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## CONTEMPORALIS HOMO SACER: BARRIERS TO ACCESSING HEALTHCARE SERVICES FOR TRANS POPULATIONS'

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### ABSTRACT

**Objective:** to examine the lived experiences of trans-identified individuals accessing mental health care, and in particular, their perceptions of barriers to access.

**Method:** this qualitative study was conducted using interpretative phenomenological analysis and supported by Agamben's theory of Thanatopolitics. Eleven one-to-one, semi-structured interviews were conducted between December 2009 and January 2010.

**Results:** in our analysis, we identified the following main barriers regarding access to the healthcare system: healthcare providers' performance; and thanatopolitics of erasure. Through the analyzed experiences, we identified the existence of a (psychiatric) panoptical despotism lead by healthcare institutions, healthcare providers and public policies. Thanatopolitical psychiatrization and other passive erasure strategies have a cumulative impact because trans-bodies are not counted or not recognized fully as healthy individuals with specific health conditions.

**Conclusion:** the findings show that although there has been some progress, numerous challenges still remain in order to overcome the barriers to accessing healthcare services.

**DESCRIPTORS:** Transsexuality. Health services accessibility. Qualitative research. Public health. Gender identity.

## CONTEMPORALIS HOMO SACER: OBSTÁCULOS PARA ACCEDER A LOS SERVICIOS DE SALUD PARA LAS POBLACIONES TRANS

### RESUMEN

**Objetivo:** examinar las experiencias vividas por los individuos auto-identificados como trans al acceder a los servicios de salud mental y, en particular, sus percepciones sobre las barreras de acceso.

**Método:** este estudio cualitativo se realizó mediante el análisis interpretativo fenomenológico y apoyado en la teoría Tanatopolítica de Giorgio Agamben. Se realizaron 11 entrevistas semiestructuradas entre diciembre de 2009 y enero de 2010.

**Resultados:** en nuestro análisis, identificamos las siguientes principales barreras de acceso al sistema de salud: desempeño de los proveedores de servicios de salud y, la tanatopolítica de la invisibilización. A través de las experiencias analizadas, identificamos la existencia de un despotismo (psiquiátrico) panóptico liderado por instituciones sanitarias, proveedores de atención médica y políticas públicas. La psiquiatrización tanatopolítica y otras estrategias de invisibilización pasiva tienen un impacto acumulativo porque los trans-cuerpos no se cuentan o no se reconocen plenamente como individuos sanos con condiciones de salud específicas.

**Conclusión:** los hallazgos muestran que si bien se han producido algunos avances en la materia, todavía quedan muchos desafíos por superar con relación a las barreras al acceso a los servicios de salud.

**DESCRIPTORES:** Transsexualidad. Accesibilidad a servicios de salud. Investigación cualitativa. Salud pública. Identidad de género.

## CONTEMPORALIS HOMO SACER: BARREIRAS DA POPULAÇÃO TRANS PARA ACESSAR AOS SERVIÇOS DE SAÚDE

### RESUMO

**Objetivo:** examinar as experiências vivenciadas por parte de pessoas auto-identificadas como trans para acessar aos cuidados de saúde mental e, em particular, sua percepção de barreiras de acesso.

**Método:** estudo qualitativo que utilizou a análise fenomenológica interpretativa e a teoria Tanatopolítica de Giorgio Agamben como referencial teórico. Foram realizadas 11 entrevistas individuais e semi-estruturadas entre dezembro de 2009 e janeiro de 2010.

**Resultados:** em nossa análise, identificamos as seguintes principais barreiras em relação ao acesso aos sistemas de saúde: desempenho dos profissionais de saúde e; as políticas de invisibilização e apagamento. Através das experiências analisadas, identificamos a existência de um despotismo panóptico (psiquiátrico) liderado por instituições de saúde, prestadores de cuidados de saúde e políticas públicas. A psiquiatria tanatopolítica e outras estratégias de apagamento passivo têm um impacto cumulativo porque os trans-corpos não são contados nem reconhecidos como indivíduos saudáveis com condições de saúde específicas.

**Conclusão:** os achados demonstram que, embora tenha havido algum progresso com relação ao acesso aos serviços de saúde canadense, ainda existem inúmeros desafios para superar as barreiras de acesso.

**DESCRITORES:** Transsexualidade. Acessibilidade aos serviços de saúde. Pesquisa qualitativa. Saúde pública. Identidade de gênero.

### INTRODUCTION

The ruling classes have created mechanisms for the social control of subjugated populations in various contexts.<sup>1</sup> One such context is through the transformation of human conditions into disorders that require medical and psychiatric treatments.

For instance, some authors explain that medicalization is a process whereby more and more of everyday life conditions have come under medical domination, influence, and supervision.<sup>2</sup> Transsexuality is one notable example of a condition that has been subject to such medicalized social control.<sup>2,3</sup>

The medicalization of transsexuality and corresponding hormone replacement therapies and surgical interventions contribute to the normalization of non-normative expressions of sex and gender.<sup>3-6</sup> Such institutional processes of medicalization, invisibilization and social exclusion, govern life and death for members of the trans\* community, both symbolically and literally.<sup>7-9</sup>

A range of social, structural and political factors influence the health of trans-identified individuals.<sup>10</sup> In the public health context, trans-identified people often face barriers to accessing necessary health services and, as a result, experience poor health outcomes.<sup>11-12</sup>

Several studies have consistently demonstrated that poor access to mental health services in particular among trans people is complicated by experiences of stigmatization and “erasure” that are underpinned by heterosexist and cisnormative policies and institutional practices.<sup>13-15</sup>

Medicalization of trans identities contributes to the stigmatization of trans individuals and aims to control gender-variant bodies and bring them into line with the psychiatric system’s normative and socially expected standards.<sup>3,8,10,16</sup> In other words, the current healthcare system seeks social “normalization” through strategies of suffering.<sup>6-9</sup>

Health and healthcare access for trans persons are impacted by sociocultural factors including a lack of healthcare providers who are sensitive to the needs of trans patients, the absence of gender diversity in medical education training, and gaps in healthcare policy implementation.<sup>12,17-18</sup>

For example, it was found in the 2015 U.S. Transgender Survey that 25% of the respondents experienced a problem within the past year with their insurance related to being transgender, such as being denied coverage for care related to gender transition or being denied coverage for routine care because they were transgender. Additionally, 33% of those who saw a health care provider expressed having at least one negative experience related to being transgender, such as being refused treatment, verbally harassed, or physically or sexually assaulted, with higher rates for people of color and people with disabilities.<sup>19</sup> Furthermore, research indicates trans people have low rates of cancer screening due to a number of factors, including discrimination in the healthcare system, and for some, discomfort with having certain body parts screened (i.e. trans men who retain breast tissue may not want to have their chests examined by a medical professional).<sup>19</sup>

\* Trans is an umbrella term that refers to all of the identities within the gender identity spectrum.

Therefore, the healthcare needs for this population may not be effectively met, in part, because healthcare providers are ill-equipped to recognize and respond to their needs, and because of the practices and policies of healthcare institutions that make trans people invisible.<sup>11,13-14</sup>

Given the health disparities and unique access challenges faced by trans-identified persons, it is important to understand the perceived barriers they experience when accessing health services, and to develop approaches that may better meet their healthcare needs and provide equitable access to lifesaving services.

Some studies have identified critical and key factors that need to be contemplated by healthcare policies in order to guarantee an integral attention to the trans community. These factors include equity and universality of healthcare and the availability of interventions to reduce the burden. Despite these recommendations, progress has been slow.<sup>14,17</sup>

In order to address these needs, this paper aims to examine the lived experiences of trans-identified individuals accessing mental health care, and in particular, their perceptions of barriers to access. For the purpose of this research we define barriers to access as any situation or condition that limits or prevents a trans individual from receiving integral mental health care or to enjoy the benefits of the mental health system. In pursuance of achieve this goal, we drew from the contemporary philosophical work of Giorgio Agamben to plot a journey through the concept of thanatopolitics.

Giorgio Agamben is an Italian philosopher who performs his reflections on the basis of the biopolitical concept and its relationship with the sovereign power. Specifically, he studies the intersection between what is legal and institutional and what is biopolitical, not separating these two areas from each other.

In particular, this philosopher seizes Foucault's concept of *biopolitics* and suggests that the production of a biopolitical body is the original contribution of the sovereign power. According to him, modern biopolitics is related more or less to the inscription of individuals' lives within the state order. And in particular, he states that the political system governs the concepts of life and death – as a consequence of direct intervention on the bodies of populations as subjugated objects.<sup>20</sup>

This philosopher comes to show the implications of bare life (life without any institutional or

moral protection) in the political sphere as the original nucleus of the sovereign power - the bare life enters into the political setting from a paradoxical qualification: zoé-bios, exclusion-inclusion.<sup>21</sup>

According to him, zoé is the natural life, governed by the rules of nature and by the “wild/animal instincts” and bios is a life based on the praxis of being a subject with civic responsibilities in the society. Consequently, for the author it is necessary to develop the concepts of zoé (concept of life that is common to all living beings), bios (concept of life common to those who have rights) and bare life.<sup>1</sup>

Agamben describes in the first volume of *Homo Sacer* the original meaning of the exception of bare life: an institutional algorithm that plays an exclusive-inclusive role. The ideas of bare life and sacred life serve as a basis to understand the discussion that arises in “*Homo Sacer III: Remnants of Auschwitz - The Witness and the Archive*”.

On this specific book, Agamben introduced the term of *muselmann*, to identify those in the camps who were still alive, but had essentially stopped being subjects, incapable of doing anything other than surviving.<sup>22</sup>

Simultaneously, he presents one archaic figure: homo sacer (one who is naked, unprotected and devoid of rights, and therefore can be killed - physically or metaphorically - or erased without any punishment for those who perform those actions) as it marks the reverse side of the explicit paradox exclusion-inclusion.<sup>1</sup>

Subject to a power of death, the life of the so-called homo sacer, or banned, appeared in the scenario with a double paradigm: human to be murdered but not sacrifice (because they still have a zoe life). It is a “sacred” life put into a gray zone in which bios and zoe constitute a compass – it is for this abandonment to the power of death, that (bare) human life is politicized, as it is a political element originated from sovereignty.

These concepts, among others, are to Agamben originating elements in Western politics that mark the relevance of his thesis of contiguity and parallelism between sovereignty and biopower. We consider that the support of this theory is significant when analyzing the participants' experiences because it explicitly helps us understand that the access to the healthcare system has become “thanatopolitical”, which means that it is dominated by the politics of death and invisibilization which leave

the trans community exposed to the operations of (psychiatric and hegemonic) power.

The operation of this type of power is highlighted in recent research that underscores that trans populations have an elevated risk of experiencing mental health concerns such as self-harm and suicidality.<sup>23</sup>

Additionally, while this population requires access to mental health treatments in order to reduce the severity and duration of emotional distress, trans persons also report discrimination and victimization in the hands of healthcare providers.

Also, trans adults indicate that transphobia in health care settings emerges surrounding insensitivity, displays of discomfort, denied services, substandard care, verbal abuse, and forced psychiatric care.<sup>20</sup> By suggesting that, we firmly consider that policies and service gaps work to extinguish the possibility of a viable, vital trans life.

## METHOD

This qualitative study framed as a secondary analysis of data, was conducted using interpretative phenomenological analysis (IPA) and supported by Agamben's theory of thanatopolitics.

Phenomenology is a method of qualitative study that focuses on human perception and emphasizes people's personal experiences as they happen, in this case trans-identified persons' experiences when accessing the healthcare system.

This research was part of a larger mixed-method study called *Pathways to Effective Depression Treatment*. The main objective of this larger project was to understand the barriers to accessing mental health care among sexual minority women and trans people of all genders in Ontario, Canada.

Out of the total 706 people that responded to the *Pathways to Effective Depression Treatment* survey, 11 interviews were conducted with trans-identified participants living in the province of Ontario between December 2009 and January 2010. This number responds to the theoretical saturation of data where the researchers considered that reached a point in the analysis that sampling more data will not lead to more information. The inclusion criteria for the current study required that potential participants: (a) identified themselves within the trans spectrum; (b) be above 18 years old; (c) be proficient in English.

The *Pathways* study was approved by the Research Ethics Board at the Centre for Addiction and Mental Health (Toronto, ON, Canada), according to Protocol Number #126/2010-09. Among the participants, 6 identified within the trans-female spectrum, 4 identified within the trans-male spectrum and 1 identified as a two spirited woman.

Participants reported their sexual orientations as lesbian (n=2), gay (n=1), bisexual (n=1), heterosexual (n=3), pansexual (n=1), asexual/bi romantic (n=1), queer (n=1) and questioning (n=1). The mean age of participants was 40.2 years.

Interviews ranged between 45 minutes and 120 minutes in length (mean: 70 minutes) and were all conducted at private locations chosen by participants. The interviewer used a semi-structured interview guide containing questions related to the participants' interactions with healthcare institutions, experiences with healthcare providers and the perceived barriers (if any) encountered when accessing supportive mental health services.

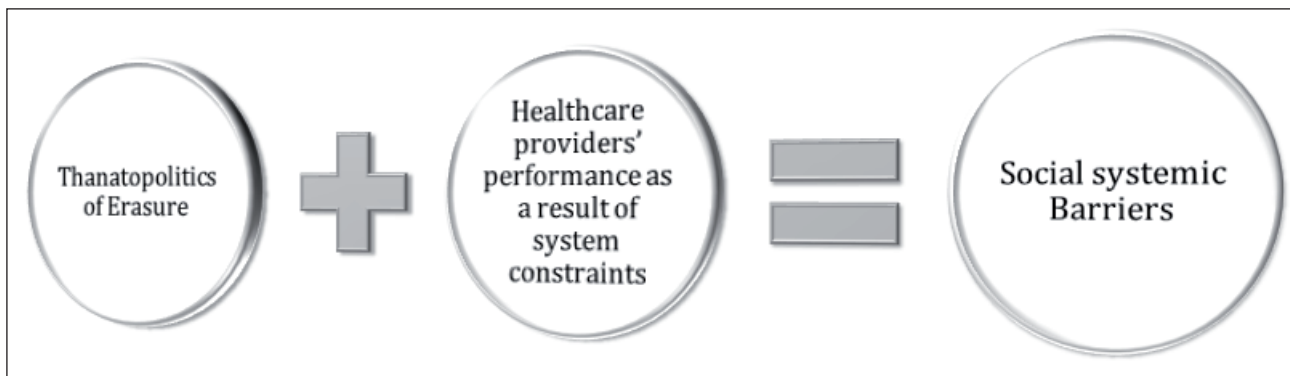
All interviews were recorded using a digital recording device and transcribed verbatim. Identifying characteristics were removed during the transcription process and the participants were assigned an identification code (Participant 1 to 11) in order to preserve anonymity.

Analysis directed the development of a preliminary thematic framework and the initial coding model structure. The transcribed data were coded and the concepts were defined following the theoretical referential.

The thematic framework was discussed and as a result we elaborated a code book with 55 initial codes grouped into 15 subcategories and 4 categories, which included explicit definitions of each theme and sub-theme. The researchers then reviewed and discussed the unified coded dataset. Following the coding process, data collected under each code were reviewed and summarized in an analytic memo list that resulted in the creation of one major category subdivided into two subcategories that will be discussed in the following section.

## RESULTS

From our analysis we identified the following main barriers regarding access to the healthcare system: (i) Healthcare providers' performance as a result of system constraints and (ii) Thanatopolitics of erasure (Figure 1).



**Figure 1 - Main perceived barriers when accessing to the healthcare system by trans identified individuals**

The major identified barriers in this research suggest that trans-identified persons may delay or avoid seeking services because of their experiences of discrimination or perceived transphobia within the healthcare system.

This article focuses specifically on healthcare concerns, although the experience of social exclusion and the processes of thanatopolitics, erasure and discrimination may also apply broadly in other settings.

### **Healthcare providers' performance as a result of system constraints**

The results show that some healthcare professionals tried to reduce the time of the consultation and also lack knowledge of trans persons' health care needs and/or have negative attitudes towards this population. These issues were characterized by persistent and diverse experiences including lack of provider interest and awareness, and expressions of apathy, disrespect and transphobia.

Here, the medical laws – embodied in the figure of the healthcare provider, represent one of the many exposed, visible faces of the machine that manages the bodies and lives of this population. That thanatopolitic scenario treats trans-identified people as living-dead beings through imposed erasure. These types of strategies were confirmed by participants through the following passive erasure actions they experienced during consultations and interactions with healthcare providers:

*At this point this counselor I'm seeing is not really supporting me. She often fell asleep during our sessions (Participant 3).*

*Just the fact that they don't specialize with transgendered issues. And there's a lack of understanding or – and sometimes it seems like there's a lack of wanting to? (Participant 9).*

*If there were more psychiatrists available who had a solid grounding in the basics of sexualities and gender identity, it would help enormously. It would help strengthen the communication between patient and clinician within a psychiatric assessment if that didn't become an unknown territory so easily to a psychiatrist. And they immediately become insecure and realize that they don't have the grounding to deal with what the patient's talking about (Participant 11).*

Some participants expected to be provided with dignity and attention, however, to their disappointment this was not always happening, despite the right to comprehensive, qualified, caring and updated services. The following participants elaborated on this theme:

*A lot of times they hear you, but they're not listening (Participant 2).*

*What parts of your life do you live full time in as a male?' And I said, 'It's all there in the file, it's all documented paper work.' 'Oh I don't read the file before the patient comes in.' And I said, 'Excuse me?' 'Oh I don't have time to do that' (Participant 10).*

Health care providers' lack of training or preparation for working with trans-identified persons, is one of the mechanisms of invisibilization used by trans thanatopolitics. This absence of professional preparation is not justifiable, mainly if we consider the growing demand for care services for trans individuals in the province of Ontario. Lack of knowledge of healthcare providers is echoed in the findings of this research where, some participants noted the following:

*I had already been told by a lot of people not to come here [to mental health institution]. So, I was reluctant to go, and then I came and it was just like hit after hit. It was worse than what was happening in emerg. Emerg you expect it from doctors and nurses that aren't familiar with trans people. But just by definition being in a gender identity clinic you would think that you know– the court rooms were as bad as the gender clinic (Participant 6).*

*I know that in the schools there isn't much learning done about transgendered issues and a lot of our new doctors have no knowledge of trans-specific issues – and that's what we need. We need doctors that are not afraid to step up to the plate because right now we don't have many doctors that are willing to start a patient on HRT [hormone replacement therapy] (Participant 5).*

The previous quotes imply that providers are unwilling to update their understanding, to transcend the old gender paradigms, and to access current available information regarding trans people. To us, this position designs a logic of cruelty that ignores, excludes, judges, classifies and orders.

To legitimize the social norms that restrain the lived experiences and feelings of human beings, thanatopolitical strategies lead to the invisibilization and pathologization of other ontological options. In other words, some healthcare practices uncritically empower and enact – without questioning – the current (conservative) political dogma on which our society is based: the existence of only two mutually exclusive ways of being and feeling. The participants' experiences of processes of medicalization and psychiatrization are summarized in the following:

*And then the first appointment [at the gender identity clinic] I had a forensic psychiatrist pathologize me and question, you know, if I had sex with animals or with kids or that kind of stuff. (Participant 4).*

*She [the psychiatrist] didn't listen at all. She came into the room with her [mental health] diagnosis ready, and I wasn't allowed to partake in my own healthcare (Participant 8).*

The preconceived and reductive conceptions by some healthcare professionals highlight the power of medical institutions. We are witnessing here a representation (a stock of values, ideas, metaphors, beliefs, and practices that are shared among the members of one group.) of care associated to the invisibilization and current psychiatrization of the trans identities.

In this sense, the psychiatric logic attempts to introduce the incomprehensible or strange in a horizon of axiological, normative and prescriptive meaning. The healthcare providers in this institutional setting have the power of deciding who can be inside and who must stay outside the system. Therefore, the (medical) law is not only normative, but also formative as it gives category to being. Some participants expressed this specific process within interactions with healthcare providers:

*They [the healthcare providers] simply just ignore you because you are like that... and 'If you push*

*it – I will do that to you', you know? 'I can squash you with a label like a flipping bug (Participant 1).*

In addition, some of the perceived barriers in mental health care were related to the lack of respect with regards to the trans condition. Respect is considered a basic component of all helpful relationships and is often cited as a core feature of successful therapeutic consultations.

Although the development of respectful and caring skills is a general feature that should be learned during medical training, healthcare providers may not recognize inherent obstacles to empathizing with patients from a different gender identity group (according to the participants' experiences, the majority of healthcare assistants were). During the interviews the participants described healthcare providers' lack of respect, and commented on the effects of this:

*When I was in front of the doctor it was all totally humiliating, the way they did everything to degrade who you are and be disrespectful. I wasn't expecting that. But that- it happens in [another hospital] too – over and over, but very subtle (Participant 7).*

*I did explain that I'd had a history of sexual abuse as a child and he just batted that off as – 'every other person that I interview has a sexual history - sexual abuse history.' 'That's normal,' he said. And it just felt like my experience had just, in a sentence, been discounted as relevant (Participant 10).*

According to participants, knowledge, interest, respect and communication were needed to facilitate the provision of trans-inclusive healthcare. This requires health care to be centered in the real needs of this population and be absent of any stigmatizing, psychiatrization and/or thanatopolitical actions.

## Thanatopolitics of erasure

The employment of thanatopolitics of erasure rather than politics of inclusion helps us to develop an understanding of the connection between trans populations and the current thanatopolitical reality and the articulation with power-domination relationships that circulates through society.

In this research, we consider the thanatopolitics of erasure as state policies based on the repression, invisibilization, and expulsion of marginalized groups such as gender minorities. Critical tactics of this thanatopolitical movement show a discursive struggle against governmental development, which legitimizes various processes of erasure i.e. the lack of policies.

This category brings to light some reflections related to the various ways thanatopolitics acts towards trans identities. The main strategies and perceived barriers according to participants are associated with: a) Lack of government support and weak policy framework i.e. Access to therapists since they are not covered by the Ontario Health Insurance Plan (OHIP), bureaucracy and waiting lists, absence of safe and trans inclusive places; b) Geographical barriers due to the gatekeeping of hegemonic institutions and the lack of professionals in different parts of Ontario.

Participants expressed these barriers in the following statements:

*well time is one of the barriers but cost is the major barrier, um, you know paying for a private therapist is really hard (Participant 7).*

*therapists are not covered for trans people. You know? Neither are hormones, which is a big barrier as well. I mean, if our hormones were covered we'd be able to express our way - ourselves the way that we wanted to, that we're meant to (Participant 11).*

There were negative reports of bureaucracy processes, waiting lists and the absence of safe and trans inclusive spaces that affected healthcare provisions. In some instances, participants waited for years in order to have access to the system, without being provided with any satisfactory health strategy beyond the psychiatrization of their condition, as several participants confirmed:

*I was still on waiting lists to get help and uh nothing was happening. I was supposed to get some help by the end of May and when May was over I basically decided that by June twenty-fourth I was going to kill myself. I realized if something was going to happen I would have gotten a phone call for an appointment, and there was none. So, I was sort of starting to prepare myself to just end my life. And uh that's where I picked the June twenty-fourth date to commit suicide (Participant 5).*

*But there was a whole pronoun issue at the gender identity clinic. Biggest thing was pronoun issue and he [the psychiatrist] was saying some, some line about, I wasn't really a guy, it was something like that, like he was directly rejecting my identity, which I found really very offensive, therefore I didn't feel safe (Participant 4).*

*I went to my appointment, the receptionist at (name of the institution) in the gender clinic is referring to me as Mr. [P64's last name] and I'm showing up like a woman. And I'm thinking of all the people in all the offices and all the hospitals, this is the one place I should be safe, right? (Participant 2).*

Such discursive ways of excluding also elide diverse ways of being individual. This politic of

erasure is lethal. Political erasure means the erasure of alternatives and the possibilities of being an individual and a citizen. The struggle against this type of erasure is a cultural struggle, not only over health conditions and needs, but also over the practices and meanings of everyday life.

In order to describe the lived experiences of the participants, it is necessary to admit that the crisis of the effectiveness of public policies lies in its design, implementation and dialogue. For example, we could say that despite the province of Ontario having within its legal framework some protectionist laws towards the trans population, its scope does not reach everywhere equally, due to the hegemony of some institutions responsible for managing diagnosis, trans-specific procedures and general attention. In addition, a lack of specialists was identified in more distant regions of the province, as expressed in the following quotes:

*I mean, we're losing them to big centers because, I mean, um, not being able to - to transition, medically, um, is a big barrier here up in the North. Um, our doctors are not willing to - to help us, you know, uh, transition medically (Participant 9).*

*Well, they always refer us to this gender identity clinic down south, which is not uh, to me, was not a very good experience. Um, it was an awful experience actually, I must say. But however, I was able to get the doctors this year, after six years of fighting with this institution, um, to finally allow me to transition medically (Participant 8).*

*And um, like I know that accessibility is also a big thing. I mean, not everyone wants to travel 12-14 hours to Toronto for 15 minute interviews (Participant 3).*

By placing biological life of some individuals (bios) over death (symbolic and literal) of others, in the center of their machinations, institutions of the state have done nothing but highlight the immemorial bond that links power with the declarations of life and death, visibility and invisibilization, consequently: thanatopolitics.

This reality places the trans-identified person as a *homo sacer* who has a bare life and who is the object (par excellence) of this thanatopolitical order. The bare life of this *contemporalis homo sacer*, brings into focus the political mechanisms and also the medical-health procedures that lead to a forfeiture of rights to live, to be and to exist.

## DISCUSSION

Trans-thanatological barriers to mental healthcare access could arise as a result of two phenomena: a) at the institutional level, the prevalence, of

a binary and hetero-cis-normative conception of gender which pathologizes and stigmatizes the diversity of the human dispositive; b) the prevalence and dominance of these (mis)conceptions are taken for granted truths within, broadly, the medical institution, and more specifically, within the domain of psychiatry.

Through our analysis, we identified the existence of a (psychiatric) panoptical surveillance (concept that was introduced by Jeremy Bentham) and regulation exercised by healthcare institutions, healthcare providers and public policies. In this scenario the panopticon takes on an institutional figure that combines (i)rationally the power of surveillance and punishment with an economy of resources: a real mechanism of control.<sup>1,21,24</sup>

This figure of observation (the panopticon) used by Foucault<sup>25</sup> but retaken by Agamben,<sup>1</sup> in the trans context, is aimed at “treating” “abnormal” behaviors through the implementation of a disciplinary regime: disrespectful treatment accompanied by a claim of control and discipline. Not coincidentally, the thanatopolitical psychiatric language converts different manifestations of human plurality (with respect to gender, but also other aspects of human experience) into diseases that corrupt the social system, and therefore justifies strategies of “normalization” and “social invisibilization”.<sup>22,24</sup>

This thanatopolitical system not only tries to make invisible and trivialize the needs of bodies that do not agree to the punitive cis-hetero-regulations, but at the same time, to delegitimize, discard and “erase” their feelings, thoughts and ontological/epistemological orientations. We acknowledge that the regulation of transition means that the system also prevents the creation (birth) of viable trans bodies.

Thanatopolitical psychiatrization and other passive erasure strategies have a cumulative impact, wherein trans bodies are not counted or recognized fully as healthy individuals with specific health considerations. The lack of interest in trans lives and trans issues among medical service providers and their governing institutions has resulted in a deficiency of information on health related topics, including issues related to medical practice, mental health, and trans-specific health care, which includes the transition-affirmation/confirmation processes as well as primary health care concerns.

In reference to Agamben’s notion of the *homo sacer*, a trans-identified person can be seen as a person who is banned and may be (metaphorically or literally) killed. In other words, according to Agamben,<sup>1</sup> a person who is declared as unprotected

by the law can consequently be murdered by anyone with impunity.

In the same way, the invisibilization perpetuated by healthcare providers and political institutions can be practiced with relative impunity, despite the extreme detrimental consequences for trans people. In this case, in fact there is some protection in law, and yet the injustices that are happening either don’t fall within the scope of those legal protections (in most cases) or providers/systems are getting away with it anyway (e.g., with extraordinarily long wait lists for gender affirming care compared to other forms of health care).

As Agamben<sup>20</sup> notes, if there is a law, we are always going to find someone inside and outside of it. With this in mind, the law protects and soothes but also legitimizes, normalizes, excludes and exterminates. In our analysis, we not only refer to the jurisdictional type of law, but to all institutional and moral law: a law that also has a gray area, an area of indistinction.

The normalization of suffering is one current thanatopolitical strategy. Specifically, this normalization is made manifest in psychiatrization, which deems trans people *homo-saceres* and therefore implies that they deserve to suffer through the “treatments” and “bureaucratic waiting lists” that bring them into line with the accepted “normal-sovereign”, i.e., the cisgender norm.

This reflects the notion of (partially) included bodies in the legal system but excluded from political life, as Mbembe<sup>26</sup> mentioned in his theory: dispossessed bodies (immigrants, refugees, deported persons, for example.) that are excluded from any political condition, are unable to identify themselves as citizens, since they lost all human rights and are exposed to death.

This chaotic reality shows indeed how the trans body could be not only an object to be dominated, but “the body itself becomes the redoubt of power”<sup>27</sup>. But here we are referring to exterminated, obviated, and bodies that are simply exposed.

Exposition in this sense it is related to be open to the possibility of a special form of negligence.<sup>28</sup> We talk about desecration of trans-identified bodies, through the silencing of abusive and neglectful behavior of healthcare professionals and institutions through their acts of invisibilization and erasure.

To be exposed and to have a bare life in the thanatopolitical sense is not confined only to the social environment. In this view it is more related to the political sphere. To be exposed then involves



the deprivation of something in life.<sup>9,28-30</sup> We can say that this kind of exposition or deprivation of access to resources that could guarantee the satisfaction of the needs of many trans-identified people.

Facing the above statement, it is valid to ask, what do the healthcare providers performance and the thanatopolitics of erasure expose? What would be the place of trans-identified bodies and their emotions in this type of dynamic? Our data suggest that trans-identified bodies have been expropriated of their own authentic individuality and identity.

They have been exposed and converted into “universal types of bodies”, threatened with symbolical death if they offer any kind of resistance to this type of power of psychiatrization. The *contemporalis homo sacer*, personified in the figure of the trans-identified person, instigates a reflection on the very meaning of the “person category”.

First, it is clear that “person” is not a simple concept. Like all moral concepts, we are not describing an entity, but rather, the “person category” is a performative device which operates (perhaps in a subliminal way) as a mechanism of control and validation.

But beyond this point, Agamben<sup>21</sup> raises whether morality (and not only the jurisdictional system) exerts a differentiation that legitimizes the value of some lives (e.g., cisgender) over others (e.g., trans). We further note that life and death in this sense are not biological concepts, nor purely legal or political concepts.

Life and death are moral categories managed by the sovereigns. In our analysis, those who exercise cruelty upon lives that have been classified as unworthy of being lived are not only politicians but also doctors and other healthcare providers. All these figures govern our lives by following (il) logic that legitimizes their moral actions and decrees of (metaphorical) death through their positions of power.

The question that is formulated by Agamben<sup>1</sup> is essential, in order to understand the moral (il) logic against trans persons: what is that zone of life that is beyond the symbolic dead? Who is the dead body now? It is obvious that here we are not talking about biological or technological stages, but political and moral. The figure of the trans-identified individual, brings forth the idea of a *Terra nullius* (nobody's land): neither life nor death, at least in the usual sense of these words, because, through the lens of the *contemporalis homo sacer*, the trans body questions the borders of the recognition of life and the exposure to death.

This figure opens a space of indeterminacy between the medical (psychiatric) field and the law, but also between what is legal or illegitimate; trans bodies therefore are governed by moral, political, and thanatopolitical power. Finally, we consider that it is not appropriate to generalize the findings in this study to all transgender people.

## CONCLUSION

This research illustrates the general lack of inclusive mental health services available and the need for change within the psychiatric model currently available to care for trans-identified persons.

The participants speak with useful detail about their experiences when accessing the systems of care through institutions and health care providers – which in general had a lack of specific trans expertise and integral care.

The data reflected here portray a thanatopolitical reality of our times. This returns us to the idea that the trans body is a *contemporalis hominis sacri* body, and as a collective body it is plausible to express disagreement with the homogenizing (even hegemonic) cis-generic strategies. We speak of *contemporalis homo sacer* that possess bodies and emotions subjected to the tactics of psychiatrization and that are exposed to the process of profanation, exhibition, invisibilization and exception.

Trans bodies that are constantly excluded by the application of asphyxiating protocols and long waiting lists. From the thanatopolitical perspective, we conclude that limited progress has been made within the field of trans inclusion.

Although there has been some progress (policies that will allow health-care professionals to provide patient referrals for gender (re)affirmation/confirmation surgeries, and accompanying reductions in the long wait lists) numerous challenges still remain. For example, the stagnant psychiatric hegemony over the trans experience and the lack of control and execution of the current laws are primary challenges yet to be addressed. In principle, we are lacking in quality of enforcement management and quality of control management.

Simultaneously, it is evident that there is a need for preparedness and professional awareness regarding the trans condition and that decentralized healthcare institutions could make inclusive care accessible to all areas of the province. This integral health approach could finally help to achieve improved equity, efficiency and quality of trans care.

It is important to note the methodological limitations of the study. As previously discussed, an important limitation in this research program is the number of participants. Future research would benefit from the use of a larger sample of participants and combine their realities among other provinces or contexts.

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