THE TRANSGENDER BINARY AND GENDERQUEER HEALTH

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by

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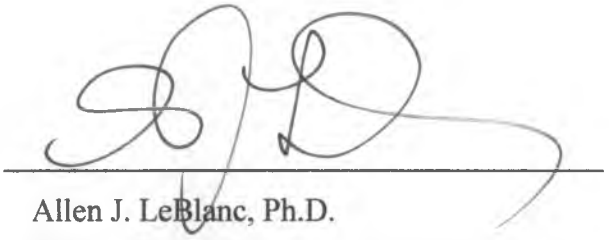
CERTIFICATION OF APPROVAL

I certify that I have read The Transgender Binary and Genderqueer Health by James Elliot Lykens, and that in my opinion this work meets the criteria for approving a thesis submitted in partial fulfillment of the requirement for the degree Master of Arts in Sexuality Studies at San Francisco State University.



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Academic discussions of transgender identities and healthcare have increased in recent years, but genderqueer and non-binary (GQ/NB) identities are largely ignored within health research. Although researchers and practitioners are aware that GQ/NB identities differ from the identities of binary transgender people who describe themselves as men or women, they continue to group GQ/NB people under binary transgender services. In this exploratory study, I interviewed ten GQ/NB people about their healthcare experiences. These interviews were analyzed using an emergent coding approach. The themes that emerged from this data include; the negative impact of medical providers who are not well versed in GQ/NB issues, the use of transgender binary scripts to receive desired health services, and issues of insurance coverage.

I certify that the abstract is a correct representation of the content of this thesis.

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5/25/2016
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PREFACE AND/OR ACKNOWLEDGEMENTS

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Terminology

This thesis uses multiple terms that describe gender. These terms focus on different aspects of gender identity that have evolved over time. Transgender is the most commonly used term for individuals who identify with a gender that differs from the sex they were assigned at birth. However, the term transgender does not adequately reflect the diversity of the broader gender minority community. Consequently, this thesis uses multiple terms in attempt to reflect the diversity of gender identity, as described below.

Non-Transgender/Cisgender: These terms refer to individuals who identify with the gender that is socially and institutionally connected to their sex assigned at birth (see Stryker, 2008). Literature often uses the term "cisgender" to describe these people, however this thesis uses "non-transgender" as a way to center trans-spectrum experience.

Trans-spectrum: This study uses the term "trans-spectrum" to identify many types of gender identities in one signifying category. Deploying the term "spectrum" next to "trans" emphasizes the diversity of gender identities, and does not suggest that most people who are not non-transgender will want to "transition". Thus, trans-spectrum refers to any gender identity that can be considered outside of non-transgender experience, including but not limited to transgender, transsexual, genderqueer, non-binary, queerfemme, butch, agro, and neutrois.

Transgender Binary: Current understandings of the identity "transgender" revolve around a transition narrative in which a person is born with XX or XY expressed characteristics, but then at some point in their lives begin to identify with the "opposite"

sex or gender. Typically, healthcare providers and scientists are well versed in this narrative, and assume that all individuals who are not of non-transgender experience have uniform desires to "transition" to the "other" sex or gender. Individuals with binary trans-spectrum identities continue to replicate the gender binary of man/woman by clearly identifying at those ends of the gender spectrum. However, this erases gender identities outside of or within that spectrum. Transgender binary refers to this narrative and the idea that individuals who "fully transition" may be considered as "binary", albeit within the transgender experience.

Genderqueer/Non-Binary (GQ/NB): Genderqueer and non-binary are included as one term in this study because the two terms are often used interchangeably, and produce the same meanings. These terms define gender identities that defy or complicate the binary nature of man/woman or transgender man/transgender woman (see Burdge, 2007 and Otis, 2015). GQ/NB defines individuals who identify themselves as an amalgamation of both female and male traits or as having a complete lack of female and male traits. GQ/NB people complicate the nature of gender identity by living in the grey space of gender.

Introduction

As we move into what Time Magazine has called the "Transgender Tipping Point" (Steinmetz, 2014), growing social discourse around gender has begun to permeate our daily lives. Terms like *gender identity* and *transition* are now frequently used within both academic and public discourses. As transgender visibility increases, society has begun to see a long-needed type of gender justice beginning to take place, in which transphobia, discrimination against trans-spectrum people, transgender-spectrum rights, and health disparities faced by gender minorities are becoming recognized and addressed. Iconic transgender-spectrum people have helped to aid this visibility by sharing their experiences, including people like Laverne Cox (a transgender woman who is most known for her role in the show *Orange is the New Black*), Lana Wachowski (a transgender woman known for her direction of the *Matrix* film trilogy), and Elly Jackson (a non-binary singer in the band La Roux) (Day, 2015). And although there is still much critical work to be done, it appears that the transgender-spectrum movement has made key advances.

But there is an important issue that has not yet been fully recognized within this historical moment. Despite increased legal rights and visibility, a large swathe of gender identities has been pushed aside. Individuals who identify as genderqueer or non-binary (GQ/NB)—or, individuals who do not see themselves as wholly male or female, or identify their gender along or outside of the female/male continuum with an amalgamation of male and female traits (Otis, 2015)—do not fit the tipping point

narrative. Public knowledge of transgender-spectrum identities often closely aligns with what media and academic studies produce, and both have continued to focus on the gender binary of male/female. In other words, transgender-spectrum people who identify and present strongly as either *man* or *woman* have become the faces of the transgender-spectrum movement, at a cost to people with other gender identities that resist the idea of man or woman. Transphobia and discrimination have been addressed politically, but advances are generally being made in clearly binary ways. For example, individuals who "transition" can clearly change their sex marker on birth certificates, use the binary bathroom that aligns with their gender identity, and access surgeries that are predicated on binary concepts of primary and secondary sex characteristics.

This binary understanding is constructed around a narrative of what it means to be transgender, and has resulted in terms like "transition" and "passing" as the focus of countless transgender inquiries. Consequently, academics and health providers often focus on the medicalization of the body when attempting to understand transgender-spectrum identities. More fundamentally, transgender identity development theories typically revolve around the central aspect of the "transition" from one gender to another, with a clear beginning gender and distinct ending gender (Coolhart, Provancher, Hager & Wang, 2008; Piper & Mannino, 2008).

Often beginning with the questioning period of gender, a common and stereotyped storyline appears within media, academic inquiry, and news articles: the person experiences cross-dressing at an early age, they eventually identify as the

"opposite" sex, they begin hormones, they change their legal name and gender marker on all of their personal documents, they undergo "top" and/or "bottom" surgery, and then they "complete" their transition (see Meyerowitz, 2009). Consequently, healthcare and medical training funnel time and resources into work that addresses each stage of this narrative (Obedin-Maliver et al., 2011). Indeed, employers and government programs have begun to cover transgender services and gender confirmation surgery (GCS) at higher rates than ever before (Herman, 2011), but these services disproportionately benefit those who adhere to this binary transgender narrative.

For example, providers often offer hormones at "cross sex" doses, assuming that each patient with a transgender-spectrum identity wants them. State governments are streamlining the process of legal documentation changes (Herman, 2013), assuming that individuals simply want to change the "M" to "F" on given documents—or vice versa—*faster* as opposed to creating a new gender marker that reflects a genderqueer or non-binary identity (see Harrison, Grant, & Herman, 2012). And lastly, as academic articles continue to produce nuanced understandings of transgender-spectrum identities, many studies fail to accurately document and represent the transgender-spectrum community in its entirety by only asking if participants' genders are male, female, transgender man, transgender woman, or "other" (Harrison, Grant, & Herman, 2012). By failing to ask questions that recognize and document their existence, the research community alienates GQ/NB people from participating in their work. As a result, GQ/NB individuals are vastly underrepresented in existing scholarship (Tate, Ledbetter, & Youssef, 2013).

In these ways, the most highly validated and visible population within the transgender-spectrum community is the binary transgender population. The binary transgender population refers to people whose identity is the social "opposite" gender of the sex they were assigned at birth (including female-to-male transgender men and male-to-female transgender women). Those that live within the non-binary area of gender are largely underserved and unrepresented, and are often delegated to the last gender response of "other" in research protocols. Consequentially, we are steadily learning and building understandings of binary transgender people and the services they need, but much less is known about the experiences and needs of GQ/NB people.

Indeed, GQ/NB populations face many unique challenges. For example, legal documents do not include gender neutral (let alone GQ/NB) gender options, surgeries still continue to offer procedures that focus on "complete" transitions, and counselors and other providers are being trained in binary transgender identities but hardly (if ever) GQ/NB experiences (Budge, Tebbe, & Howard, 2010). It is essential to better understand these challenges in order to begin addressing the health needs of GQ/NB people. In response, this thesis examines the experiences of GQ/NB people as they seek and access healthcare and gender affirming services in order to clearly document what it means to access healthcare as a GQ/NB person.

Literature Review

An examination of the literature illustrates a lack of knowledge surrounding GQ/NB persons, especially regarding their experiences of healthcare. An historical

account of transgender-focused studies and cultural understandings helps illuminate why such underrepresentation occurs.

Creation of the Binary Transgender Narrative

Most historical recounts of the transgender movement begin with Christine Jorgensen, who was considered a pioneer of the transgender movement as being the recipient of one of the first documented "sex reassignment" surgeries (Doctor, 2008). The construction of the binary transgender narrative has evolved from this early conception of what it meant to "transition" between two clearly delineated sexes, with Jorgensen embodying the societal fascination of hypermasculine to hyperfeminine, as seen in her "GI Joe to Bombshell Beauty" story (Meyerowitz, 2009). One did not simply "stop" mid-transition if they were "truly" transgender. During this period—in part due to the visibility of Jorgensen—academics and medical institutions began to fully embrace the medicalization of transgender bodies and began developing advanced scientific techniques that made gender confirmation surgery possible (then known as sexual reassignment surgery) (Bockting, 2009; Meyerowitz, 2009).

As medical discourse around transgender bodies grew, the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) incorporated "Gender Identity Disorder" (GID) among its listings of psychiatric disorders in 1980, which further psychopathologized transgender-spectrum identities (Zucker, 2000). However, this did lead to an increase in transgender-related medical procedures, with hospitals and surgical centers in the 1950's incorporating gender-related surgeries in their services.

Most notably, the Johns Hopkins' Gender Identity Clinic was built in 1965 and became the first US medical institution to offer gender confirmation surgeries; funding for this clinic was largely made possible due to the DSM-III's inclusion of gender identity disorder (Meyerowitz, 2009). However, while resources began to be ciphered into services and research that focused on genital surgeries, cross-sex hormones, and chest reconstructions, very little time was spent on understanding the psychosocial experience of transgender-spectrum people (Meyerowitz, 2009). In turn, the reputation and power of these medical institutions helped form the public's understanding of transsexualism (the word used at the time to describe transgender-spectrum people) as a medical phenomenon in which hormonal deficiencies naturalized transgender-spectrum identities, further cementing a connection between physical body alterations, physiological causes of gender identity, and transgender-spectrum people.

In recent years, greater attention has been paid to the healthcare needs of transgender-spectrum populations. In 2013, the newest version of the DSM—the DSM-V—updated the previous diagnostic title of "gender identity disorder" to "gender dysphoria" in an attempt to curb the blatant transphobia in the healthcare industry—by doing so, the American Psychological Association (APA) highlighted that emotional problems which arise from gender dysphoria actually stems from societal stigma, rather than the transgender-spectrum identity itself (Chan, 2011). At the time of this thesis, aversion and conversion therapy has been deemed illegal for minors in five states,

effectively stopping the practice of forcibly converting transgender-spectrum youth to non-transgender identities (Shear, 2015).

However, the language used to focus on transgender-spectrum rights continue to highlight binary transgender people. Because the transgender movement has focused on binary transgender people, it has done very little for those that live outside of the binary. GQ/NB people cannot simply be swept into the binary transgender definition. Living within the grey area of the gender spectrum brings with it unique experiences distinct from binary transgender experience, especially in the context of seeking and accessing healthcare (Budge, Rossman, & Howard, 2014).

What We Currently Know About Genderqueer and Non-binary Health

The transgender-spectrum population experiences health disparities, including higher rates of HIV/STDs, harassment, and poor mental health (IOM, 2011, p. 190). Emerging evidence shows that within this population, the GQ/NB subpopulation faces even greater disparities. The 2010 National Transgender Discrimination Survey (NTDS) showed that GQ/NB people face unique aspects of discrimination and health disparities compared to their binary transgender peers (Grant et al., 2010). GQ/NB people reported elevated rates of minority stress-related health issues (a term coined by Meyer; see Meyer, 2003), including harassment, sexual assault, suicidal ideation/attempts, and discrimination in healthcare settings. GQ/NB youth experience high harassment rates in K-12 schools (83%) compared to other trans-identified people (77%). The reported rate of sexual assault in K-12 schools was also 6% higher for GQ/NB people. Suicide

attempts were also slightly higher for GQ/NB people (43%) than binary transgender people (40%). And, perhaps most relevant to this thesis, 36% of GQ/NB people in this sample postponed medical care due to a fear of bias, as compared to 27% of binary transgender respondents (Harrison, Grant, & Herman, 2012).

Despite the fact that GQ/NB people make up a large percentage of people within the transgender-spectrum community (22% in a national sample of 1,416)(Grant et al. 2011), only recently has research revealed that GQ/NB people experience health issues that are unique and separate from binary transgender health disparities. This may be because our knowledge of GQ/NB health is limited due to a preconception of "transgender health" as solely involving individuals who have medically transitioned to either man or woman. In addition, research on GQ/NB health remains stunted due to the term "genderqueer" missing from the medical field—a field that usually focuses on "transsexual" as the term of choice for those that exist outside of non-transgender experience (Deutsch & Buchholz, 2015; Kuper, Nussbaum, & Mustanski, 2012). In addition, the DSM played a role in obscuring GQ/NB people by not including them in the definition of the first three editions of GID, causing psychological literature to continuously neglect GQ/NB people within psychological research (Bilodeau, 2005). Thus, we know very little about how GQ/NB access and experience healthcare. Some research has illustrated best practices for clinicians and providers who work with GQ/NB clients by highlighting the importance of intake forms with multiple pronoun choices (see

Hendricks & Testa, 2012). However, we have failed to document the lived experiences of GQ/NB people as they seek and access healthcare.

This thesis aims to draw attention to the unique healthcare needs of GQ/NB persons. In order to alter the binary transgender narrative—in which important aspects of GQ/NB lives are made invisible—studies such as this one are needed to more clearly document the diversity of experience within the trans-spectrum community.

Methods

This study used a qualitative research design to gather data regarding healthcare experiences among GQ/NB people. Qualitative interviews are ideal for this project because they can produce detailed personal accounts of social experiences, which allows researchers to present these narratives in the participants' own words (Berg, Lune, & Lune, 2004). A semi-structured interview protocol focusing on healthcare seeking and access experiences was developed and administered to 10 GQ/NB people. Questions were inspired by literature surrounding transgender-spectrum health disparities. I encouraged participants to tell stories that went beyond the scope of the structured questions. By doing so, participants were able to organically describe their attitudes and experiences of healthcare beyond the semi-structured protocol. Interviews lasted approximately 45 minutes. All participants received a $10 Visa Gift card for participating in the study. See Appendix A for the full interview protocol.

Recruitment

I purposively recruited a sample of GQ/NB identified adults, ages 18 and over, who spoke English, had accessed healthcare at least once in the past 6 months, and lived in the San Francisco Bay area. A representative sample of GQ/NB people was not possible because we do not currently know the nature of the GQ/NB or greater transgender-spectrum population at large (Chalabi, 2014). Thus, purposive sampling was needed in order to capture individuals who identified as GQ/NB. Once Institutional Review Board approval was secured, I worked to identify venues and organizations popular with GQ/NB communities across the SF Bay Area. This was done using a Google search for LGBTQ organizations and groups. Search terms included LGBTQ, transgender, organization, center, and group. Study fliers were posted on public posting boards at the located recruitment venues.

Participants found the study flier and followed the presented link to an online screener survey (For a copy of the screener, see Appendix C). Once the screener survey was complete and the participant was deemed eligible, I reached out to them in order to set up an interview. Individuals who agreed to participate met with me at offices in the Center for Research and Education on Gender and Sexuality (CREGS) at the downtown San Francisco State University office or the Health Equity Institute office on the San Francisco State University main campus. Interviews lasted approximately half an hour to 45 minutes. All interviews were audio-recorded and transcribed, and then the resulting transcripts were de-identified.

Participants

On the screener, all participants reported that they identified as GQ/NB, in addition to self-reporting their gender identity in their own words in response to an open-ended question. In order to capture this subset of GQ/NB people, it was important to document expressed and personalized terms for gender identity, while still maintaining a quality check to insure that participants did identify themselves within the GQ/NB category. The table below illustrates the nature of the sample, using pseudonyms to protect participant confidentiality.

The mean age of participants was 26.6 (range: 23 to 33), with eight participants assigned female and two participants assigned male at birth on their original birth certificate. All participants indicated in the pre-screener survey that they identified as genderqueer or non-binary. In addition, all participants used the pronoun they/them. Further gender identities reported are genderqueer/trans, genderqueer/femme, non-binary/agender, genderfluid, Two Spirit, and feminine other. Five participants identified as White, two as American Indian, two as Asian, and one as Mexican. While the participants did answer the screener question on racial identity using the census racial/ethnic identity categories, I chose to list the racial/ethnic identities that participants used during interviews. It is important to note that the census categories received criticism from participants, thus my decision to report their self-defined racial categories here.

The majority of participants identified their sexual orientation as queer ($n = 9$), and one participant identified their sexual orientation as asexual. In addition, nearly all participants had health insurance ($n = 9$). For those who had health insurance, seven participants received health insurance through their job. Further, participants chose their own pseudonym for this study. Lastly, participants had their most recent doctor's visit in the past month ($n = 6$) or in the past six months ($n = 4$).

Table 1. Participant characteristics

Name	**Age**	**Gender**	**Sex Assigned at Birth**	**Race/ethnicity**	**Sexual orientation**
AJ	24	Genderqueer	Female	White	Queer
Harper	25	Genderqueer Androgynous	Female	Mexican	Queer
Lee	33	Genderqueer Trans	Female	White	Queer
Ren	29	Feminine Other	Female	Asian	Queer
Ryan	24	Genderqueer	Female	White	Queer
Samir	24	Non-binary, Agender	Female	White	Queer
Simone	25	Genderqueer	Female	White	Queer
Skyler	30	Genderqueer, Femme, Two Spirit	Male	American Indian	Asexual
Vera	29	Two Spirit	Male	American Indian	Queer
Vern	23	Genderfluid	Female	Asian	Queer

It is important to note that it was particularly difficult to locate and recruit individuals who identified as GQ/NB and were assigned male at birth on their original birth certificate. Only two participants indicated that they were assigned male at birth on their original birth certificate. The sampling of the NTDS found that 73% of genderqueer

respondents were assigned female at birth (Harrison, Grant, & Herman, 2012), pointing to a higher prevalence of GQ/NB identities among individuals assigned female at birth. Reasons for this remain unclear, but should be considered when working with GQ/NB people.

Analysis

This study utilized an emergent coding approach to document participants' experiences as GQ/NB people seeking and accessing healthcare. This approach allows critical and organic themes to surface across participants, and highlights shared experiences that are particularly salient and meaningful (see Braun & Clarke, 2006). Multiple codes were derived from the transcripts. I read the transcripts in depth multiple times and simultaneously located and coded prominent themes in order to accurately capture concepts, terms, and issues brought up by participants. If a concept spoke directly to the experience of seeking and accessing healthcare as a GQ/NB person, that concept was coded and documented. Codes were then categorized into eight discrete themes with titles that described the overall nature of the theme. For a list of all themes with coding definitions, see Appendix B.

The most common theme was the providers' inability to see beyond the transgender binary, which resulted in GQ/NB people being incorrectly labeled as transgender. This overarching theme was considered the root of many problems faced by GQ/NB when accessing healthcare. The themes discussed afterwards are effects of the

binary transgender narrative, and how this narrative affects experiences of GQ/NB people seeking and accessing healthcare.

Findings

(1) "Nobody Knows What to do With a Genderfluid Body." – Lee

Providers' Inability to See Beyond the Transgender Binary

Within healthcare experiences, a common theme emerged among participants: the inability for providers to envision and understand gender variant identities outside of non-transgender or binary transgender. This overarching theme illustrates the shared experience of being a GQ/NB person seeking and accessing healthcare. Most importantly, the transgender narrative does more harm than good for GQ/NB people who wish to access gender-related care. Nearly all participants (90%) had experienced providers who attempted to reword the participant's needs in terms of binary transgender care. Most often, this was reflected in the actions of providers who provided prescriptions for hormones or letters of support for gender confirmation surgeries that the participants did not request or desire. Even when participants pushed back against this assumption and explained that their identity did not always correlate with the desire for surgeries or hormones, providers consistently used the binary transgender narrative as a way to justify their recommendations for medical interventions.

Samir speaks to the idea of the binary transgender narrative, and how it has affected their experiences of healthcare:

> "So I think that ways that providers can acknowledge us is just not assuming that any particular medical intervention that you're seeking out necessitates that you get the other. For instance, when binary trans people tend to seek out things, the standard formula is you get on hormone replacement, and then you get top surgery, and then you get bottom surgery. You would handle all that in those steps. And that's the standard idea in the medical field [...] And you know that narrative doesn't apply for every binary trans person, and even more so for non-binary trans people because it's even less clear sometimes what people need if you're non-binary. Because medical people have this idea of what you should or can get if you identify that way, but they don't have a notion of what a non-binary person is supposed to look like. They can look like anybody. So the idea of transition doesn't work for us. So, I think that just has to do, personally, with whatever that person feels like they have to do to their body to um, be comfortable in their body. And they know that best, more than anybody else does."
>
> *Samir, 24, Non-binary Agender, White*

Skyler illustrates the frustration that came about when their provider insisted that they consider hormones and surgeries, despite the fact that Skyler did not desire these medical procedures. In addition, Skyler's provider consistently labeled Skyler as a transgender woman, despite the fact that Skyler said otherwise. This labeling went so far

as to assume that Skyler wanted services that are common within the binary transgender narrative, including hormones and surgeries:

> "The doctor there, you know she was very nice […] and I said I wasn't sure what I wanted. I told her about my identity when she asked me. And I remember she asked me if I was a transgender woman. I felt a little taken aback at that but it was understandable, most people like me may be perceived as transgender women. But the problem was after I told her that, it didn't convince her. She asked me if I had ever thought about transitioning, and I told her I couldn't, because I was already male and female. And at that point I was just upset and snappy at her. Well, she didn't get it. She kept asking me if I had ever considered breasts, or how did I feel about my penis. She was very adamant about it. Even after I was visibly upset. She kept asking to the moment I left, if I needed a letter for surgery to come to her. But I never asked for any of that."
>
> *Skyler, 30, Genderqueer Femme Two Spirit, American Indian*

A similar experience was shared by Vera, who explained that they ceased their medical care because their provider consistently failed to acknowledge their identity by insisting Vera would need medical interventions. Vera shared a narrative about a provider's assumption that they did not like their genitals and would need gender confirmation surgery (i.e., bottom surgery):

> "I remember that she [the provider] thought I hated my penis. This was so bizarre to me, you know, because I used it, I was fine with it. But she was

> seriously convinced [I hated my penis] when I said I was non-binary. She told me on—well, she told me like three separate times—literally three separate times—to consider removing it, to consider bottom surgery. Like to transition, whatever that means. She didn't even really believe that I liked using it for sex. I left after the third time, I couldn't take it anymore."
>
> *Vera, 29, Two Spirit, American Indian*

Simone echoes the frustration of these assumptions, and further describes that these assumptions are based on providers' belief that they know what is best for GQ/NB patients:

> "Yeah, so I don't know what he thought, but he, well when he gave me the letter for top surgery I said I didn't want it, and he said… well, he basically said take it, because, you're gonna change your mind later. You're gonna want this, when you, when you finally get around to it. And can you actually believe that? So, what, I don't know, like I don't know my own body? You know my body better than me?"
>
> *Simone, 25, Genderqueer, White*

Harper also describes the frustration of providers attempting to push them into a binary transgender narrative by prescribing them large doses of testosterone (frequently shortened to "T" within the community), which had an impact on the relationship between Harper and their provider:

> "But you know I think the thing that really made me nervous was like, he, well when I told him like I wasn't like my friends who came in like I didn't know what I wanted or anything like that, in terms of like how much T I would be taking or something like that… um, I told him you know doc, I only want a small dose, I'm not trans or anything. He was really confused and that made me nervous 'cause you know it's understandable and everything, like he was used to my friends who wanted, like, well I guess they wanted a higher dose and stuff. But here I was wanting a smaller dose and I told him because I'm genderqueer I don't wanna look like no, um, wrestler, I didn't want the muscles or anything like that. I wanted to be in between and keep my androgynous look. Then it was hard for me to see him [the provider] after that."
>
> *Harper, 25, Genderqueer Androgynous, Mexican*

When GQ/NB people access gender-related services, they are often put into a position that forces them to either ascribe to the binary transgender narrative or defend their GQ/NB identity. Vern speaks to "doubly defending" their gender identity from the binary transgender narrative when they access healthcare:

> "Yeah I mean I wish people just would care about pronouns more, and not just assume I want, like I was saying like I don't want high T. The very few providers, like I've met very few providers who even know what genderqueer kinda means. But you know, even for people who like understand, like they know when I say genderqueer and they know what that means and that I probably go by they and

them pronouns. But they still think I want to transition, they still think I want to take a shit ton of T and look like a hyper bodybuilder. They think I want all of this stuff. And so when I walk in, I gotta defend my gender identity, which even sometimes trans people don't have to do if they're at a good clinic. But like even trans clinics, I gotta first defend my gender identity, then I gotta secondly defend why I don't want all this transition stuff."

Vern, 23, Genderfluid, Asian

Ren also speaks to the experience of being apprehensive about accessing gender-related care because they do not want to access hormones at the level that most binary transgender people do. This fear stops Ren from accessing gender-related care because they believe they will be turned down for not fitting the binary transgender narrative:

"My friend, well he's trans and he wanted top surgery and he got it. No question. And he got it here at the clinic, and it was easy for him, um, doctors gave him top surgery. I don't want that though, but I want, maybe a chest reduction surgery, um, but I don't want pecs. I don't want a man torso, just slimmer, I think. So doctors I don't think will do that. So I want different stuff um, that maybe doctors don't consider as trans surgeries, so maybe they won't do that. I don't think they'll serve me. So why go?"

Ren, 29, Feminine Other, Asian

Lee spoke about how the entire medical establishment—not just providers—is established around an understanding of "transgender" as inherently binary. Because Lee does not fit this narrative, they experience a frustration when trying to access hormones. This includes the insurance company that Lee has health coverage with, which Lee says depends on the binary transgender narrative in order to prescribe the "appropriate" dosage of hormones for transgender-spectrum people, which is problematic for GQ/NB people who do not desire the high dose of hormones:

> "My insurance, like when it does cover trans stuff, it probably covers like a national average for like, okay if you're a transguy and you weigh this much, this is how much T you get. But like, I'm not a transguy. I don't want that much T, or, you know, or, I want less, so they don't have a standard for that, so like, what do I do then? It's like nobody knows what to do with a genderfluid body. I don't even know what I need, I just know like, maybe I want some facial hair, and like, top surgery. That's it. So I don't know, it's, insurance and providers are yeah, like, these big barriers, I don't even know how to change it."
>
> *Lee, 33, Genderqueer Trans, White*

Lastly, AJ describes that this transgender binary narrative has a lasting impact on the GQ/NB community as a whole. Because services and resources have been largely geared towards binary transgender services, GQ/NB people are left with few or no

services that are geared solely towards their identities and unique gender experiences. This allocation of resources further diminishes GQ/NB individuals:

> "The problem is that this is extremely harmful. Sure, it's great that my binary trans friends can get services. But I can't. And neither can my genderqueer friends. We either have to lie that we're trans or deal with no hormones. And all this money is going to these clinics that only work with binary trans people. So where do we get help? Why aren't people funding research on genderqueer stuff? There's so much emphasis on binary trans people, and how great they look after transition. But that leaves the rest of us in the dust."
>
> *AJ, 24, Genderqueer, White*

As highlighted by these participants, the binary transgender narrative has serious consequences for GQ/NB people seeking and accessing healthcare. This binary narrative is entrenched within many services, and immediately puts GQ/NB people in a position in which they must defend their identity and subvert this narrative in order to receive services. Subverting this narrative caused participants to feel stress, and often induced anxiety about accessing healthcare. The following themes further describe the effects of the binary transgender narrative, and how it effects GQ/NB seeking and accessing healthcare.

(2) "I Don't Need Trans Health Stuff. I Need Genderqueer Health Stuff." – Harper

Provider Competency Affects the Experience of Seeking and Accessing Healthcare

When accessing services, all ten participants spoke about the experience or fear of being served by an incompetent provider, which made them feel invalidated, ignored, or mistreated. Ryan describes the distress of an emergency room experience with a provider who had little to no understanding of GQ/NB experience:

> "I had health problems, and we were trying to figure out what they were. And it was getting worse with more frequency since I had come out as genderqueer, so I asked [the doctor] if my testosterone could be aggravating that. So like, I get that doctors don't know everything, but she got like real defensive about not knowing it and made it clear that she was unaware of why I would be taking it anyway. So I also asked about binding and she said that I shouldn't be doing it. I tried to explain why I do wear it and she just dismissed me. I left feeling so worn out and beaten down. It was so upsetting."
>
> *Ryan, 24, Genderqueer, White*

Lee also spoke about how the language that providers who lack cultural competency in transgender-spectrum healthcare use can be extremely embarrassing and invalidating. Lee described the following incident:

> "I was getting uh, well I was getting my period back even when on T, and you know I thought that wasn't supposed to happen. I didn't want any of that. I called a doctor at my school's clinic. So I went to see this doctor and right away I was

like shit. She came out and first she said my legal name. And I was thinking fuck okay, and I was already freaking out. So I went back there and she said something like 'So I heard your womanly flow has returned.' Or something really fucking ridiculous like that. She obviously did not know how to speak to someone like me. Fucking embarrassing. And I was scared to go back there for weeks."

Lee, 33, Genderqueer Trans, White

In addition, participants highlighted that some providers are competent with transgender-spectrum healthcare issues, but fail to consider the unique perspectives and healthcare needs of GQ/NB people. Harper mentions that transgender-spectrum competency is not necessarily the same as GQ/NB competency:

"…once you know someone's identity, you can give them the right care. At that point in time, you're no longer guessing what's best for them […]. Would like, would a young person walk into a clinic and the doctor give them an exam for like, Alzheimer's? […] No probably not, 'cause they know it's inappropriate. Same kinda thing here. They're wasting their and my time, 'cause I'm not trans, and I don't need trans health stuff. I need genderqueer health stuff, I need androgynous healthcare. Is there an androgynous clinic? No, but there's trans clinics."

Harper, 25, Genderqueer Androgynous, Mexican

Harper's sentiment is further amplified by Simone, who illustrated that even when gender-specialist providers are trained in transgender competency, they continue to

neglect GQ/NB identities. This experience further illustrates that transgender-spectrum training and competency in medical settings is centered around the transgender binary, and fails to include gender identities outside of man/woman or transgender man/transgender woman:

> "And you know, just recognizing too that, they [the providers] might have transgender competency training and all that jazz, but at the end of the day I'm not the kind of trans person you probably got during those trainings. I'm not a man, I'm not a woman. I'm not here for you to just sign off on top surgery, because what if I didn't want that? And no, I don't want a crazy high dose of T, so what then? So like, what is that? That's not transgender competency training they need, it's just fucking gender competency, or I guess genderqueer competency."
>
> *Simone, 25, Genderqueer, White*

Samir explained that sometimes this incompetency results in seriously misguided forms of assistance. In Samir's experience, asking for hormones at a transgender clinic while simultaneously identifying as GQ/NB prompted their providers to recommend mental healthcare:

> "The nurse didn't really know what to do about genderqueer issues, so they just directed me to like, the psych behavioral unit at [city]. And the person who took my information from the intake just basically gave me a psych intake, which was actually a lot of questions that really didn't apply to me. And it kind of put more of like a, you know, they had a very heavy behavioral concern for me when I told

> them I was non-binary. Rather than an 'Okay you want hormones and let's get you in touch with the right people for genderqueer stuff,' it was more like 'Oh this is very serious and there must be something wrong with you.' Just because they thought I was having problems about gender. I clearly don't look completely male, so they thought I was suffering. They never thought I just wanted a more ambiguous look."
>
> *Samir, 24, Non-binary Agender, White*

A lack of cultural competency is not solely found within providers. Vern explained that they noticed cultural incompetency at their clinic as soon as they were registering for a doctor's appointment due to the lack of gender identity options on the medical intake forms. This further highlights that providers who lack cultural competency around GQ/NB issues are not the sole issue—rather, the entire context in which services are sought and accessed continue to be inherently binary, which is perhaps most readily illustrated with the typically used medical intake forms:

> "So I went to see a provider, hoping to find some good provider for gender stuff. And this place, it was a trans clinic, but they didn't really know what to do with me, because… well they don't really have words for non-binary people. So they didn't have that on the sign up form. When it asked gender, I couldn't click anything. I saw trans, but. I knew that the intake form wasn't gonna have what I wanted on there, like, a gender box for me. But I was hoping. I ended up just leaving."

Vern, 23, Genderfluid, Asian

Vera also explained that the lack of gender options on their clinic's medical intake forms made them question the competency of the clinic, and whether or not the doctors there would truly know how to serve their needs:

> "You know I think the biggest thing is when I first walked in, I see this form and they don't even have a fill in space for gender. I gotta pick male, female, trans. So immediately I'm thinking okay they don't know what they're getting into. They never took a gender class in med school, clearly. I'm not gonna trust them with me or my money then, you know."

Vera, 29, Two Spirit, American Indian

On the other hand, participants who spoke about particularly good healthcare experiences highlighted this issue and often stated that GQ/NB-competent providers made all the difference when they accessed healthcare. Ren illustrates a good experience in which they felt validated by their healthcare provider:

> "I was scared to go the first time, but the first time was really, really good. I think they said, um, when we were talking about gender and I told them that I felt weird in my body. They asked me you know. They didn't say 'You must be trans.' They asked me, um, do I feel feminine? Or masculine? Or neither, I think. And um, nobody had ever asked me that before. Even when I said my gender is wrong nobody said well what do you feel, then? Um, so when they asked me that, and it

was like, it was like I trusted them immediately because they knew a part of me that I didn't."

Ren, 29, Feminine Other, Asian

Lee also describes a particularly good healthcare experience in which their provider treated them as a human before they treated their gender needs. This increased rapport quickly and made Lee feel confident that their provider could be a resource for appropriate care:

"So I saw this doctor and I remember walking in and him like shaking my hand real nice, like, he really kinda knew I was there to get hormones, and obviously you know. But he talked to me first. And he was just very like calm and said eventually like, 'Okay, so let's talk about hormones.' And he kinda gave me the in and out of hormones and told me what I could do. Never pressured me. So… that was a pretty good time. It was easy."

Lee, 33, Genderqueer Trans, White

When faced with incompetent providers, some participants sought to create their own supportive environment in which they received healthcare through the form of support groups. As described by Skyler, they needed to escape incompetent health providers within medical institutions in order to find a service that was truly supportive for them:

"Well I guess the biggest barrier is that people do not understand what two spirit is. They don't know what genderqueer femme means. I have to explain myself

every time. [...] I think that stops me from being able to access services because there's no service for me. I have to make the service myself. I have to make do with what is available and spin it to a person in a way that makes sense for them. That's why my support group is more helpful than any medical doctor."

Skyler, 30, Genderqueer, Femme, Two Spirit, American Indian

(3). "They're Not Gonna Understand Genderqueer, but They're Gonna Understand Trans." – Harper

Borrowing the Trans Label to Access Services

A number of participants reported experiences in which they needed to identify themselves under the transgender umbrella in order to receive the care they desired. Typically, participants utilized the term "transgender" because they believed that providers and healthcare services would be unable to understand identities like genderqueer or non-binary. By using the term "transgender" or "trans" to identify themselves, participants believed that they would avoid unnecessary complications and situations in which they would need to defend their gender identity in order to access health services. In many situations, participants found that wearing the "trans" label—rather than their true GQ/NB identity—allowed them to navigate services with relatively little problems. For example, Harper illustrates the idea that one must "lie" and present themselves as transgender in order to access gender-related services:

"You know, this is like a thing because I've talked to a couple of people like me, you know queers, or at least genderqueer people, and they don't say they're trans.

> But you know, you gotta lie when you go in to a clinic, you gotta say you're trans and you gotta say you want hormones and surgery. They're not gonna understand genderqueer, but they're gonna understand trans. And you gotta say you've always felt this way [...] So I said I was trans a lot, when I wasn't. But I wanted my hormones more than anything else."
>
> *Harper, 25, Genderqueer Androgynous, Mexican*

This experience is also shared by Lee, who further describes borrowing the transgender label in order to move through the necessary medical institutions they must access in order to receive care:

> "... if it's not my main doctor and I need something, like I'll just say I'm trans 'cause I can pass as trans and they [the doctors] get that term. But in reality like, I mean ideally if I could say genderqueer and get the service I want then, yeah, I'd say it. But they don't get it so trans it is. So like I can move through services saying I'm trans and access this stuff but at the end of the day I'm not trans. And I don't really wanna be seen as trans but I have to, to get the, uh, stuff I want."
>
> *Lee, 33, Genderqueer Trans, White*

AJ states that identifying themselves under the transgender umbrella aids them in getting the medication they need (in this case, testosterone). However, to achieve the physiology they desire in order to appear more genderqueer than binary, they take less than the prescribed amount of hormones per week:

> "Do you know how much easier it is to say trans than genderqueer? I don't get second glances if I just say trans. So what I do is get the full dose by saying I'm trans. But I don't take the full shot every week because I want less effects from T. So yeah, to get the T I have to say I'm trans because I don't want to be questioned. But then on my own I just limit the amount of T I take."
>
> *AJ, 24, Genderqueer, White*

Finally, Samir notes that they frequently use the term transgender in order to access services, but this comes at a cost to their own identity. They experienced a sense of loss when they were unable to be themselves and request the medical services they needed:

> "So for a long time I was just telling doctors that I was trans, but that was really tiring because I had to make sure I was saying the right things. And all I really wanted was to explain to someone that I was non-binary, that I wanted to be seen that way. So for a long time I had to put myself on the back burner, because doctors probably wouldn't acknowledge my existence. It was like I wasn't worth my word."
>
> *Samir, 24, Non-binary Agender, White*

(4) "In a Best Case Scenario, I Would Walk in and See Nothing but Genderqueer People." – Vern

The Importance of Representation in Medical Settings

Participants spoke often about the inability to see themselves reflected in medical and healthcare staff. The majority of the time, this lack of representation resulted in decreased service utilization or a complete lack and fear of service utilization. Even with instances in which participants sought or accessed care through transgender-specific clinics, if there were no GQ/NB-identified staff, participants were far more wary of the service, and hesitated when thinking about accessing the health service. Thus, while some participants desired to seek healthcare and medical services, they stopped themselves from doing so in fear of culturally incompetent providers.

Vera speaks to their complete lack of service utilization within medical clinics in the past six months due to this lack of GQ/NB-identified providers. Vera would rather access a service where they would see a person "like them", which may mean that they hoped to see a person who openly identified as GQ/NB, possibly in the form of a Two Spirit identity. Because Vera could not locate a clinic where they could see themselves reflected in the staff as a Two Spirit person, they access a different form of care through support groups, where they can simultaneously avoid providers and feel represented:.

> "I am completely terrified of being persecuted because there are no people like me at the clinic. Even some trans people do not understand me, but, if I saw someone like me at the desk, of course I would go. But at this time, I only access

> my support group. At least there are Two Spirit people there. For the past six months I have only been there. That is enough for me, and at least there are people like me there."
>
> *Vera, 29, Two Spirit, American Indian*

In contrast, service utilization may be a more enjoyable and validating experience when participants see themselves or their community reflected in staff. As Lee illustrates, having a GQ/NB-identified provider alleviates the stress of medical visits by eliminating the barrier of defending their gender identity. This speaks to the importance of having openly identified GQ/NB providers on staff:

> "[My doctor], he's a transguy. He used to be genderqueer. And that's the main reason I see him… he understands my identity completely and you know never batted an eye when I said I wanted a lower dose of T. He gets the genderqueer thing at least, you know, and I've been lucky because I've never had to explain gender to him or my pronouns, obviously he gets it, but you know a lot of people don't have that. I was lucky I got someone who's like me, at least, you know, that way I can go to him for pretty much anything and I'm not really having to like worry about explaining anything."
>
> *Lee, 33, Genderqueer Trans, White*

Although it is possible to experience positive healthcare services with a doctor who has a different gender than your own (indeed, non-transgender individuals see doctors with varying genders), being able to see GQ/NB-identified providers seems

particularly salient to some GQ/NB people. As described by Samir, simply putting up images of prominent GQ/NB people within clinics makes them feel more welcome and able to access services. This is a form of representation that is especially important to them:

> "And the people that work there are amazing. They're great. They have like posters of Angel Haze up on the wall, the, they're an agender rapper, and they definitely have genderqueer competence, and they just work really well with you. And I remember walking in and seeing Angel, that poster. And I instantly felt like okay, I'm allowed to be here. Their therapists are also, you know, trans-identified or genderqueer and they're open about it. And it's great that they're employed people that you can kinda connect to and share experiences, that, you know, they'll understand the struggles of getting healthcare as a transperson."
>
> *Samir, 24, Non-binary Agender, White*

Vern mentions that, if they knew GQ/NB people would be the ones providing the healthcare services, they would be much more likely to access those services. However, they have been unable to find such representation, and consequentially do not access the gender-related care that they desire:

> "I mean in a best case scenario, I would walk in and see nothing but genderqueer people. That way I wouldn't have to like defend who I am. But there's no genderqueer clinic ran by genderqueers. If there is one, I haven't heard about it. But I mean at that point I would be able to get all the services I wanted, I would

be able to get my hormones and surgery. But right now I have to be okay with not having those things yet."

Vern, 23, Genderfluid, Asian

(5) "If I Ask Them to Cover Genderqueer Stuff, That's a Whole Other Story." – Simone

The Issue of Insurance Coverage

A huge barrier to services for GQ/NB people is a relatively common one for a number of people; the sheer difficulty in understanding insurance coverage stops GQ/NB people from being able to receive gender-related care. Vern described the confusion that arose from not knowing what is considered a significant and medically necessary procedure in order to have their insurance company cover the services. During their research on gender related coverage through their insurance, they discovered that insurance companies sometimes require an additional in-person defense in order to consider the procedure as medically necessary. This can be particularly difficult for people who do not follow the binary transgender narrative. Because insurance and medical procedures rely on following a narrative in which a patient feels uncomfortable with their body and have high levels of distress, GQ/NB people who do not report this narrative may be denied medical care. At this revelation, Vern became hesitant in accessing any sort of healthcare, which resulted in distress:

"Within the past three months I started seriously doing research on like top surgery and accessing hormones, cause I had always thought about top surgery,

> ever since like the whole gender journey. But I had never really thought about hormones until like more recently, and I was starting to look into it. […] And it was like confusing as fuck. And it was also really depressing, because I was trying to be like very meticulous about like reading and trying to understand it, even though it's like created to be obscure, um. And when I got to the part that was like, 'You should be prepared to like defend why you want any medical procedures to be covered by insurance.' And that was just really, really depressing. And it kind of like, um, kind of like pushed a cloud over me."
>
> *Vern, 23, Genderfluid, Asian*

This fear of having to defend what is considered a "medically necessary procedure" and consequentially not accessing services is shared by Simone, who feels that insurance companies would likely ask Simone to defend themself and their GQ/NB identity in order to receive medical coverage:

> "But yeah, I can't afford it. My insurance doesn't cover much, I don't think, anyway. And even if I ask them to cover genderqueer stuff, that's a whole other story, cause then I have to defend myself and come out as genderqueer. Which is a whole other argument on the phone with somebody I can't even see, and like, I don't even know them. So forget that, I would rather go without it, as shitty as that is."
>
> *Simone, 25, Genderqueer, White*

Lastly, Lee further illustrates that insurance companies can be entirely clueless when it comes to providing adequate care for their GQ/NB clients, which consequentially makes insurance coverage more obscure and less accessible. Lee explains that they are not even sure if their insurance company is aware of their GQ/NB identity:

> "I mean for years I didn't even know that my insurance even covered genderqueer stuff. I didn't know my T was gonna be like ten bucks. So I stopped myself from going because like my insurance didn't make it clear at all what they were gonna cover. They didn't even ask my like gender history, I'm not even sure they knew I was genderqueer, or like, trans at some point. They never told me anything."
>
> *Lee, 33, Genderqueer Trans, White*

Discussion

As illustrated by participants in this study, GQ/NB people are distinct from binary transgender people and have a plethora of qualitatively different experiences when they seek and access healthcare. Their unique experiences are important to understand, as it has implications for GQ/NB health and service utilization. Most importantly, when GQ/NB feel invisible or treated poorly by providers who do not understand GQ/NB needs, they report feeling invalidated, harmed, and demeaned.

Indeed, the binary transgender narrative appears to be pervasive in healthcare settings, and is arguably the root cause of many uncomfortable healthcare experiences for GQ/NB people. This binary transgender narrative is so pervasive that even the transgender clinics that participants visited still had medical intake forms that failed to

include gender options outside of binary transgender terms (i.e., transgender man or transgender woman). Thus, GQ/NB participants had to frequently navigate clinics and providers that ascribed to this narrative in order to access gender-related care, and often feared service utilization due to the consequences of this narrative. Other consequences of this narrative included stigmatization, being incorrectly labeled as transgender, and being denied services.

This binary transgender narrative puts GQ/NB people in a tough situation. Participants in this study generally wanted and sought gender-related care, including hormone replacement therapy and gender confirmation surgeries. However, the care they sought did not fit with the predominant transgender timeline of hormone access, top surgery, and/or bottom surgery as a means of conforming to a new binary identity. Indeed, they desired an amalgamation of these services. They did not necessarily access them as a complete package or in the particular binary transgender order, which traditionally begins with hormone replacement therapy and ends with gender confirmation surgeries (Meyerowitz, 2009). Consequently, GQ/NB reported a difficult situation in which they desired gender-related care, but often did not access services due to consequences of the binary transgender narrative.

While most participants went to transgender-specific healthcare organizations or clinics, healthcare professionals at these settings were not necessarily competent in terms of knowing how to understand, communicate with, and offer care to GQ/NB people. Incompetency did not just occur within the way providers interacted with patients. At the

least, it manifested within intake forms that did not provide proper gender markers for GQ/NB people seeking services. At worst, it manifested in providers discouraging GQ/NB people from accessing services due to negligence, incompetency, prejudice, and stigma. Competency was a large determinant of healthcare access and service utilization, and was often the difference between avoiding healthcare and seeking it voluntarily. Interacting with providers who were not aware of GQ/NB needs often resulted in emotional distress and a severe feeling of being unacknowledged.

These issues are huge barriers to seeking and accessing healthcare, and discourage GQ/NB people from locating and utilizing the services that they need. As a result, a number of participants discontinued (or never accessed) gender-related care, or altered their treatment in order to meet their own needs (as seen in the instances in which a high dosage of testosterone was given to participants, but they took a smaller dose than what was prescribed in order to achieve a more androgynous look). These findings are disheartening, considering the health disparities experienced by GQ/NB people. The need for competent care is clearly present, but the opportunity to provide GQ/NB people appropriate care is missed due to an overwhelming reliance on the binary transgender narrative across multiple healthcare areas, including insurance agencies.

A number of these issues of incompetency are fixed if providers are aware of what GQ/NB identities mean and do not assume that GQ/NB people always desire the same medical procedures as binary transgender people. In addition, having GQ/NB-identified people on staff was an essential aspect of a good healthcare experience for

many participants, and was often followed with proper care, trust, and rapport. It is important to note, however, that the presence of binary transgender people on staff does not necessarily lead to better care-related experiences for GQ/NB patients, and that rapport was actually connected to the representation of GQ/NB people on staff. In addition, one must consider the possibility of a specialized GQ/NB clinic, or whether gender clinics should expand their services beyond the transgender binary. As mentioned by the participants, they are far more likely to access services if they see themselves reflected in staff (i.e., if a provider who is GQ/NB openly identifies as such and is providing medical services).

Finally, access to services is a complicated issue in which insurance coverage plays a role in whether a GQ/NB person can use the service or not. Gender-related services are often expensive, despite being covered by a number of insurance companies. Participants were unsure if they were considered under the transgender category on their insurance plans, and thus hesitated to access services. Many times, they were unsure if the insurance plan would cover their costs if they were not categorized as transgender. This resulted in participants borrowing the transgender label in order to cover their services. Insurance companies are also very good at obscuring coverage information in regards to gender-related care, and participants stated that they had a hard time discovering whether or not their insurance even covered the gender services to begin with.

Information regarding GQ/NB identities is vital to countless health services, even when the service is not necessarily gender-related. In other words, gender-related care should be thought of as a broad definition for a number of services that may or may not include physiological interventions, including hormone replacement therapy and gender confirmation surgery. For example, a number of participants described their mental healthcare as having gender-related aspects. These individuals found support for their mental well-being through support groups and considered these therapeutic groups as central to their gender identity and well-being. Indeed, even when considering healthcare for GQ/NB people, one must keep in mind that the GQ/NB community in itself is highly complicated and varied. In addition, addressing sex assigned at birth may be an important variable that leads to the diversity of healthcare experiences—and healthcare needs—of GQ/NB people. While this study did collect sex assigned at birth data, future studies should consider the unique needs of GQ/NB individuals by further examining the effects of birth sex and corresponding medical needs.

A core aspect of the participants' gender identity was that they defined it in many ways, as seen as the labels in the participant characteristics. Because of this, GQ/NB healthcare is not simply "fixed" by providing services to GQ/NB people as one gender. GQ/NB people have an amalgamation of traits, and want medical procedures in varying degrees, from no medical intervention to full medical intervention (including HRT and GCS). In an ideal world, medical providers would consider each patient as having a unique gender with unique medical needs and desires.

Limitations

The study is based on a small, qualitative sample recruited from the GQ/NB community in San Francisco, CA. Therefore, these findings are not generalizable to any larger GQ/NB population. In addition, eight participants were assigned female at birth. Only two people who were assigned male at birth were located and recruited into the study. Further, despite the fact that I have attempted to argue that GQ/NB people should not be grouped together under the transgender umbrella, I have still lumped GQ/NB people under a GQ/NB umbrella. Meaning, while all participants identified themselves under the GQ/NB identity label, they all wrote in their own gender identity terms to describe themselves. It is worth noting that each participant likely has unique experiences based on their own identity definition, whether that be two spirit or genderqueer femme. Documenting each separate experience was not within the scope of this study, but it does limit the generalizability of the findings to the greater GQ/NB community.

Future Directions

The qualitative nature of this study makes it difficult to quantify the experiences of GQ/NB people seeking and accessing healthcare. In order to present a greater snapshot of this phenomenon, future studies should consider using mixed methods in order to capture both the qualitative and quantitative nature of accessing healthcare as a GQ/NB person. Quantitative reports that are supported by qualitative data may be particularly helpful when searching for healthcare or research funding for GQ/NB projects from medically focused institutions like the National Institutes of Health. In addition, while

this study did represent racial and ethnic minority identities in half of the sample, future studies should further consider the unique aspects of intersectionality among GQ/NB people with racial or ethnic minority backgrounds. As seen in the data presented here, gender identities (such as Two Spirit) may be more prominent in American Indian populations, which may further complicate the narratives detailed here. Further, studies on GQ/NB populations would benefit from examining the different experiences among older participants. And lastly, this study was limited to one geographical location, the San Francisco Bay Area, which is a historically progressive and dense urban context. Future studies should consider other locations within the states, particularly in the Southern portion of the US and rural areas, where LGBTQ rights are entrenched in largely conservative rhetoric and are in need of more research.

Healthcare providers should work towards making their services more gender inclusive by considering these experiences of GQ/NB people. First, providers should acknowledge that patients with a GQ/NB identity likely know what is best for themselves and should be considered experts of their own body. This idea extends to medical procedures. GQ/NB participants stated that they often did not want to access transition-related medical procedures, and if they did, they wanted to access these procedures at smaller rates and at augmented levels. Providers should be willing to prescribe lower levels of hormones for hormone replacement therapy and offer surgeries that are more GQ/NB appropriate (i.e., a breast reduction rather than a double mastectomy). Second, the issue of competency should be addressed in all healthcare institutions. Transgender

competency training is clearly not enough, and all mandatory gender trainings should be enhanced in order to include discussions around GQ/NB people. This idea is further reflected in the lack of GQ/NB-centered clinics. In an ideal world, tailored clinics for GQ/NB people would exist. At the very least, gender clinics that focus on binary transgender people would do well to increase their services by hiring GQ/NB-identified providers, thus providing a more inclusive environment for GQ/NB people to access healthcare. Healthcare services should also implement more detailed medical intake forms that include additional gender options. Currently, medical intakes forms that list "man, woman, transgender" are not enough. By simply adding "genderqueer", "non-binary", and "another gender not listed here", GQ/NB people would be far more likely to access the service.

Conclusion

In sum, GQ/NB people deserve healthcare that is tailored to their unique experiences. Transgender-focused healthcare, including providers and clinics that claim to be gender specialized, often fail to consider these unique experiences and are often insufficient and ill prepared to serve GQ/NB people. It is simply not enough to lump GQ/NB people within the transgender umbrella due to these reasons. Although a number of GQ/NB people want to access medical services that many binary transgender people do, GQ/NB people experience a unique gender within the "grey area" of man or woman, and have different experiences that result in a variety of desires for medical interventions.

In the end, we must alter societal perceptions of what it means to live outside of non-transgender experience (isn't this more generally "outside of the gender binary"?) and access gender-related care. Society's current understandings of transgender people, which assumes and celebrates binary identities, are far too limited, and leaves little room for individuals who do not identify at the far ends of the gender spectrum. These issues go beyond merely limiting possibilities for GQ/NB people—it also erases them from the healthcare field and fails to provide them adequate care. As long as these concerns remain unaddressed, GQ/NB people may face additional stressors and health disparities due to a lack of service utilization. We can make healthcare a more universal right and positive experience for many GQ/NB individuals by incorporating these lessons? learnings into academia and the healthcare field.

References

Berg, B. L., Lune, H., & Lune, H. (2001). *Qualitative research methods for the social sciences*. Boston: Allyn and Bacon.

Bilodeau, B. (2005). Beyond the gender binary: A case study of two transgender students at a Midwestern research university. *Journal of Gay & Lesbian Issues in Education, 3*(1), 29-44.

Bockting, W. O. (2009). Transforming the paradigm of transgender health: A field in transition. *Sexual and Relationship Therapy, 24*(2), 103–107.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101.

Burdge, B. J. (2007). Bending gender, ending gender: Theoretical foundations for social work practice with the transgender community. *Social Work, 52*(3), 243-250.

Budge, S. L., Rossman, H. K., & Howard, K. A. (2014). Coping and psychological distress among genderqueer individuals: The moderating effect of social support. *Journal of LGBT Issues in Counseling, 8*(1), 95-117.

Budge, S. L., Tebbe, E. N., & Howard, K. A. (2010). The work experiences of transgender individuals: Negotiating the transition and career decision-making processes. *Journal of Counseling Psychology, 57*(4), 377.

Chalabi, M. (2014). Why we don't know the size of the transgender population. Retrieved May 18, 2016, from http://fivethirtyeight.com/features/why-we-dont-know-the-size-of-the-transgender-population/

Chan, A. L. (2011, January 4). Gender Dysphoria: DSM-5 Reflects Shift In Perspective On Gender Identity. Retrieved March 01, 2016, from http://www.huffingtonpost.com/2013/06/04/gender-dysphoria-dsm-5_n_3385287.html

Coolhart, D., Provancher, N., Hager, A., & Wang, M. N. (2008). Recommending transsexual clients for gender transition: A therapeutic tool for assessing readiness. *Journal of GLBT Family Studies, 4*(3), 301-324.

Day, E. (2015). Lives transformed: Do famous transgender people help the cause? Retrieved May 16, 2016, from http://www.theguardian.com/society/2015/aug/23/famous-transgender-help-the-cause-caitlyn-jenner-laverne-cox-kellie-maloney

Deutsch, M. B., & Buchholz, D. (2015). Electronic health records and transgender patients: Practical recommendations for the collection of gender identity data. *Journal of General Internal Medicine, 30*(6), 843-847.

Doctor, R. F. (2008). *Becoming a woman: A biography of Christine Jorgensen.* New York: Routledge.

Grant, J. M., Mottet, L., Tanis, J. E., Harrison, J., Herman, J., & Keisling, M. (2011). Injustice at every turn: A report of the National Transgender Discrimination Survey. The National Center for Transgender Equality.

Harrison, J., Grant, J., & Herman, J. L. (2012). A gender not listed here: Genderqueers, gender rebels, and otherwise in the National Transgender Discrimination Survey. *LGBTQ Public Policy Journal at the Harvard Kennedy School, 2*(1), 1.

Hendricks, M. L., & Testa, R. J. (2012). A conceptual framework for clinical work with transgender and gender nonconforming clients: An adaptation of the Minority Stress Model. *Professional Psychology: Research and Practice, 43*(5), 460.

Herman, J. (2013). California Governor signs law giving trans people easier access to updated ID documents. Retrieved January 01, 2016, from http://www.glaad.org/blog/california-governor-signs-law-giving-trans-people-easier-access-updated-id-documents

Herman, J. (2011, January 24). More Employers To Cover Transgender Surgery, But New Hurdles Expected. Retrieved January 04, 2016, from http://www.huffingtonpost.com/joanne-herman/transgender-surgery-with-_b_803495.html

Human Rights Campaign. (n.d.). The Lies and Dangers of "Conversion Therapy" | Human Rights Campaign. Retrieved May 01, 2016, from http://www.hrc.org/resources/the-lies-and-dangers-of-reparative-therapy

IOM (Institute of Medicine). 2011. The health of lesbian, gay, bisexual, and transgender people: Building a foundation for better understanding. Washington, DC: The National Academies Press.

Kuper, L. E., Nussbaum, R., & Mustanski, B. (2012). Exploring the diversity of gender and sexual orientation identities in an online sample of transgender individuals. *Journal of Sex Research, 49*(2-3), 244-254.

Meyer, I. H. (1995). Minority stress and mental health in gay men. *Journal of Health and Social Behavior*, 38-56.

Meyerowitz, J. J. (2009). *How sex changed: A history of transsexuality in the United States*. Massachusetts: Harvard University Press.

Michael Shear. (2015, April 08). Obama Calls for End to 'Conversion' Therapies for Gay and Transgender Youth. Retrieved March 01, 2016, from http://www.nytimes.com/2015/04/09/us/politics/obama-to-call-for-end-to-conversion-therapies-for-gay-and-transgender-youth.html?_r=0

Obedin-Maliver, J., Goldsmith, E. S., Stewart, L., White, W., Tran, E., Brenman, S., Wells, M., Fetterman, D. M., Garcia, G., & Lunn, M. R. (2011). Lesbian, gay, bisexual, and transgender–related content in undergraduate medical education. *Jama*, *306*(9), 971-977.

Otis, H. (2015). Genderqueer: What It means. *Undergraduate Research Journal at the University of Northern Colorado, 4*(3).

Piper, J., & Mannino, M. (2008). Identity formation for transsexual individuals in transition: A narrative family therapy model. *Journal of GLBT Family Studies, 4*(1), 75-93.

Steinmetz, K. (2014). The transgender tipping point. *TIME Magazine, 183*(22), 38-46.

Stryker, S. (2008). Transgender history. Berkeley, CA. Seal Press.

Tate, C. C., Ledbetter, J. N., & Youssef, C. P. (2013). A two-question method for assessing gender categories in the social and medical sciences. *Journal of Sex Research*, *50*(8), 767-776.

Zucker, K. J. (2000). Gender identity disorder. In *Handbook of developmental psychopathology* (pp. 671-686). Springer US.

Appendix A

Interview Protocol

Part 1: Establishing Rapport/Background Information

1. Let's start with talking about identities. Can you tell me a little bit about your pronouns and gender identity, and how you came to identify this way?

Part 2: Health Experience/Health Care Access

1. We've talked about your identities and some of the experiences that come along with being within the genderqueer and non-binary spectrum. Now I'd like to talk to you about your experiences with healthcare. Do you currently access any sort of health service?

2. Do you currently access any sort of health service that is gender-related?

> If participant is unsure of "gender-related care", prompt with: And by gender-related care, it can be anything from surgeries or hormones, or support groups and other types of care. It is however you define "gender-related".
>
> If participant does not access health services for gender-related care, prompt with: Have you ever thought about accessing health services for gender-related care?

3. Thinking back on the last time you went to a health care setting, how was that experience?

4. At any time in the past, can you tell me about a particularly good health care experience you've had?

5. At any time in the past, can you tell me about a particularly bad health care experience you've had?

Part 3: Health Care Barriers

1. Can you tell me a little bit about the first time you accessed health care for gender-related services?

    If participant has not accessed health care for gender-related services but is thinking about accessing, prompt with: What do you think your first experience with reaching out to health services for gender-related care might be like?

2. What were some of the gender-related care services that you accessed?

3. Did you face any barriers when accessing (or thinking about accessing) health care?

    If yes, did facing those barriers affect your decisions on accessing health care? If no, were you worried that you might face barriers?

4. Can you speak a little bit about the role that insurance plays in how you access doctors and gender-related services?

Part 4: Health Care Improvements

1. What are some of the ways that health services can improve when considering your gender identity?

2. How might your identity differ from transgender people who want/need to "fully transition"? Meaning, individuals who seek medical procedures (like hormones or surgeries) and identify as completely male or completely female?

    If there are differences between yourself and transgender people who want/need to "fully transition", what are some of the ways that health care providers can acknowledge those differences?

Part 5: Wrap-up

1. We've talked a lot about the healthcare system and how that affects the way you interact with doctors, clinics, etc. Does anything else come to mind when you think about your gender identity and the health industry?

Appendix B

Codebook

Access: Any instance in which the participant expresses concern, experiences, or issues with healthcare access, including monetary issues, location-based issues, and time/resources to go to the provider.

Competency: Any mention of incompetent or competent providers and resource centers, and how this affects the participant's service utilization and experience of accessing healthcare.

Identifying Under the Umbrella: Any instance in which a participant states that they identify themselves as "transgender" to medical providers in order to receive services that doctors would not otherwise give them if they did not follow this narrative. Is also used when participants use "transgender" in order to avoid having to defend their true GQ/NB identity.

Representation: Any mention of the presence of GQ/NB-identified providers within services accessed by participants, and how this effects the experiences of participants accessing healthcare.

Transgender Binary: Any mention of the transgender binary narrative, in which providers or society assume that GQ/NB people ascribe to similar desires and needs of transgender people who identify on strong ends of the man/woman binary.

Appendix C

Study Screener

Genderqueer Health

This is a screener survey for participating in the study GENDERQUEER HEALTH PROJECT. For this project, we are looking for a diverse group of genderqueer- and non-binary-identified people to speak about their health care experiences. Participants will meet with the interviewer to talk about their experiences as a genderqueer person accessing health care and will be given a $10.00 Visa gift card as a token of our appreciation. The interview will take place in downtown San Francisco and take approximately 45 minutes to complete. If you are at least 18 years of age, identify as genderqueer or non-binary, and reside in the San Francisco Bay Area, please complete this survey. The following questions will ask demographic information and questions about your current health care access. These questions may bring up sensitive topics. If you ever feel uncomfortable, you are able to stop taking the survey at any time. The screener survey should take approximately 10 minutes to complete. If you have any questions, please contact the head researcher, James Lykens, at jlykens@mail.sfsu.edu or 805-621-3872. Thank you!

1. What is your full name?

2. What is your email?

3. What is your phone number? (Please include area code).

4. What is your date of birth? (DD/MM/YYYY)

5. What sex were you assigned at birth, on your original birth certificate?

6. In a few words, how would you describe your gender identity?

7. Do you identify as genderqueer or non-binary?
   Yes
   No

8. Are you Hispanic/Latino/Latina?
   Yes
   No

9. What is your racial/ethnic identity? (Please check all that apply.)

American Indian or Alaskan Native
Asian
Black or African-American
Native Hawaiian or Other Pacific Islander
White
Another Race (Please list) _____

10. Which term best describes your sexual orientation?

Lesbian
Gay
Bisexual
Pansexual
Queer
Straight
Other (Please specify): _____

11. Do you currently have health insurance?

Yes
No

12. Do you receive health coverage through your job?

Yes
No

13. Do you receive health coverage through Medical or a similar agency?

Yes
No

14. When was the last time you visited a doctor?

This month
In the past 6 months
In the past year
Last year
More than 2 years ago
I have never visited a doctor