that might be particularly associated with defying normative practices or roles (such as Lolita fashion, or BDSM⁶⁸ communities) or which challenge a gay/straight binary model of sexuality (notably bisexual communities) were explicitly highlighted as spaces appreciated by non-binary participants. This implies that the commonalities between non-binary gender identification and norm/role/binary disruption may equally be a source of affinity and support as communities oriented around transgender status. Indeed, due to the breadth of possibility under the transgender umbrella, tensions may

⁶⁸ Bondage and Discipline, Dominance and Submission, Sadism and Masochism.

readily manifest between different individuals. Whilst a non-binary identity may currently be associated with anti-normative gender politics, having a binary trans identity cannot and does not indicate an individual's beliefs or approach towards gender, with the potential to be conservative and reject queer or non-binary articulations, as was also expressed by participants who had observed this.

Participants shared a multiplicity of rich and nuanced views, and direct accounts of medical care. Experiences included examples where participants were impressed by service provider's efforts and sensitivity, or significantly distressed by their inadequacies. Accounts were divided into those not pertaining to medical transition related services in chapter six, and those which were, in chapter seven. Of those which were not, many examples still related to 'gendered medicine' – services that inherently depended upon, related to, and differentiated on the basis of how physiology is gendered, but through assumptions of concordance with the social categories of 'men' and 'women'.

In primary care (or secondary care unrelated to gender transition) contexts, non-binary patients were highly aware of how symbolic readings of them (or their genders) could impact their experiences of healthcare. Whilst some participants were clearly determined in ensuring a *change* of gender be recognised on records, it could be that removing association with the gender assigned at birth was of greater criticality than whether this was corrected to a binary or non-binary marker – in terms of distress mitigation. Participants expressed that anxiety over the perceived likelihood of lack of understanding or potential stigma in primary care contexts could delay them from scheduling important medical checks or condition management, or even result in total avoidance of ever engaging as a patient.

Problems could be encountered with medical practice prior to doctor-patient interactions. Administrative processes, documentation, and exchanges with clerical staff could erase identities. Such difficulties could require significant patient labour in order to be recognised, or place an individual into a vulnerable state prior to a medical appointment. Participants expressed how trans identification could be inappropriately conflated with, or distract from, independent health issues. This point reiterates how some social and medical experiences are similarly experienced by binary and non-binary trans people, however appreciation of specificity may produce necessarily different approaches for improving a given problematic interaction. Valuably, some participants were able to offer interactions with healthcare providers in contexts where they were not (at that time) positioned as a patient. This raised issues such as the

potential for problematic or offensive behaviour from staff when patients are not within earshot, evidencing a cisnormative culture within medical practice.

The referral process, whereby primary care practitioners formally have a patient placed on a waiting list for an appointment with a particular GIC, was of significance to many participants who wished to access a medical transition but had not yet done so. Examples were given where GPs would attempt to assess participants prior to referral, which in addition to being unnecessary under best practice guidelines, inadvertently reinforces the binary gender hegemony that virtually all medical practitioners uncritically reify in patient interactions.

The theme of obscuring or omitting non-binary identification carried into tertiary care contexts, as explored in chapter seven. It is notable however that whilst participants with positive experiences in their receipt of gender transition related care did not want to imply that services were without (systemic) faults, they did discuss positive aspects. Those who had not accessed clinics directly were highly concerned with negative experiences that were discussed within transgender community contexts. There has been extensively problematic treatment of trans people in clinical contexts, under now antiquated modes of practice. Lack of transparency in methods of assessment and medical decision making means that shared community knowledge nucleates from those trans individuals who pass through GICs. As all service users wish to conclude their interactions with the GIC as quickly and easily as possible, there is significant focus on performing those gendered roles that best satisfy clinicians. This can be significantly more difficult when openly non-binary, due to lack of historical clinical context. Insecurity related to not being trans enough was observed in relation to all three subdivisions of interaction under an SI framework. These are not feeling trans enough by one's own standards (intrapsychic interactions), anxiety over being seen as trans enough by other community members (interpersonal interactions), and being considered to be trans enough to correspondingly be given access to medical services by clinicians (cultural, or structural interactions). Further, the anxiety over the uncertainty of a 'smooth transition' means that communities are likely to focus on negative narratives over positive ones, in order to 'be prepared' for clinicians with particular reputations.

It was demonstrated that at least some tertiary care practitioners do not engage with non-binary articulations of gender identity as being equally valid to binary transgender identities. Concerns with non-binary patients being 'more difficult to treat' were grounded in a reliance on clinical precedent rather than holistic engagement with the

individual. In addition, such practice risks assuming that desired medical interventions for non-binary people are necessarily able to be demarcated from binary trans desires, when no particular medical treatment (or lack thereof) is essentialised to, or defines, binary or non-binary identification. Transgender expert patienthood (supported by interactions and resources shared within transgender communities) was obtained in order to manage practitioner expectations and the medical gaze. However, performances of gender not only served to fit into the role of a 'good patient', but necessarily as patient at all, in the first place. The necessity of a distress-dependent experience oriented around embodied dysphoria in order to be deemed 'diagnosable' by physicians limits the narratives that can be safely explored in a clinical context due to the anxieties surrounding the potentiality of service provision denial.

Recommendations from this Research

One of the most fundamental recommendations for medical practice that can be made is inspired by those communities that non-binary people expressed affinity with, such as bisexual and kink communities. Such spaces were sensitive and reflexive to gender plurality, and tended to construct language and space to be more fully inclusive. Gendered assumptions rooted in cisnormativity should be challenged within medical practice. Much of this may be attained initially through the provision of training to both medical students and existent medical staff and administrators. The significance of language in erasing non-binary genders and potentially triggering dysphoria is such that the use of gender neutral forms of address ('good morning', rather than 'hello sir', for example) when individual preferences/needs are unknown may be normalised in practice towards all patients. This would also benefit binary trans people who are pre-transition, or who do not pass as their identified gender.

Practices in gendered medicine may be similarly adjusted at the administrative level to improve preventative health screening for trans individuals. An example being who receives letters reminding of the necessity of smear tests. At present, this relies upon the flawed conflation of the categories 'women' and 'people with cervixes'. This benefits more of the population than binary and non-binary transgender individuals, such as people with known intersex conditions, and women who have had mastectomies or hysterectomies. Systemic changes would also need to be accompanied by standardisation of training on transgender healthcare within medical and nursing degrees, as well as staff training for administrative roles. Such actions would render

transgender identities generally as more intelligible, and equip staff in delivering medical practice that has been clipped of gendered assumptions.

With regards to gender affirming medical services, good practice guidelines stipulate that “patients are presumed, unless proven otherwise, capable of consenting to treatment” (Wylie et al., 2014, p. 14). The fact that individuals referred to GICs are required to undergo a process of third party scrutiny prior to being able to access HRT illustrates how patient competence and willingness are insufficient under current (NHS) provision. I particularly draw attention to HRT because of the comparable simplicity of its administration in comparison to surgeries, and that a significant proportion of transgender people (binary and non-binary) are highly confident of their desire for HRT, whilst surgery may be uncertain or unwanted. Even were it not the case that culturally constructed and maintained binary norms of gender influence tertiary clinical practice, such that non-binary identified patients are potentially coded as more difficult or more complicated, it is problematic that any transgender transition-oriented care does not grant autonomy over how an individual wishes to negotiate their embodiment. Further, this is in a context whereby gender identity services are seeing significant increase in demand, without corresponding growth in resource allocation or staffing.

Given constraints on NHS budgeting, there is clearly a finite amount of funding available to assist GIC patients. Therefore, there are at least two critical factors indicating that the current healthcare system results in patients being positioned as competing for resources. Firstly, there is the necessity for patients to fulfil imperfect diagnostic protocols and subjective clinician expectations. Secondly, resource limitations, partially a result of more general underfunding of the NHS (Pym, 2016; Campbell, 2015), inefficiencies (Niemi, 2016), under-recognition of the importance of GICs, and the rapid growth of the transgender population trying to access services. For as long as the patient population continues to grow without proportional resource allocation, tertiary care providers will only be equipped to facilitate a limited number of transitions over a given period of time. Whether individual waiting times are adjusted on the basis of clinical urgency (at the discretion of practitioners) is unknown, due to lack of transparency concerning clinical practices. There is a need for assumptions around non-binary people being viewed as ‘less certain’, or as experiencing less significant dysphoria than binary people, to be explicitly addressed.

Non-binary and binary trans hormone access equivalence could be established and significant relief granted on GIC resources through the allowance of hormone access without the absolute necessity of a GIC appointment. This does challenge the doctor’s

role as gatekeeper as it has been constructed in the context of transgender health and many other examples of healthcare provision, however trans identity is unique in depending entirely on self-reporting in all cases, whilst also being now accepted as a non-pathological state of being (Richards et al., 2015). In the context of hormone provision, a primary care practitioner would review expected physiological changes, and any associated health risks. A blood test is taken in order to establish initial hormone levels and a consent form is signed. A simple, non-specialised psychological evaluation may also be performed in order to eliminate the rare possibility of mental health conditions that can sometimes present with delusional cross-gender identification. Such practices all currently occur at the primary care level in health provision contexts for cisgender patients.

These tasks are all within the remit of primary care provision. By centralising patient agency, deference to gender specialists (who do not have specific or particular training in how they respond to service-user reports of being trans) is no longer necessary. Correspondingly, individuals who desired access to HRT only (or initially, only) would no longer need GIC referral, such that waiting lists would be significantly reduced. The fact that patients already require primary care appointments to obtain referrals, and receive hormone prescriptions from primary care practitioners on the recommendation of GICs, means no additional burdens would be placed on the primary care context. Further, the transparency with which such a model could be implemented would mean that any delays or denial in hormone provision for an individual can be easily justified and contextualised, such that anxiety around lack of transparency in practice may be mitigated (O'Reilly, 2012).

Recommendations for community organisations are inevitably less structured. Difficulty may be experienced by administrators who encounter tensions between group members, especially when feeling unequipped to diffuse or police such interactions, and indeed, the total elimination of intragroup tensions is not feasible. Being mindful of the potential harm of self-validation through comparison to (less 'successful') others, and of the risks in assuming the homogeneity of transgender identities (such as wishing for surgeries) would likely improve community experiences for non-binary people. This may be attained through increased communication between community leaders and organisers, which is significantly easier through digital community spaces such as via the websites Facebook, and Tumblr.

Cautions, Limitations, and Future Directions

Recognition that this research has served to offer a snapshot of non-binary experiences and views within a particular cultural context and at a particular time is important in considering this work's impact. Formal policy, medical training practices, the cultural intelligibility of non-binary identities, and community norms and practices continue to develop and shift. Recognition of non-binary narratives is essential for queer communities and medical practice to be inclusive of gender plurality.

Problematizing cisnormative cultural practices, whereby all individuals are assumed to be cisgender by default – and correspondingly therefore, that trans individuals may be necessarily visibly identified – is a macrosociological observation. However, examples within the data drew attention to individual acts of practitioner and community member insensitivity. I argue that this is illustrative of widespread issues on the basis of social context in addition to participant accounts, but this is not generalisable to *all* healthcare practitioners, or queer community members who are not non-binary. Whilst it is undeniable that there exist individuals who engage in discriminatory and offensive behaviours, the significance of the lack of awareness of non-binary gender identities in particular cannot be overstated. At the level of the individual, education initiatives that challenge simplistic and assumption-oriented judgement-making in social interaction would have a marked impact, yet the structural constraints of gatekeeper-oriented healthcare that has been recognised and criticised particularly within trans communities will still remain. From this research, it is not possible to make definitive inferences as to whether the negative views of medical care within the non-binary population are entirely rooted in examples of problematic practice. These certainly occur to a disproportionate standard, as supported by existent transgender health studies (Ellis et al., 2015; Hagen and Galupo, 2014; Kosenko et al., 2013; Bradshaw and Ryan, 2012; McNeil et al., 2012; Bauer et al., 2009; Dewey, 2008; Bockting et al., 2004). However, aspects such as the potential for individuals to be sensitised by communities to expect poor experiences, or for non-binary people to articulate poor experiences as acceptable because of exceeding especially low expectations, require more detailed attention.

With regards to the demographics of the sample, as discussed in chapter three, all except for one participant were white; therefore the sample did not reflect the experiences of gender diversity that may be found amongst different ethnicities. All but one participant had attained (or were in the process of earning) a degree. Extrapolating on the basis of educational attainment and the overall contexts that researcher-

participant interactions have allowed, I therefore suggest that the sample is skewed towards middle class representation. Whilst Harrison et al. (2012) evidence that non-binary people (in their North American sample) had above average educational attainment, my sample is nonetheless not necessarily broadly comparable to the overall UK population. This is likely a result of some of the avenues used in the recruitment process, such as university-based LGBTQ societies, and the potential for a homogenised sample as a result of snowball sampling.

Limitations associated with the methods used in this research were also articulated in chapter three. However, the extensive labour involved in diary-keeping was certainly apparent in seven out of twenty-five original participants withdrawing from the project, many due to feeling unable to commit to the extent of participation required. Further, the number of participants with prior diary-keeping experience suggests that the method may have played some role in self-selection; non-writers may have become less accessible due to this. Whilst one goal of the diaries was to access day-to-day or more routine aspects of non-binary life and experience, the interviews emphasised more demarcated, unique happenings such that relatively recent interactions were possibly overemphasised, particularly if compared to the roles of queer community or medical practice in participant's lives prior to the diary keeping exercise.

This study did not target any particular sites of medical practice, GICs, or community organisations for scrutiny of their interactions with non-binary people. Therefore, recommendations cannot be made in relation to any specific organisation's current policies, as it is unknown to what extent participant experiences would necessarily be representative for a given set of service users. However, the data does allow for a more general approach to service improvement, which if borne in mind could see policy becoming more standardised, whilst care may become both more efficient and more holistic.

With regards to future research directions, an enormous amount of possibility remains open for research in relation to gender beyond the binary. Lack of quantitative data on non-binary people beyond very rudimentary extrapolated estimations from community members renders population studies difficult. Adjustment of census questions so as to be able to record people identifying outside of the gender binary, and also with a trans identification more generally, would open a wide range of research possibilities. Intersections between non-binary gender identities and different forms of social inequality would also provide excellent sites for academic scrutiny. In the contexts of other disciplines, there is a significant absence of culturally competent and sensitive

medical research considering transgender health experiences that transgress historical norms (such as the impact of lower doses of hormones in different bodies at different ages, for example).

We're Here, We're Genderqueer, Get used to it!

In summary, the integration of non-binary individuals into queer communities is most apparent in the specific contexts of transgender communities, more so than broader LGBTQ examples. Some participants indeed highlighted cis gay men as a group more likely to express intolerance or lack of understanding of non-binary identities, in a manner which may alienate. There were multiple examples of non-binary involvement and integration with various sexuality or gender-related communities, but with the commonly shared trait among community members of being particularly accepting of differences in gender identity and expression.

The negotiation of existing medical practices is currently fraught with anxieties and potential difficulties for non-binary individuals, perhaps most centrally a lack of intelligibility amongst the majority of healthcare practitioners. The specific circumstances of care may necessitate different forms of educational or policy intervention in order to see improvement. Whilst experiences were certainly not universally negative, the recent cultural emergence of non-binary identities means that health services need to respond quickly in order to avoid risk of harm to this significant minority group of service users.

For queer community organisations, non-binary identity emergence implies that recognising the necessity of resisting the uncritical incorporation of gendered norms into community practices is required for pluralistic, inclusive, and inviting spaces and events. It can be argued that the relative social disempowerment of cisgender gay men and lesbian women (when compared to the trans population) has considerably lessened since the new millennium (McCormack, 2013). This, together with the fracturing of queer solidarity along the lines drawn through identity politics can mean that non-binary identities risk being stigmatised. This may nucleate through homonormative ideals, or depoliticised and over-simplistic internalisations of gender by some members of the community. That said, there are also examples of non-binary individuals being celebrated and embraced by communities, and also the creation of increasingly specific and nuanced groups and networks, particularly in synergy with digital technologies.

In the context of trans/queer healthcare, non-binary gender identities suggest that discourses are shifting so as to render the sustained inclusion of arbitrarily rooted and uncritical gender roles within medical practice increasingly untenable. Non-binary identities highlight the importance for *all* medical practitioners to have a basic appreciation of the potential problems and limitations of gendered assumptions in any social interaction, particularly in the prospective situation of engaging with a vulnerable individual. Non-binary gender identities also provide a valuable avenue for the reinterpretation of many narratives of de-transition. This further suggests that holistic transgender healthcare is not possible without full acknowledgement of the possibilities of gender plurality, particularly as individual's needs change over time.

This thesis has made clear the relationship between non-binary identities, queer communities, and medical practice of all kinds. In doing so, it is hoped that the benefits of sociological analysis can be harnessed to pragmatically impact upon both systemic cultural norms, and individual lives for the better.

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Appendix 1 – Recruitment poster

Do you identify *outside* of the gender binary?

Then you are invited to participate in a research project looking at how both LGBT/queer communities and medical practice affect non-binary people!

The project will involve keeping a diary for four months, followed by an interview. Diaries will be 'mixed media' – meaning you are invited to use any media you like, including drawing, scrapbook keeping, audio, video, as well as classic written entries!

For further information or to express interest please contact Ben Vincent at:

ssbwv@leeds.ac.uk

This project has received ethical approval from the University of Leeds
ethics reference: AREA 14-044

Project supervised by Dr. Sally Hines: s.hines@leeds.ac.uk

Appendix 2 – Template email to organisations

To whom it may concern,

I am emailing to enquire whether it would be possible to circulate the attached flyer to your group's membership.

I am a PhD student researcher at the University of Leeds, and I am working on a project titled 'Non-Binary Gender Identity Negotiation – Roles of Queer Communities and Medical Practice'.

I am seeking participants who would be interested in keeping a 'mixed media diary' for a period of four months between February and May of 2015, with a follow-up interview to be arranged after this period. I can provide further information for anyone who might be interested.

This project has received ethical approval from the University of Leeds, and has the ethics reference of AREA 14-044. Should you wish to contact my PhD supervisor, her name is Sally Hines and can be reached at s.hines@leeds.ac.uk

Thanks very much and best wishes,

Ben Vincent

Appendix 3 – Participant consent formParticipation Consent Form

Title of Project: 'Non-binary Gender Identity Negotiation – The Roles of Queer Communities and Medical Practice'

Name of Researcher: Ben Vincent

Please initial the box to the right of the corresponding statement to indicate that you agree.

- I confirm that I have read and understand the information sheet dated _____ explaining the above research project, and I have had the opportunity to ask questions about the project.
- I understand that my participation is voluntary and that I am free to withdraw until 1 month following interview without giving any reason, and without there being any negative consequences. In addition, should I not wish to answer any particular question or questions when interviewed, I am free to decline without giving any reason and without there being any negative consequences.
- I consent to the follow-up interview being recorded by Dictaphone in order to be transcribed for the PhD project.
- I understand that I may withdraw consent to use particular material from my diary and/or interview until one month following the date of the interview, after which point completion of the PhD thesis would be jeopardised by the need to remove data after this point. I understand I may not withdraw consent to utilise information from my diary and interview at any point following one month after the completion my interview (which I will be notified of).

- I agree to take part in the above research project and will inform the named researcher (Ben Vincent) above should my contact details change.
- I understand that I may ask any questions at any time by contacting Ben Vincent by email at ssbwv@leeds.ac.uk, and that if I have a complaint concerning the research procedure I can contact Sally Hines by email at s.hines@leeds.ac.uk

Please underline ONE of the following two statements to indicate your preference:

1. I wish to be anonymised in this research.
2. I wish to be identifiable by first name in this research.

If you have underlined choice 1:

- I understand that my responses will be kept strictly confidential.
- I give permission for the above named researcher to have access to my responses in full before anonymization. I understand that my name will not be linked with the research materials, and I will not be identified or identifiable in the report or reports that result from the research.
- I understand I may change my mind and be made identifiable (and accept the conditions contingent with this choice) at any time until 3 months after the date of my interview.

If you have underlined choice 2:

- I understand that I may be potentially identified as the source of my responses and diary entries.
- I give permission for the above named researcher to have access to my responses in full. I understand that my name will be linked with the research materials, and I may be identified or identifiable in the report or reports that result from the research.
- I understand I may change my mind and be made anonymous (and accept the conditions contingent with this choice) at any time until 3 months after the date of my interview.

Name of participant

Date

Signature

Researcher

Date

Signature

Appendix 4 – Information sheet for participants

Information Sheet

This document provides an outline of the project 'Non-Binary Gender Identity Negotiation', so as to provide guidance for participation, explain what is involved, and what you are consenting to.

What is this project investigating and why?

This project looks at important factors that may influence how non-binary people experience their gender identities – queer communities, and medical practice. In doing so, the factors that influence what being non-binary means for individual people may be better understood. There may also be important findings which could influence the policy formation for both medical practice and LGBTQ groups, in order to better recognise and serve the needs of non-binary people.

What criteria do I need to fulfil to be involved?

- 18 years old or more at the time of participation
- A current resident of the United Kingdom
- Fluent or near-fluent written and spoken English
- A non-binary gender identity

A non-binary gender identity generally refers to any identity other than simply 'man' or 'woman'; though whether you fulfil this criterion is simply for you to decide. This project wishes to involve any and all people whose gender identities are situated outside of the gender binary, in whatever way or to whatever extent.

What will participation involve?

Participants will be keeping a 'mixed media diary', in order to give insights into experiences of, and/or thoughts concerning LGBTQ communities, and experiences of medical practice. Following this, participants will also take part in a single interview with the researcher to discuss the contents of the diary.

How long will the study last? How much time does it need from me?

Diaries will be kept for a period of four months. This will be between 1st February and 31st May 2015.

The researcher will make weekly email contact to help maintain engagement with the project, and to also offer potential ideas if you find coming up with things to write about difficult.

The follow-up interview which will be arranged after the diary keeping period is complete will take approximately 1 hour, plus any travel time to meet at the location which we agree upon.

What are my rights?

You will be asked to consent for the interview to be recorded (audio only, by Dictaphone) for later transcription and use by the researcher. You have the right to ask for a copy of this recording if you so wish, and to request that any particular parts of the interview are not referenced or used in any academic research.

You have the right to be made anonymous when quotations or images from your diary and/or interview are used in academic research. You have the right to choose your own pseudonym if you wish.

If you so choose however, you also have the right to be identified as a participant within this research (by first name only). Private information (such as your address) would remain confidential. The researcher cannot be held responsible for any unforeseen negative circumstances resulting from the choice to use one's real first name within the research.

If you wish to withdraw from the study completely you have until 1 month following the completion of your interview. If you have chosen to be identifiable but change your mind, you have the right to request anonymity until 3 months following completion of your interview.

None of the data produced in this project (your diary entries, the audio recording of your interview, or the interview transcription) will be shared with any third party, for any reason. Any personal correspondence between you and the researcher will also remain confidential. The only conditions in which confidentiality may be breached are if I am to

believe you pose a serious threat to yourself or others, or if it would be illegal not to breach confidentiality.

Once the PhD being written from this project has been completed, you will have the right to request a digital copy. You may also at this point request to have your diary sent back to you if you so wish.

How long will my diary and interview transcript be kept?

In keeping with the [RCUK Common Principles on Data Policy](#), your diary and transcript will be kept for 3 years from the end of data collection, or 2 years from publication, whichever is longer. This is to ensure that work utilising the data can be completed fully with faithful reference to the data collected.

Appendix 5 – Guidance Included with Diary

Guidance for engaging with the diary project

Thank you once again for engaging with this project. Below are some details which you may refer to if you struggle to think of what you could write (or produce through other means!). If you have any problems with the project, please email me at: ssbwv@leeds.ac.uk

Here are some questions that may help you produce diary entries:

- How are you involved with LGBTQ communities?
- What are your experiences with other LGBTQ people, with regards to your gender identity?
- What are your thoughts on other LGBTQ people's attitudes to non-binary people, generally or with regards to your personal experiences?
- What are your thoughts on medical practitioner's attitudes to trans people, and specifically non-binary people?
- What have your experiences been of using medical services, in relation to your gender?

LGBTQ communities

This is defined very broadly, so as to potentially include any interactions with other LGBTQ people. This could include your partner or partners (in private or public settings), or experiences of an LGBTQ/gay/queer/trans scene. It may include time with a friend or group of friends, or experiences working with or being supported by LGBTQ charities, clubs, or other organisations.

This list is by no means exhaustive. If you have any particular interactions in which you find your gender to be relevant, made relevant, or otherwise brought to mind, this may be a great topic to consider making a diary entry about. Include as much or as little descriptive detail of places, people and/or events as you feel allows you to best express yourself. You may wish to focus on how things make you feel, and why that might be.

Medical Practice

This is also defined broadly. Consider if you have previously accessed, are accessing, or may consider accessing in the future any form of gender affirming medical service (such as hormones, or surgery).

If this isn't relevant to you, don't worry! If, during the diary keeping period you access any other kind of medical service (for example, seeing a GP due to injury or illness, chronic or acute) – was your gender made relevant to the situation by another person, or did you think about your gender in relation to this experience in any way?

Relevance

If you are not sure whether writing about something is relevant, it's completely fine to include it anyway. The use of diaries is to try and view a 'snapshot' of your lived experiences. The process of keeping the diary aims to be a positive one for you (as a form of enjoyment, interest, or catharsis). Please remember you are not compelled to produce entries about anything you do not feel comfortable about.

Other Points

With the diary you have received an addressed envelope. This is for the diary's return (after 31st May). Please keep it safe until then, though if lost this can be replaced.

If you lose, or complete all the pages of your diary during the research period, please be in touch by email – I will provide a replacement.

You do not have to use the diary every day (but if you want to, please do!). I would estimate that using the diary at least weekly is necessary.

Remember that you may produce entries however you wish. Consider:

- Drawings
- Poetry
- Collages
- Video
- Audio
- Play-like dialogues
- Others...!

If you wish to use a computer instead (or as well as) this diary, that is fine. Please save digital text entries in one document, preferably Microsoft Word, with dates separating entries. Any non-text entries done on a computer can be saved separately – please use your name and the date of the entry as the file name. These can be returned by email after the diary keeping period finishes.

If you want to use bigger pieces of paper for entries than the pages, simply date them and include them in your return envelope. Please write the date (and time if you wish) with each diary entry.

Any further questions, please be in touch!

Ben Vincent

Appendix 6 – Interview Framework: General Questions

- Tell me about your interactions with the queer community. Do you use it for specific things?
- Do you have many queer friends?
- Does queer interaction affect how you feel about your identity?
- Do non-queer people do things which undermine your sense of identity? What/how?
- Do queer people ever do things which undermine your sense of identity? What/how?
- How do you deal with these things, respectively?
- Do you feel your identity has changed over time? How? What might have affected this?
- How do you talk about gender with different people in your life? What are your feelings about these interactions?
- How do you feel LGBTQ communities could improve?
- Has interaction with queer communities affected coming out experiences for you? If so, how?
- Have coming out experiences affected your queer community interactions? If so, how?
- How has queer community interaction shaped your feelings on:
Pronouns?
Public bathrooms?
- Have you ever had feelings of ‘not being trans enough’ or ‘not being non-binary enough’?
- Do you think people view non-binary identities as a stepping stone to a binary transgender identity (in queer communities, and by medical practitioners)?
- Is the gender binary manifest in queer spaces/interactions? If so, how?
- Do you experience dysphoria?
- What are your thoughts on the medical community’s interactions with transgender people? How about non-binary people in particular?
- How do you feel about GPs and medical staff more generally?
- Do you feel your identity impacts your experience of accessing medical services for non-gender related issues?

- Do you wish to access gender affirming medical services? Do you feel being non-binary affects this?
- What have your experiences been of medical administration? How has this affected you?
- How do you feel medical practice for non-binary people could be improved?