“How Does My Not Being Able to Fit Into a Box Affect My Care?”: The Risks and Rewards of Disclosing Non-Binary Gender to Health Care Providers

By

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BACKGROUND

I am drawn to transgender health research because I want my transgender loved ones, and all transgender people, to be able to receive respectful and compassionate health care. My research is inspired by my experiences as a Trans Buddy, a peer advocate for transgender patients at Vanderbilt University Medical Center. While accompanying transgender people in the health care system, I discovered that their interactions with health care providers are complex and fraught with difficult decisions about how to discuss being transgender. As a queer cisgender woman, I also face choices around disclosing my sexuality to health care providers, though I feel that the stakes in these interactions are much lower for me than they are for most transgender people. My positionality as a queer transgender peer advocate with transgender loved ones was instrumental to why and how I conducted this research, and I encourage you to keep my positionality and yours as well in mind in relation to this work.

In this thesis, I use interviews and a focus group to explore transgender people's decisions about whether to disclose to their health care providers that they are transgender. I especially focus on non-binary transgender people, who do not solely identify as men or women. I find that non-binary transgender people encounter unique obstacles in their interactions with health care providers due to the transnormative medical enforcement of the gender binary, but that there are also many rewards to choosing to disclose transgender identity to health care providers. Though many health care scholars assume that coming out as LGB is health-enhancing and should be encouraged, I find that transgender people often keep their genders out of their interactions with the health care system because disclosing that they are transgender may put them at risk in many ways. Health care is an institution that systematically perpetuates transphobia, and navigating through it requires transgender people, and especially non-binary transgender people, to do the work of managing risk and uncertainty in every interaction.

Transgender People and the Health Care System

The transgender community is a diverse group who have diverse experiences of gender. Transgender people are those whose gender does not align with the assigned sex at their birth, while cisgender people are those whose gender aligns with their sex assigned at birth. A 2016 study estimated that 0.6% of the U.S. population is transgender, which accounts for at least 1.4 million people, an increase from a 2011 estimate of 0.3% of the U.S. population (Flores et al. 2016; Gates 2011). As a group, transgender people face discrimination in most aspects of daily life, including at school and work, and when accessing public services, housing, and health care (James et al. 2016, 2). Many transgender people experience harassment and violence because of their genders. Positive information about transgender people is rarely made public and transgender people are seldom represented by the media in respectful ways (Victims or Villains 2012). Despite these challenges, the number of people who are transgender in the U.S. has continued to grow. Transgender identities continue to resonate deeply with more and more people despite the systemic oppression faced by the transgender community.

Transgender people often have relationships with many different kinds of health care providers in order to meet their health care needs. I define "health care providers" to include physicians, nurses, psychologists, therapists, and any other professionals who provide health care in clinical settings. In addition to receiving typical health care services, many transgender people also work with health care providers who provide medical gender transition. Medical transition is treatment that allows transgender people to physically alter the sexual characteristics of their bodies. In the past, transgender people who underwent any medical transition were referred to as transsexuals while those who did not undergo medical transition were referred to as transgender. However, the term "transsexual" is now considered to be covered by the umbrella term "transgender", which may include both those who choose medical transition and those who do not (Stryker 2009, 30). Some people certainly still identify specifically as transsexual, but here I will refer to gender-variant people in general as transgender.

Transgender people often face mistreatment and marginalization in the U.S. health care system when seeking routine health care or medical transition. The 2015 U.S. Transgender Survey gives the most

recent picture of the experiences of transgender people in the U.S. health care system. It is the largest survey of transgender people in the U.S. to date with over 27,000 respondents recruited through convenience sampling. Of the respondents who had seen a health care provider in the previous year, one-third reported a negative experience, including receiving inappropriate questions about their gender or having to educate their provider about transgender people (James et al. 2016, 96). These negative experiences with health care providers and fear of discrimination prevent transgender people from receiving the treatment they need: when asked about their barriers to accessing health care, nearly a quarter of respondents reported not seeking health care when they needed it out of fear of being mistreated as a transgender person (James et al. 2016, 98).

Transgender people must navigate unpredictable and often difficult relationships with their health care providers in order to obtain the care they need. Disclosing their transgender status can cause negative reactions from providers who may hold anti-transgender opinions. Even if a provider does not actively discriminate against transgender people, they may lack knowledge of transgender people's health care needs, and this may cause tension in the patient-provider relationship. When transgender patients are obliged to educate their providers about their medical needs, the provider's position of authority may be undermined. This undermining may cause the provider to become defensive, and they might then fall back on stigma to discriminate against the transgender patient and reinforce their own medical authority (Poteat, German and Kerrigan, 2013). Transgender people must determine whether giving their health care providers information that may help their care is worth possibly hurting their relationship with their provider. They must constantly assess their providers and tailor their behavior accordingly in order to stay safe.

In addition to receiving regular medical care, transgender people may also depend on health care providers for access to medical transition. Some transgender people experience gender dysphoria, a mental disorder defined by the American Psychiatric Association's Diagnostic and Statistical Manual 5 (DSM-5) as "the distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender" (American Psychiatric Association 2013). Many transgender people

choose to ease gender dysphoria by transitioning between genders socially by changing their name, personal pronouns, and appearance. They may also choose to transition medically with hormones and gender-affirming surgeries such as chest masculinization or vaginoplasty. Transgender people with working testes may take androgen-blocking drugs, estrogen, and progesterone, which can cause physical changes including breast growth, body fat redistribution, and muscle reduction. Transgender people with working ovaries may take testosterone, which can cause physical changes including body and facial hair growth, voice deepening, and ceasing of menstruation (Radix 2016, 358). These hormones also often have the effect of changing thought patterns and feelings which may help to lift gender dysphoria (Costa and Colizzi 2016). Medical transition makes many transgender people dependent on their health care providers not just for normal care, but also for allowing them to medically affirm them as transgender people.

The medicalization of transgender people allows health care providers to exert power over transgender people who want to transition medically by deciding whether or not to provide medical transition for them. Medicalization is "the process by which some aspects of human life come to be considered as medical problems, whereas before they were not considered pathological" (Maturo, 2012). Medicalization of transgender people means that transgender is taken to be part of the domain of the medical system, making health care providers gatekeepers who control access to the medical aspects of transgender transition. Past guidelines from the World Professional Organization for Transgender Health (WPATH) stipulated that transgender patients go through a period of psychotherapy before beginning medical transition and meet the criteria for gender dysphoria. This step was meant to both ensure that the transgender individual was mentally healthy enough to begin transition, and that the individual was truly transgender. Many health care providers still require this letter and a diagnosis of gender dysphoria to vouch for the validity of their patient's gender before allowing them to transition medically. This model holds transgender people to a higher standard than cisgender people when making medical decisions and imposes significant hardship on transgender people, especially if they live in an area where it is difficult to find a mental health provider who is familiar with transgender care. The WPATH currently stipulates

this step, but they also accept the practice of informed consent. In the informed consent model, an individual's primary care provider or general provider screens the individual for mental health and physiological issues themselves, then may prescribe hormones without ever referring the individual to any other providers (Radix 2016, 353). Regardless of whether health care providers use informed consent for medical transition, they have the ultimate authority to determine whether a transgender person receives access to medical transition.

Disclosure of LGBT Identity to Health Care Providers

Transgender people are typically included when studying the issues that affect the entire lesbian, gay, bisexual, and transgender (LGBT) community. However, issues of visibility and coming out in health care settings have already been well-studied for the lesbian, gay and bisexual (LGB) community while studies have rarely addressed these issues for transgender people. Many studies have explored the factors that influence disclosing LGB identity to health care providers as well as the benefits of coming out. Most importantly, coming out to health care providers allows better tailoring of care to patients' needs (Durso and Meyer 2013; St. Pierre 2017). Disclosure of LGB identity to supportive health care providers is related to patient perceptions that their relationship to their provider is good, and disclosure to providers may help to create authentic patient-provider relationships rooted in trust (McNair et al, 2015). Disclosure is also associated with preventative self-care, such as not smoking, and health-seeking behaviors, such as going to see a health care provider when needed (St. Pierre, 2017). Most of this literature assumes that coming out to health care providers is generally a good thing without considering the various self-protective reasons why patients do not come out.

The lack of corresponding literature on disclosure of transgender identity to health care providers may reflect the smaller number of transgender individuals in the population as well as the tendency to see transgender health care through the lens of medical transition. In a 2015 survey of millenials from the Public Religion Research Institute, 7% of the sample identified as lesbian, gay, or bisexual, while 1% identified as transgender (Jones and Cox 2015, 46). The much smaller numbers of transgender people

compared to LGB people may contribute to the lack of attention to disclosure of transgender identity in health care. This topic may also seem less relevant to researchers because of the medicalization of transgender people. Homosexuality has certainly been medicalized in the past, but is no longer recognized as a distinct psychological disorder to be addressed by health care providers (Stryker 2008, 98). Though it is important for providers to know the sexuality of their patients in order to better screen them for health issues that disparately affect the LGB community, being LGB is not necessarily associated with a specific medical treatment. Transgender people are medicalized through medical transition and are seen as an issue to be addressed by medicine. Researchers might assume that most transgender people must be out to their health care providers because they need transition-related therapies, and so there might be less of a choice of disclosure of transgender identity to health care providers.

Despite the medicalization of transgender people, many transgender people do not need to disclose that they are transgender to their health care providers because they are not seeking medical transition, or because certain health care providers are not involved in their transition-related care. The 2015 U.S. Transgender Survey found that only 78% of their transgender respondents wanted to receive hormone therapy and 49% had actually received therapy (James et al. 2016, 100). In the same survey, 40% of respondents said that all of their healthcare providers know that they are transgender, and 31% said that none of their health care providers know (James et al. 2016, 51). The transgender people who are not trying to access hormone therapy or gender-affirming surgery would not necessarily need to disclose that they are transgender to their health care providers. Additionally, for those who do medically transition, there is always a choice about whether to disclose that they are transgender to other providers they see who are not in charge of their transition-related care. It may be emotionally taxing or dangerous for a transgender person's health to not disclose that they are transgender or that they have a history of medical transition to health care providers, but in some situations their safety may require it. Choices to disclose transgender identity to health care providers or to keep it private are a complex and important piece of navigating the patient-provider relationship.

Disclosing Non-Binary Transgender Identity

Scholars in the social sciences and in medical fields have studied the experiences of transgender people in the health care system for decades but have paid little attention specifically to non-binary transgender people. The 2015 U.S. Transgender Survey defines non-binary transgender as "people whose gender identity is not exclusively male or female, including those who identify as no gender, as a gender other than male or female, or as more than one gender" (James et al. 2016, 7). Non-binary transgender can include genders such as *genderfluid*, which refers to someone whose gender changes over time, *bigender*, which refers to someone who experiences more than one gender simultaneously or sequentially, *agender*, which refers to someone who experiences no gender, and those who experience a gender that is neither male nor female (Genderqueer and Non-Binary Identities & Terminology, 2015). Non-binary transgender people may also be *gender non-conforming*, which means that aspects of their appearance or behavior do not align with the gender that corresponds to the sex they were assigned at birth or the gender they are perceived to be (Wiley et al., 2010). They may also be perceived as male or female and may not appear gender non-conforming. Gender identity and gender presentation do not necessarily correspond, and gender identity should not be assumed based on appearance or behavior.

Non-binary transgender people represent a significant and emergent portion of the transgender community. Of the over 27,000 U.S. transgender people sampled in the 2015 U.S. Transgender Survey, around one-third were categorized as non-binary transgender (James et al. 2016, 44). Nearly two-thirds of non-binary transgender respondents were ages 18-24, while less than half of the binary transgender respondents fell in that age range. In comparison, around one-third of non-binary transgender people were ages 25-44, while nearly half of binary transgender respondents were grouped in that age range (James et al. 2016, 46). This indicates that most non-binary transgender people likely belong to the millenial generation. Google search trend data show that Google searches in the topic "lack of gender identities" have increased dramatically in the last several years. Between July 2013 and July 2018, the term achieved 7% popularity in June 2013, 18% popularity in June 2014, then reached 100% popularity in June 2015, April 2016, and May 2017 (Google Trends, Lack of Gender Identities 2018). Between July 2013 and July

2018, the search term “non-binary transgender” grew from 0% popularity in July 2013 to between 0 and 10% popularity during the months of November 2014 through July 2018, spiking in popularity during April 2016 (41%) and June 2017 (100%) (Google Trends, Non-Binary Transgender 2018). The group of people who are non-binary transgender or who are curious about non-binary transgender identities are an ever-larger part of our community.

The possibility of identifying outside the gender binary is not well-known or accepted except in communities of young LGBT people. This lack of knowledge likely reflects the newness of the identity and the small number of non-binary transgender people, but is also driven by the foreignness of living outside the gender binary. Institutional and social enforcement of binary gender norms causes non-binary genders to be incomprehensible, preventing most people from being able to easily grasp how a person could be neither a man nor a woman. When I asked Catherine, one of my non-binary transgender participants, what would it would be like to disclose that they are non-binary transgender to a physician, they answered that “most likely I’d be mocked or told that I don’t know what I’m talking about. I get a lot of people talking about how they don’t understand ‘these new fads’ and all the labels kids these days make up and such.” From their experience, Catherine believed not only that their gender would be incomprehensible to their physician, but that it would not even be taken seriously. Non-binary transgender people commonly meet this kind of misunderstanding and resistance as a reaction to their identification outside of our institutionalized categories of male and female.

The general lack of understanding of non-binary genders makes it more difficult for many non-binary transgender people to disclose that they are transgender. The 2015 U.S. Transgender Survey measured non-binary transgender people’s attitudes about disclose that they are transgender by asking how often they would correct people who assume that they are binary gender. Approximately half of non-binary participants said that they would not correct the speaker, half said that they would sometimes correct the speaker, and the remaining 3% said that they would always correct the speaker. Those participants who never or sometimes correct others’ assumptions about their genders had various reasons for not correcting these assumptions and disclosing their transgender identities. These included expecting

that people would not understand their identity (86%), feeling that it is easier not to explain (82%), anticipating that they might face violence (43%), and being afraid that they might not get the health care they need (24%) (James et al. 2016, 49). Others' lack of understanding of non-binary transgender identities as well as the emotional energy that it requires to explain these identities seem to overcome participants' desire to make their non-binary gender known. Additionally, those participants who would sometimes correct assumptions would be making active choices about whether or not to disclose that they are transgender in different situations, and these decisions would likely be based on factors such as how safe they felt or whether they had the energy to explain themselves. Lack of understanding of non-binary gender creates a barrier to disclosing transgender identity that prevents many non-binary transgender people from living authentically.

Non-binary transgender people usually choose whether to be visible as non-binary transgender people by choosing whether or not to explicitly disclose that they are transgender; their visibility is typically in their own hands. If non-binary transgender people do not explicitly disclose that they are transgender and others do not disclose their status, in most situations they are perceived as cisgender or binary transgender. For transgender people, being perceived as a cisgender person of the gender to which they have transitioned may or may not be desired (Serano 2007, 126). Binary transgender people may have visible signs that they have transitioned between genders that make them perceptible as transgender people, like body hair or vocal pitch. Of course, non-binary transgender people who transition may also have all of these attributes, but if they are perceived to be transgender, they are typically mistaken as binary transgender because of the lack of understanding of non-binary gender. According to the 2015 U.S. Transgender Survey, when non-binary transgender people are assumed by others to be a certain gender, over half said they were perceived to be cisgender women, less than one-fifth were perceived as cisgender men, and one-fifth said assumptions vary (James et al. 2016, 48). Non-binary transgender people were not assumed to have a non-binary gender because non-binary genders are not normative and run completely counter to gender expectations. As my non-binary transgender participant Paul said, "...there's no passing as non-binary, really, because people are going to think you're one or the other, so I have control over, in

my mind, do I want to be read as male or female?" The normative assumption that non-binary genders do not exist means that the choice to disclose that they are transgender represents the only way a non-binary transgender person can choose to make themselves visible specifically as non-binary transgender. Choices around gender disclosure for non-binary transgender people, then, are choices between perceived as a cisgender person or a binary transgender person, and being known as a non-binary transgender person.

Disclosing transgender identity in health care settings is complicated for non-binary transgender people because letting their identity be known may compromise their ability to get the care they need. Disclosure may damage a relationship to a health care provider or result in losing access to necessary care, whether it is normal health care or related to medical transition. Access to medical transition is especially fraught for non-binary transgender people. The 2015 U.S. Transgender Survey reports that 13% of its non-binary respondents had taken hormones to transition, and nearly half wanted to take hormones (James et al. 2016, 99). However, non-binary transgender people often have trouble fitting the criteria for medical transition. The guidelines for diagnosis of gender dysphoria in the DSM-5 still emphasize wanting to be rid of one's primary and/or secondary sex characteristics or wanting the primary and/or secondary sex characteristics of "the other gender", which non-binary transgender people often do not experience. However, it does stipulate that in relation to gender dysphoria, "experienced gender may include alternative gender identities beyond binary stereotypes" (American Psychiatric Association 2013). Many mental health care providers may not believe that non-binary transgender people experience gender dysphoria according to these criteria and to their own internal set of characteristics that qualify a person as transgender. Non-binary transgender people must balance all the risks and benefits of disclosing that they are transgender in a clinical setting any time they seek health care, but especially when they seek medical transition.

LITERATURE REVIEW

U.S. Transgender History: Mid-19th Century to Present

Transgender identities in the U.S. have a complex history as clinical, academic, and personal conceptions of transgender identity converged, diverged, and became entangled. These interactions produced different sets of knowledge about transgender people and diverse agendas for them based on this knowledge. Clinical, academic, and personal conceptions of transgender identity hold differing levels of authority in different communities, yet clinical conceptions have come to exert the most overt control over transgender people's lives. Here, I will outline the history of transgender people in the U.S. from the mid-nineteenth century to the present in order to shed light on why interactions with the health care system are so important to transgender people and why non-binary transgender people may deal with the health care system in a different way than binary transgender people. In this section, I will use the term *gender-variant* to refer to people we might currently identify as transgender because they lived in historical periods before the use of the term *transgender*.

Gender variance emerged as an issue that required state regulation in the U.S. due to the growth of urban gay communities in the mid-nineteenth century and lesbian communities in the early twentieth century. At that time, homosexuality was understood to be caused by gender inversion, or the inclination of men to supposedly female traits and the inclination of women to supposedly male traits, and so was closely tied to gender variance. State and local governments regulated sexuality and gender variance together, for example, cities including San Francisco and Chicago made municipal laws against cross-gender dressing that were specifically targeted against homosexuals starting in the 1850s and continuing into the 1970s (Stryker 2008, 31-4). Over time, sexuality and gender came to be considered as characteristics with fundamentally different origins, but the early understanding of the two as inseparable lead to their co-regulation.

Between the early- and mid-twentieth century, categories of gender variance were defined by European sexologists who initially brought the concepts of transsexuality and medical transition to the

U.S. German sexologists including Otto Weininger, Magnus Hirschfeld, and Harry Benjamin espoused the theory of bisexualism, which claimed that each individual has a certain mixture of both feminine and masculine traits and that variance from sex and gender norms is typical (Meyerowitz 2004, 22). These sexologists saw themselves as advocates for gender-variant people and sought to help them confirm their sex through medical transition, including Benjamin, who was a physician who started providing hormone therapy in the U.S. after 1914 and referred many patients abroad for gender affirmation surgery (Meyerowitz 2004, 45). Benjamin was interested in distinguishing different types of gender variance from one another, using the term *transsexual* for his patients who wanted gender affirmation surgery and *transvestite* to refer to those who did not want surgery (Stryker 2008, 49). Despite Benjamin's establishment as a medical authority on gender variance and his efforts to promote his work, transsexuality, transvestitism, and medical transition remained relatively unknown in the U.S. until the 1960s.

During the 1950s and 60s, the American medical community took up gender variance as an object of its expertise separate from sexuality, and the emergence of the modern concept of gender became the primary way to explain transsexuality. Research on intersex people by John Money and Joan and John Hanson in the first half of the 1950s lead Money to develop the concept of gender as distinct from sex, referring to "'outlook, demeanor, and orientation'" (Meyerowitz 2004, 114). Gender and gender roles stood apart from sex as aspects of self-concept, rather than physical reality. Gender became the dominant way to explain transsexuality by the end of the 1960s as psychologists and physicians took up the concept (Meyerowitz 2004, 117). Proponents of medical transition saw gender as an immutable part of self-concept and physical sex as a much more fluid reality that could be changed around gender (Meyerowitz 2004, 99). Research showing the benefits of medical transition convinced more physicians to offer the treatment, but they were also concerned with upholding traditional gender norms and roles, not upsetting them (Meyerowitz 2004, 124, 128). These physicians were invested in understanding and "fixing" gender-variant people so that they fit into society (Stryker 2008, 113). University-based sex-change programs, such as the program at Johns Hopkins University, were founded during the late 1960s and early

1970s (Stryker 2008, 93). These programs were part of a push to use the new concept of gender to reestablish traditional gender norms, allowing gender-variant people to medically transition only if they would adhere to the traditional standards of their new gender after transition (Stryker 2008, 94). Though medical transition was promulgated by those who claimed to be working for the freedom of gender-variant people, its life-changing potential was institutionalized by the medical system as a tool to integrate gender-variant people into a binary gender society, excluding gender-variant people who would not or could not fit into this system.

The medicalization of gender variance and the separation of gender identity from sexuality were achieved together through the medium of the American Psychiatric Association's Diagnostic and Statistical Manual, which is the authoritative text for classifying and diagnosing mental disorders in the U.S. Lesbians and gays started to organize to depathologize homosexuality starting in the 1950s, and won the removal of homosexuality as a mental disorder from the DSM in 1973 (Stryker 2008, 98). At the same time, Benjamin and other health care providers who treated transgender people pushed for the inclusion of the diagnosis Gender Identity Disorder (GID) in the DSM, and it was added in 1980 (Stryker 2008, 111). Benjamin had created standards of care and diagnostic criteria for transsexuals which called for several months of psychotherapy to establish a GID diagnosis, then receiving hormones from an endocrinologist and living for a year as the opposite gender socially, and finally receiving a psychological evaluation for gender-affirming surgery (Stryker 2008, 112). This protocol served to screen out most people who wanted gender-affirming surgery because they were not able to consult with every health care provider required in the process, they did not have the patience to go through the entire ordeal, or because their therapist did not believe their gender experiences qualified them for a diagnosis of GID. Though many transsexuals and feminists pushed back against the pathologization of gender identity, health care providers were able to move forward and establish the current system of gatekeeping around medical transition, which enforces the gender binary and often prevents non-binary transgender people from transitioning (Meyerowitz 2004, 255-6). Additionally, the medicalization of gender variance served to further separate sexuality and gender: as homosexuality became more socially acceptable, gender

normative gays and lesbians gained privilege by distancing themselves from gender variance and disavowing transsexuals (Valentine 2007, 236-7).

While middle-class white transsexuals were seen as respectable and worthy of receiving medical transition starting in the 1970s, gender-variant people of color and poor people experienced marginalization along converging lines of class, race, and gender identity. While white, middle-class gender-variant people often strove to fit into middle-class white society and make their transsexuality invisible, gender-variant people of color and poor people lived their lives more publicly. Forming diverse communities with gays, lesbians, and prostitutes, they often lived outside the strictures and privileges of middle-class white society and openly expressed their identities, for example by throwing elaborate drag balls (Stryker 2008, 63). Criminalization and targeting of these communities by law enforcement lead to public clashes with police, most iconically in 1969 at the Stonewall Inn, a gay bar in Greenwich Village, New York. Though Stonewall is the most-cited example, similar incidents had occurred for an entire decade before Stonewall (Stryker 2008, 82). The climate that produced Stonewall also gave rise to radical organizations such as the Gay Liberation Front, which were primarily populated by middle-class whites (Stryker 2008, 85). Gender-variant people were often excluded from these spaces and formed their own organizations such as the Transsexual Activist Organization in 1970, where they advocated for their dignity as people who would not and could not integrate into white, middle-class, gender normative society (Stryker 2008, 88). In the eyes of the medical establishment, gender variance outside the gender binary and the white middle class was not considered treatable through medical transition. Health care providers legitimated the genders of white, middle-class, gender normative transsexuals by allowing them access to medical transition, while those who did not want to or could not access medical transition became a separate class of gender-variant people.

A**s** gender-variant people were regulated by the medical system, they were also subject to the analysis of feminist academics. Transgender was constituted as an object for academic inquiry by radical feminist academics in the second wave of feminism in the 1970s**.** Some feminist scholars, primarily Janice Raymond, claimed that womanhood was defined by female biology or socialization (Hines 2014).

For feminists such as Raymond, transsexual women represented the opposite of gender liberation, and she went so far as to argue that they were men who were raping women by appropriating their bodies for themselves (Raymond 1979, 104). They viewed transwomen as men infiltrating women's spaces, taking what little room women had kept for themselves (Bettcher 2014). This analysis discounted the validity of transsexual women, erased transsexual men entirely, and did not reckon with the idea that there might be gender-variant people who ascribed solely to either gender.

Despite this harsh judgement and the regulation of acceptable transgender identities by the medical system, new generations of gender-variant people began elaborating new identities and ways of being in the world in the 1990s. Factors including the growing visibility of transsexual people who were not perceived as cisgender men or women, the closure of university-based gender clinics and the opening of private clinics where requirements for receiving transitional therapies were less stringent, and the Internet lead to rapid growth of the movement. Parts of the new movement sought to embrace all gender-variant people, not just those who identified within the gender binary. Many white, middle-class activists began to use the term "transgender" to describe themselves and signify that they did not comply with gender norms (Valentine 2007, 33-35). Transgender "implies movement away from an initially assigned gender position", and unlike transsexuality does not necessarily mean a movement toward the other binary gender or a rejection of sexual characteristics, but includes many expressions of gender variance that include transsexuality (Stryker 2008, 19). The expulsion of transgender woman Nancy Jean Burkholder from the Michigan Womyn's Festival in 1991 and the murder of transgender man Brandon Teena in 1994 mobilized many transgender and transsexual people and lead to the first highly visible trans demonstrations (Beemyn 2014, 524-5). The organizing of groups such as the Gender Public Advocacy Coalition in 1995 (by Riki Wilchins) lead to large-scale lobbying and organizing within trans communities in the 1990s (Beemyn 2014, 528).

As the concept of transgender developed in the 1990s, the field of transgender studies opened space in academia for transgender people to theorize about their own lives and the radical possibilities presented by gender variance. Transgender cultural studies scholar Sandy Stone wrote the founding essay

of transgender studies, *The Empire Strikes Back*, in 1987 to counter Raymond's account of transsexuality. Stone argued that radical feminist and medical discourses on transsexuality represented specific genres of thinking about transsexuality. She advocated for a space for transsexuals to write as themselves and to tell their own stories, rather than to hear their stories told to them by others. Transgender writers Leslie Feinberg and Kate Bornstein were more interested in the possibilities for transgender people to defy gender norms. Bornstein coined the term "gender outlaw" to refer to transgender people who defied identification within the gender binary (Bettcher 2014). The book *Genderqueer,* published in 2002, broke new ground by documenting the first-person accounts of people with gender s and expressions outside the male-female binary (Wilchins 2002). After decades of feminist academics telling transgender people's stories in ways that were often disrespectful, some transgender people were able to enter academia and tell their stories themselves.

Outside of academia, transgender people began actively navigating American society beyond the gender binary. In 1997, Sphere, one of the first communities of genderqueer transgender people, many of whom considered themselves to be non-binary, was founded as a website and listserv "for people who bend even the boundaries of transgenderism" (Sphere). In the succeeding years, out non-binary transgender people have become common enough in the U.S. that in 2017, both Oregon and Washington, D.C. began offering X as a third gender option on their driver's licenses (Segal 2017). Nepal, India, Pakistan, and Bangladesh have legally recognized hijra, a third gender, for years (Anam 2015). Activism by transgender people has also pushed institutions from colleges to hospitals to offer gender-neutral restrooms that are accessible to people of all genders (Dickson 2016; Gender Neutral Bathroom Initiative). Non-binary transgender people are continually pushing for new ways to live in a binary-gendered world.

The idea of being non-binary transgender is historically contingent, owing its existence to the separation first of gender variance from sexuality, and then the separation of gender from sex in the mid-twentieth century. The definition of gender as an aspect of self-concept attempted to separate it from the body and from sexuality and allowed for its fluidity. At the same time, gender is still expected to

correspond neatly with binary categories of sexuality and conceptions of the body, which makes non-binary genders difficult to parse. The medical community has historically only granted medical legitimacy for gender-variant people who wanted to and could fit themselves into binary gender norms and who also had the class and racial privilege to be deemed respectable. This history colors the interactions of non-binary transgender people with their health care providers whether or not they are seeking medical transition, making clinical encounters fraught with risks for gender policing and seeded with possibilities for new understanding.

Gender Normativity and Accountability

The theories of transnormativity, doing gender, and the medical model of transgender identity help illuminate how health care marginalizes non-binary transgender people. Transnormativity is part of a cluster of four concepts, also including heteronormativity, homonormativity, and cisnormativity, which describe how LGBT people are socially marginalized. Heteronormativity was proposed by social theorist Michael Warner as a way to understand how social institutions enforce straight culture. Heteronormativity orders society such that "everyone and everything is judged from the perspective of straight". It does not mean that everyone must be straight, but that deviations from straightness will be held to heteronormative standards (Chambers 2003). Structures of heteronormative accountability are embedded within most Western institutions so that lesbians, gays, and bisexuals violate norms around gender, marriage, family, and health simply by existing (Warner 1991, 6). Heteronormativity effectively erases homo- and bisexuality from the public view by imposing consequences for deviation from straightness. For example, LGB people are seldom represented in popular media and most sexual education does not address LGB relationships (Robinson 2016). Warner claims that heteronormativity is a phenomenon so ubiquitous as to be invisible, allowing for widespread and unnoticed homophobia and oppression of LGB people in all aspects of society (Warner 1991, 8).

Heteronormative culture punishes LGB people for behaviors that deviate from its norms, and homonormativity structures these punishments while privileging certain LGB people over others through

a hierarchy of behaviors and relationships. Lisa Duggan developed the concept of homonormativity as part of her critique of neoliberalism, defining it as "a politics that does not contest dominant heteronormative assumptions and institutions, but upholds and sustains them, while promising the possibility of a demobilized gay constituency and a privatized, depoliticized gay culture anchored in domesticity and consumption" (Duggan 2003, 50). Homonormativity is centered around a heterosexual ideal that is not only straight but white and middle-class (King 2009). Thus, hetero- and homonormativity appraise LGB people not only in relation to sexuality, but in relation to sexuality defined by whiteness and wealth (Robinson 2016). By privileging LGB people who participate in heteronormative institutions including monogamy, marriage, domesticity, and reproduction, homonormativity creates a class of people that are as similar to their straight, white, middle-class counterparts as possible without actually being straight.

Though hetero- and homonormativity relate to the marginalization of LGB people, they also serve to regulate gender in relation to sexuality. Anthropologist David Valentine explores the emergence and consequences of the idea that gender and sexuality are completely separate components of human experience. The separation of sexuality and gender occurred through the work of the second-wave feminist movement of the 1970s as well as LGB activists from the 1950s on. Visible gender variance, originally thought of as gender inversion, had long been considered a characteristic that caused homosexuality. Homosexual activists defined homosexuality against visible gender variance, claiming that the two characteristics had fundamentally different origins. This allowed clinicians to depathologize homosexuality, removing it from the American Psychiatric Association's Diagnostic and Statistical Manual (DSM) in 1973, while gender variance entered the DSM in 1980 as gender identity disorder, now gender dysphoria (Stryker 2008, 98; Beemyn 2014, 520; Valentine 2007, 56). Confining gender-variant people to their own separate identity group ("transgender") with no obvious overlap makes it possible for LGB people in general to seem more heteronormative by separating themselves from the gender-variance that was associated with LGB people, especially gay men, for over a hundred years (Valentine 2007, 64). Heteronormativity requires not only normative sexuality, whiteness, and class privilege, but also gender

normativity. Homonormative structures and institutions work to "minimize the difference between homosexuality and heterosexuality, precisely by removing the visibility of (class-inflected and racialized) gender difference from the category 'gay'" (Valentine 2007, 133). Hetero- and homonormativity work hand-in-hand not only to enforce norms around sexuality, but also to enforce the gender norms inherent in straight culture.

Though hetero- and homonormativity relate to gender as well as to sexuality, the term cisnormativity was coined within the transgender community as a way to specifically explain the marginalization of transgender people as an analog to heteronormativity. Cisnormativity describes "the expectation that all people are cissexual, that those assigned male at birth always grow up to be men and those assigned female at birth always grow up to be women". Bauer et al. first used the term in an academic article to help explain how health care settings erase transgender people. They found that cisnormativity does not allow for the existence of transgender people, with the consequence that health care systems and providers do not expect to encounter them and are unprepared to treat them (Bauer et al., 2009). Transphobia and the marginalization of transgender people is underlain by cisnormativity and the privileging of cisgender identities.

The concept of transnormativity was developed by transgender people to relate to cisnormativity, heteronormativity, and homonormativity. Evan Vipond defines transnormativity as "the normalization of trans bodies and identities through the adoption of cisgender institutions by trans persons" (2015). Transnormativity results in the social valuation of normative or conventional transgender identities, including binary genders, over non-normative genders, including non-binary genders, which are seen as abnormal and deviant. Vipond adds that "to be [transnormative], one must ascribe to the social categories white, middle class, mentally and physically able, heterosexual, and adhere to normative notions of gender (masculine man and feminine woman)". Transnormativity creates categories of "acceptable" and "unacceptable" transgender people: "acceptable" transgender people stay within the lines of the gender binary, identifying and being perceived as white, able-bodied, middle-class straight men or women, and

"unacceptable" transgender people are those who do not or cannot adhere to these categories (Vipond 2015).

Transnormativity is closely linked to the medical model of transgender identity, which understands transgender identity as a medical issue defined by the psychiatric disorder of gender dysphoria and regulated by medical transition to the opposite gender. The gender studies scholars Evan Vipond and Austin Johnson have each related transnormativity to the medical model. Vipond argues that transnormavity upholds overall gender normativity and the bigender system which claims that male and female are natural, invariant genders that are inherently linked to an individual's genitals. Transnormativity is enforced through the medical model of transgender identity. In order to access gender-affirming therapies, the medical model requires that "trans persons must convince their doctors that they are "truly" transsexual by conforming to [transnormative] standards in order to appease medical practitioners and access services". Additionally, the medical model assumes that transgender people transition by moving directly to having characteristics of the opposite gender, not stopping in between or never physically transitioning at all (Vipond 2015). For Vipond, the medical model of transgender identity creates transnormative transgender bodies and identities that serve to uphold the binary gender system, which in turn casts non-transnormative bodies and identities as pathological or deviant.

Johnson's argument uses doing gender theory, a sociological theory of gender developed by Candace West and Don Zimmerman, to show how the medical model of transgender identity creates transnormative bodies and identities. Doing gender theory sees gender as "a routine, methodical, and recurring accomplishment" that occurs through social interaction, not as an inherent characteristic of individuals (West and Zimmerman 1987, 126). West and Zimmerman use the idea of sex category to understand the relationship between sex and gender. Sex is the socially accepted biological criteria for males and females and is communicated through sex category, or bodily displays that serve as a proxy for sex. Gender, then, is "the activity of managing situated conduct in light of normative conceptions of attitudes and activities appropriate for one's sex category" (West and Zimmerman 1987, 127). In this model, it is possible for a transgender person to communicate a sex category that is different from their

sex, or to enact gendered behavior that is different from their perceptible sex category or their imperceptible sex. Every social interaction involves gender and the possibility for participants to be assessed and held accountable for the way their gender, sex category, and sex do or do not align (West and Zimmerman 1987, 136). For West and Zimmerman, gender only exists socially, and is shaped by accountability structures that affect how individuals enact their gender.

Johnson uses the medical model of transgender identity together with doing gender theory to show how the medical model provides a normative accountability structure that guides how transgender people are held accountable for doing their gender. The medical model-based accountability structure affirms expressions of transgender identity that align with transnormativity and marginalizes other ways of expression. Though many transgender people may find the medical model accurate or helpful, it is a hegemonic ideology to which transgender people are held accountable whether or not their experience aligns with the medical model. Non-binary transgender people and transgender people who do not seek medical transition do not align with the medical model, which leads to restriction of their access to "gender affirmation in interactions with both transgender and cisgender people and institutions" (Johnson 2016). Johnson shows that transgender individuals are held accountable to the medical model not only in health care settings, but also in legal and community settings, which are all conduits of transnormativity (Johnson 2015). Johnson extends Vipond's understanding of transnormativity and the medical model of transgender identity to detail how transnormative bodies and identities are created by the medical model not only in clinical settings, but through many institutions and interactions.

Gender accountability is a complicated concept in doing gender theory, and further explanation of it will better show how it applies in health care settings. Jocelyn Hollander elaborates on West and Zimmerman's understanding of gender accountability, claiming that accountability refers to both the external consequences that people face for their gender expressions and also their internal awareness of these potential consequences. She breaks accountability into three parts: orientation of thoughts, perceptions, and behavior to social expectations around sex category, assessment of oneself and others' behavior in relation to their perceived sex category, and enforcement of accounts of gender through

interactional consequences (Hollander 2013, 10). Examples of consequences for gender non-conformity include directly calling it out, such as asking a transgender woman why she is in a women's restroom, making indirect comments about someone's gender, enacting physical punishment, or ending social interaction (Hollander 2013, 11). Hollander's elaboration of accountability shows that transnormative accountability structures are at work outside the individual, but that assessment is continually being carried out by the individual in relation to themselves and others as well. Assessing and anticipating the consequences of one's own behavior or appearance and adjusting in relation to this risk is part of gender accountability. In my work, I focus on how transgender people internally hold themselves accountable to transnormative standards and make decisions on whether to risk being held accountable for their gender by disclosing that they are transgender to health care providers. Navigating our complex gender system requires transgender people to devote energy to anticipating the possible consequences of disclosing or not disclosing that they are transgender, and in the remainder of this thesis I explore these decision-making processes in light of transnormativity, the medical model of transgender identity, and gender accountability.

AIMS AND METHODS

This study aims to 1) explore how non-binary transgender people approach relationships with their health care providers and how they go about seeking care, including medical gender transition; and 2) investigate how binary and non-binary transgender people make decisions about disclosing that they are transgender to health care providers. In order to answer these questions, a qualitative approach based on interviews and a focus group with both binary- and non-binary-identified transgender people was used. This study uses qualitative data to expand the quantitative data from the 2015 U.S. Transgender Survey that indicate that many non-binary and binary transgender people may not disclose that they are transgender to health care providers, and to further investigate previously unreported experiences of non-binary transgender people in health care (James et al. 2016, 49, 51). A small-scale qualitative approach allowed for fleshing out the existing thin data and to convey the experiences of individuals, which may be helpful for health care providers seeking to improve their practice. This approach also helps to connect the present-day experiences of transgender people with the history of the medicalization of gender variance and uses gender and queer theory to help place these experiences in a broader context.

This study uses individual interviews with 11 transgender people, 3 of whom were binary transgender and 8 of whom were non-binary transgender, as well as a focus group with one non-binary transgender and two binary transgender participants in order to both focus on the individual experiences of the participants and to allow the participants to discuss and compare their experiences. The size of this sample, especially the focus group, was small but manageable in a short timeframe. The sample was a convenience sample of the author's transgender acquaintances and some later participants were also referred by earlier participants. The sample is fully characterized in the beginning of the Results section. The lack of racial and age diversity and the lack of participants who were assigned male at birth in the sample as well as the small focus group size are major weaknesses in this study, but due to the timeframe and to the relatively small number of transgender people in the population it was beyond the parameters of this study to recruit a larger or more diverse sample.

For the interviews and focus group, the interview and focus group guides used are found in appendix I. These guides were developed through pilot interviews in the context of a class project, which helped to focus the study's approach from exploring the experiences of the participants in health care to understanding how participants make decisions about disclosing that they are transgender to health care providers. The study and study materials were approved by the Vanderbilt IRB (approval number 170343) before any research activities took place, and every attempt was made to keep participants' information confidential due to the danger of outing participants as transgender and revealing their personal information. These efforts included limiting access to study recordings, transcriptions and notes to the author alone, conducting all communication with participants through e-mail hosted on secure servers, and using pseudonyms for all participants. Interviews ranging from a half hour to an hour were conducted over the course of approximately a year both in person and over the phone, and interview participants who were local to the Nashville area were invited to a one hour focus group at the end of that time. The interviews and focus group were audio recorded and later transcribed by the author.

The interview and focus group data were analyzed separately through three passes of coding. The first pass used open coding to generate a set of codes that reflected themes within the transcriptions. The second pass used axial coding to refine and develop relationships between the initial codes. The third pass used selective coding to look for cases that illustrated each code and further develop the major themes present within the data in relation to the theoretical background of the study. The data were coded by the author alone and were not validated by any other coders, which is a major weakness in this study because it allows the author's bias to go unchecked.

RESULTS

Figure 1: Sample Characterization

Pseudonym	Gender	Age	Race
Ben	Non-binary	22	White
Calvin	Transgender man	54	White
Cameron	Non-binary	25	Multiracial Southeast Asian
Catherine	Non-binary	22	White
Devin	Non-binary	20	White
Evan	Non-binary	22	White
Keller	Non-binary	22	White
Marshall	Transgender man	25	White
Micah	Non-binary	22	White
Paul	Non-binary for interview, transgender man for focus group	19	White
Quinn	Transgender man	51	White

In the sample of 8 non-binary transgender participants, the mean age was 21.75 and the age range was 19 to 25. One participant claimed a non-white race/ethnicity. Seven participants were assigned female at birth and one participant was assigned male at birth. Four participants had undergone some form of medical transition, including hormone therapy, and four had not. Four participants lived in Nashville, two lived in Texas, and one each lived in Maryland and New York.

In the sample of 3 binary transgender participants, the mean age was 43.3 and the age range was 25 to 54. No participants claimed a non-white race/ethnicity, and all three participants were assigned female at birth. All three participants had undergone some form of medical transition, including hormone therapy and chest reconstruction. Two lived in Nashville and one lived in Maryland.

In the focus group, 2 participants were binary transgender, ages 19 and 51, and 1 was non-binary transgender, age 20. No participant claimed a non-white race or ethnicity, and all participants were assigned female at birth. Both binary transgender participants had undergone medical transition, including

hormone therapy, and the non-binary transgender participant had not. All three participants lived in Nashville.

Interview Results

Two main categories of codes emerged from the interview coding process: reasons to disclose transgender identity to health care providers and reasons not to disclose transgender identity to healthcare providers. Here I present the categories and their associated codes with representative quotes.

Reasons to disclose transgender identity to health care providers

Certainty about a health care provider's positive response to disclosure of transgender identity

Participants often relied on the reputation or characteristics of a health care provider to provide some certainty about what might happen if they disclosed their gender to them. When I asked Ben about what they thought might happen if they came out to their nurse practitioner, they replied, "I don't imagine that it would go badly. My nurse practitioner is pretty radical, he's young and very kind of an open person. So I don't think that that would be too much of an issue." For Ben, the provider's age and his seeming openness made Ben feel like disclosing that he was transgender would not cause problems. In response to a question about what made them feel like talking about their gender with a health care provider, Evan cited both the providers' actions and the environment they created in their clinic.

> Just them letting it be known that they're welcoming. By things like showing up to community events or having trans affirming posters up in their lobby or whatever it might be. And I also feel more comfortable when [on forms] you have "Gender" with a line rather than "Gender, check male or female" because that makes no sense!

In this case, it was not only the interaction with their provider that might make Evan feel safe to disclose, it was also the atmosphere the provider could choose to cultivate through community involvement, visible support for the transgender community, and inclusive language on forms.

Other participants chose to seek out health care providers that they knew by reputation were respectful of transgender people in order to create a space where reactions to disclosing that they were transgender could be predictable. When Quinn was first seeking medical transition, he "asked around about who other people were seeing" in order to find a provider who he knew he would be able to work with. Since not all providers who care for transgender patients are knowledgeable about non-binary transgender patients, looking for providers who would have predictable, positive responses to disclosure of non-binary transgender identity involved an extra layer of complexity. When I asked Cameron about whether they had talked about being non-binary transgender with their endocrinologist, they expressed that they disclosed that they were transgender to her and had carefully sought her out by reputation.

> Yeah, [I came out to her] because that was part of her questioning, but she has worked with other non-binary people too, like I know that there are some doctors who are trans friendly but not non-binary friendly, so I've tried to find someone who I've heard good reviews for in that sense.

The extra work of screening providers not only for transgender acceptance but also awareness of and respect for non-binary transgender people is an important difference between the health care experiences of non-binary and binary transgender people.

Disclosing transgender identity to health care providers may enhance health care or health

Many participants felt that their gender was relevant in health care settings and disclosure of transgender identity was important for their health and for receiving high quality health care. For participants who were seeing mental health care providers, disclosure of gender was often an important aspect of their treatment because their gender affected their mental health. Keller described gender dysphoria as "something that can have a negative effect on my mental health in just the same way that feeling bad in any other way does", and this made their gender relevant to their mental health care providers. Gender was so central to several of my participants' mental health that not disclosing their

gender to mental health providers would have undermined their treatment. For example, Calvin felt that he was partly in charge of his own health care and had an obligation to enhance his care by disclosing his transgender identity.

> I mean, my [mental] health care is only going to be as good as I'm able to communicate. If I'm not communicating something that probably is a big part of my life, I'm not going to get the care that I need.

Keller also felt a responsibility for their mental health care, that "not including that information [transgender identity] would not get me the best treatment...and it would be a bit self-sabotaging for me". Evan thought that not disclosing their non-binary transgender identity in therapy "was not serving me well or my therapist well" and so had to discuss their transgender identity in order to get the care they needed.

The relevance of gender to health care was more complex outside of mental health care and was especially relevant for those who were perceived as a gender other than the gender they were assigned at birth. They often needed their health care providers to know their transgender identity so that they could receive care appropriate to their anatomy. Marshall, who is a binary transgender man who is typically perceived as a cisgender man, needs his primary health care providers to know he's transgender because "they're about to look at my nether regions" and they need to understand his anatomy to provide good health care. When Calvin ended up in the Emergency Department, he was perceived as a cisgender man and had to deal with wrong assumptions made about his anatomy: "They were like, you need to give us a urine sample, and they gave me the male container. Well, alright, then, I guess I'll see how we'll make this work!" For both Marshall and Calvin, not disclosing that they were transgender to health care providers could cause awkward situations because of their anatomy. Non-binary transgender people who were perceived to be cisgender men, like Cameron, also encountered this problem.

> Ok, the risk of not coming out as trans specifically is just not getting adequate care in multiple senses...So, say, like for me, if I go in, and a doctor is reading me as what they consider biologically male, they're assuming things about my body...They might overlook things to do with my body that could be affecting my health.

For Marshall, Calvin and Cameron, being perceived as cisgender men offered the privilege of not being required to discuss their gender, but also came with the danger of having important aspects of their health overlooked because of false assumptions their health care providers made about their bodies.

Many of my participants who were medically transitioning also felt that their genders were relevant to their physical health care. In order to access medical transition, my participants had to seek health care based on their transgender identities, disclosing that they were transgender was necessary to access treatment. Calvin discussed the necessity of talking with his psychologist about his transgender identity because "the whole point of going to that psychologist was getting my letter for surgery". Additionally, some participants felt that disclosure of gender to health care providers was necessary when they were taking hormone therapy because not disclosing that they were taking hormones could have put them at risk for adverse drug interactions. Generally, my participants felt that disclosing their hormone therapy would lead a provider to the conclusion that they were also transgender, so mentioning their hormone therapy was a form of disclosing that they were transgender. As Ben said, not disclosing their transgender identity would mean "I'd also have to not tell them what hormones I'm on and risk drug interactions", and they concluded that "I guess it wouldn't really be safe for me to do that [not disclose] at this point". Of course, non-binary transgender people do not have to disclose that they are non-binary transgender even if they tell their health care providers that they are on hormones, and they do not have to disclose that they are non-binary when seeking medical transition. This brings up another layer of complexity for non-binary transgender people to navigate as they try to get adequate medical care without alienating their health care providers.

Disclosing transgender identity to health care providers is important for creating authentic and trusting relationships

Building trusting relationships with health care providers was part of receiving good health care for some of my participants and disclosing that they were transgender could be a part of this process. Despite the risks of revealing their non-binary gender, for Micah, a provider's positive reaction to their

disclosure “creates a level of trust that you can’t have if you never come out” and is an important part of the patient-provider relationship. For some of my participants, this relationship started with an initial affirmation that the provider would be able to respectfully work with them. As discussed earlier, Keller viewed their gender as central to their mental health and felt that they needed their therapist to be able to respect them as a non-binary transgender person.

> I have not actually found a therapist yet...but when I do, that will also be something that I’ll be very up-front about. I’ll be like, I am non-binary, that is important, if you can’t deal with that I’m going to find someone else.

Micah also felt the need to screen their therapists to make sure that they would able to “deal with their gender”. Both Keller and Micah anticipated giving their future therapist a kind of test to determine their ability to establish a therapeutic relationship with them, and in so doing would actively shape an environment that was safe for them to express their gender and where they could receive good mental health care.

Other participants articulated differences in the need to disclose transgender identity between short-term and long-term relationships with health care providers. For example, Devin felt that for a one-time visit with a psychiatrist there was no need to disclose their gender, so they “just didn’t tell that one anything because it’s on-the-spot care”. The longevity of any relationship, not just with a health care provider, was an important factor in deciding to disclose transgender identity for Quinn.

> And you know,... if it’s a colleague of mine, if I’m going to have a relationship with them for a long time, usually I like to disclose because I don’t want to be hiding parts of myself or not be authentic. But if it’s someone like the eye doctor, I’m going to see this person one time, do I really want to go into this? So it depends on the kind of long-term relationship I’m going to have with somebody.

Overall, my participants found it important on some occasions to disclose their transgender identities to health care providers in order to enhance the patient-provider relationship, but relationship-building through disclosing was less important in short-term relationships with health care providers.

Disclosing transgender identity to health care providers is important to feel authentic and to preserve mental health

Aside from relevance to specifically medical aspects of their experience, some participants found that disclosing their gender to health care providers was important for their own personal integrity. When they did not disclose that they were transgender, providers were not able to see them authentically and often made wrong assumptions about them. Cameron discussed their experiences with the assumptions made about their gender if they did not explicitly disclose that they were transgender.

> If you're not out as non-binary, it's more psychological trauma, it's more...someone assuming that you're ok with being binary and being addressed as he or him, or people not knowing that non-binary people exist, especially that non-binary people go on hormones, and are likely to treat you in more bro-ey ways.

Cameron felt that if they had to present themselves as binary instead of non-binary transgender to a health care provider, "it would just feel wrong on so many levels": not only would they risk receiving inadequate health care, they would also not be able to be seen as a whole person.

Other participants commented that authenticity in relation to their gender was important to their mental health. When I asked Catherine why they felt it was important to disclose that they were transgender to their health care providers as non-binary transgender, they said that "being open and honest about my identity is important to my mental health". Similarly, Evan related that if they presented themself to a health care provider as binary instead of non-binary transgender, they would have concerns about their own integrity.

> Yeah, I just feel like if I'm going to represent myself or say I'm a certain thing, for me it has to be true, like authenticity is really important to me, and it doesn't feel good or right to not be 100% authentically myself...I think it would just cause more inner turmoil [to not present as non-binary].

For Evan and Catherine, openness and honesty about their non-binary genders contributed to a positive state of mind and mental health.

Reasons not to disclose transgender identity to health care providers

Disclosing trans/non-binary identity in medical settings does not have a certain outcome

My participants often had to navigate feelings of uncertainty about how their health care provider would react to disclosure of their transgender identity. Even when filling out a simple medication disclosure form, Cameron had to think about the consequences of their honesty.

> I remember thinking that this is my first doctor appointment since I've been on T, and the fact that I have to write down on my intake form any medications I'm on, and it's like testosterone, 160 mg every two weeks! I just remember wondering about that, will this be a problem because it's Tennessee?

For Cameron, their answers on a routine form could end up causing "a problem" depending on who read it, making it risky to disclose that they were transgender. Quinn's feelings of uncertainty about the outcome of disclosure sometimes held him back from disclosing. As he stated, "there are just some days when I don't want to disclose my trans status. I mean it doesn't feel safe, it doesn't feel like I know how they're going to react". Despite feeling that "the risk of discrimination against white trans men in medical settings is much lower than it was", Marshall still did not think that he should disclose his transgender identity to a doctor that he saw only once because it "introduced the risk of discrimination". Disclosing in uncertain circumstances can result in a good outcome, but my participants found it difficult to ignore the possibility of a bad outcome. The remaining codes in this section more specifically address some of the risks of disclosing in uncertain situations.

Disclosing transgender identity to health care providers is not relevant for health care

Many of my participants described their genders as irrelevant to health care relating only to their bodies. Quinn talked about his opthamologist's questions about his prior surgeries and his decision to not disclose his transition-related surgeries because "well, I could be wrong, but I'm not sure what my eyes have to do with my genitals!" Calvin related a similar opinion about disclosing that he was transgender in situations where transgender identity did not seem to affect his physical health.

> Going to my opthamologist, how is it relevant that I've changed my physical sex over the course of my life? I mean, if you see something weird on my eyeballs,...if there's some eye-related anomaly related to testosterone, then yeah I'd disclose, but if I get an ingrown toenail, it's not because I'm a transman. It's because I'm on my feet all day!

Cameron and Keller, both non-binary transgender people, felt that their non-binary genders specifically were often not relevant to their bodily health. Keller discussed why they do not feel the need to talk about being non-binary transgender with their gynecologist: "Functionally my body is no different from a ciswoman's. I don't treat it differently from a ciswoman's. So it [transgender identity] doesn't come up." Cameron, who is medically transitioning, detailed how they feel that their identity as transgender in general is more relevant in most clinical situations than their specific identity as non-binary transgender.

> So say at a clinic visit,...what is relevant is a) you're trans, and b) your body is x way, whether that incorporates...your genitalia or your hormone levels or whatever. I'm less and less likely to bring up being non-binary in a circumstance like that than to bring up that I'm trans.

For them, their transgender identity was relevant in clinical encounters mostly because it affected the assumptions that health care providers made about their body. Both Cameron and Keller expressed that their non-binary genders do not come into play in their bodily health care because they do not directly affect their bodies.

Others more specifically expressed that they did not feel the need to discuss such a personal part of their identities with physicians. When I asked Micah why they have told their physicians that they are a transgender man, not a non-binary transgender person, they replied that they don't feel that they need to talk about how they "navigate the world" with their physicians or bring in important parts of their personal life. Ben also typically keeps their non-binary gender to themself because "it's a personal thing that I don't talk about that much", and they don't find their gender to be "really relevant for my treatment". Micah and Ben have both drawn boundaries around certain parts of their lives that they do not believe should be part of their relationships with health care providers.

Disclosing transgender identity to health care providers may compromise health care or health

Though some of my participants identified disclosure of transgender identity as promoting health and quality health care, it could also compromise health and health care. For example, a provider may choose to turn a patient away if they know they are transgender. Catherine's assessment of the consequences of disclosing that they are transgender is uncertain, but includes the possibility of being

unable to work with a provider: “I guess there’s a chance nothing would happen, and a chance I’d be asked to leave and refused services”. Devin chooses to work around their non-binary gender with their psychiatrist rather than disclose their transgender identity because they would “rather have a psychiatrist”. In other situations, disclosure may not result in the loss of a provider but may affect how care is provided. When Calvin had an ear infection, he chose not to disclose his transgender identity and his hormone therapy because his hormone therapy likely contributed to his high blood pressure. He was afraid that if his doctor knew he was on hormone therapy, the doctor would recommend stopping hormones to bring his blood pressure down.

> That doctor was much more concerned about my blood pressure at that moment rather than the fact that my ear is killing me, and probably would have recommended, oh, you need to go off your hormones or you need to cut back or you need to do this or that.

Calvin believed that his doctor in this situation would not understand that taking him off hormones would affect his gender dysphoria, which was as much a part of his health as his blood pressure and his ear infection, so he chose to eliminate this risk by not disclosing his hormone therapy or transgender identity.

In terms of mental health, Keller believed that disclosing an identity that a mental health care provider did not understand could put their mental health care at risk by introducing an erroneous psychiatric diagnosis.

> One of the classic criteria for Borderline Personality Disorder is identity problems, I guess, basically having a disconnect with your identity. So for practitioners who do not understand non-binary genders, someone who seems to adhere to society’s conception of standard female gender, like me, who comes in and says I’m not actually a woman,...that can look a lot like a disconnect with your identity. When combined with other aspects, because I do have other diagnoses, like depression, obsessive-compulsive disorder, and ADHD,...that can look like Borderline Personality Disorder, which I’m reasonably certain is not true.

The risk of an incorrect diagnosis did not stop Keller from telling their mental health providers that they were transgender, but it was certainly a possibility that they had to keep in mind with every new provider.

Lastly, for Ben, a U.S. military veteran with military health insurance (TriCare), disclosing to the wrong provider could mean that they would actually lose their health insurance. Earlier in their medical transition when they were not perceived as a cisgender man, they chose not to disclose that they were taking hormones on a visit to the Emergency Department because “it was more important to me that my

insurance wasn't messed up" than it was to avoid a drug interaction. Though they said that they would no longer risk their health by not disclosing their transgender identity and hormone therapy, Ben's difficult decision between telling a doctor about their hormone therapy and keeping their health insurance illustrates the health risks my transgender participants navigated during each health care encounter when deciding whether or not to disclose their transgender identity.

Disclosing non-binary identity or gender non-conformity may have consequences for being able to access medical transition

Though transgender people need to discuss their transgender identities with their health care providers when seeking medical transition, this discussion was complicated for my non-binary transgender participants. Many providers do not believe that non-binary transgender people meet the DSM-V criteria for diagnosis of gender dysphoria and so may consider them ineligible for medical transition. My non-binary transgender participants who sought medical transition often assumed that they would encounter this obstacle. When Ben was seeking medical transition, they chose to tell their nurse practitioner that they were a binary transman because they "didn't want to risk them not giving me treatment", and they worried about their non-binary gender "influencing my treatment or my relationship with my healthcare providers". Similarly, Paul felt that they could disclose their non-binary gender to a health care provider who did not prescribe their hormone therapy because "she's someone who I think just doesn't have the power to gatekeep anything from me...I'm not trying to get papers signed, and prescriptions [for medical transition], so I don't feel the need to hide that I'm a non-binary trans person". When seeing the health care provider that prescribes their hormone therapy, Paul told their provider that they are a cisgender man because they were afraid that the provider would not understand why they needed medical transition: "I was always afraid of that, like why do you want to go on T if you're not male?" Micah also "puts up a front" of being a cisgender man when they are seeking medical transition because they're afraid that if they said that they're non-binary transgender, they "wouldn't be able to get T [testosterone] or a referral for top surgery because I'm not 100% a guy". Micah was also concerned that

their health care provider would not provide them with hormones because their desired appearance did not conform to masculine standards.

> There's an idea that you have to be extra-super-careful with prescribing hormones, and if there is doubt they might not prescribe to you. Especially since I am not trying to be a big burly man on hormones, and there's an idea that if you are taking T [testosterone] you want to be big and burly. So I don't want to give a provider an excuse to deny me hormones.

My participants made it clear that it could be risky to disclose non-binary transgender identity or their desire for a gender non-conforming appearance to the providers who could give them access to medical transition. The necessity of seeming "trans enough" to access medical transition was an important factor in my participants' decisions to disclose that they were non-binary transgender to their providers.

Disclosing transgender identity in medical settings is uncomfortable or difficult

Many of my participants found explaining their genders difficult and often not worth attempting, especially in short-term relationships. For example, when I asked Cameron what would happen if they came out to a CVS Minute Clinic provider as non-binary transgender, they replied, "mostly awkwardness, probably. So in that case, if I tried to say hey, I actually go by they/their pronouns,...I don't know if it would even register". Quinn sometimes felt up to discussing his transgender identity with health care providers, but for him, "there's other days where I'm like, I just don't want to go there", where disclosing that he was transgender felt more like a burden. Evan is not out to their general practice physician as a non-binary transgender person. When I asked if it bothers them to be misgendered by their doctor, they replied that "yes it bothers me, but it doesn't bother me enough to have that conversation...like I don't want to have that conversation, I just don't. Especially in the South." They then expanded on how they feel about talking about being non-binary transgender and the expectations that are placed on transgender people who choose to transition medically.

> I think it's not just a waste of my time, but there are so many places, like your doctor, the police, the courts, your school, that you just have to pick and choose when it's important to come out. And like, right now it's not important to have that full conversation,...like if I was binary I think it would be a little bit different, but as a non-binary person, especially as someone who doesn't plan on changing their voice or physical features very much, it's just a whole other conversation than if I transition medically or if I'm going to transition medically, it's yes I'm non-binary, then there's a lot of expectations, like you're trans so you want these things, and that's not necessarily true. And I don't really want to have that conversation all the time.

The emotional labor associated with disclosure did not always stop after the first time my participants came out to a health care provider. Devin related experiences of therapists and psychiatrists forgetting their non-binary gender and pronouns. When that happened, they had to decide if they wanted to remind their providers about their pronouns, but they often did not because of the effort involved: "I don't have the emotional energy to correct cause I just don't". The emotional labor involved with disclosure and correcting names and pronouns was a drain that many of my participants chose to avoid in interactions with health care providers, especially when the relationship was temporary.

Disclosing transgender identity to health care providers allows them to reject or ignore the identity

Disclosing that they were transgender not only opened the door to discrimination that threatened health and health care for my participants, it also allowed them to be hurt emotionally by a health care provider ignoring or rejecting their identity. Both Catherine and Cameron related their concern that their health care providers would not understand their non-binary genders which could result in rejection. When I asked Catherine what they thought might happen if they discussed their non-binary gender with their general practice doctor, they replied that "most likely I'd be mocked or told that I don't know what I'm talking about." Cameron was more worried that their health care provider might feel undermined by confrontation with an unfamiliar experience, and that this could lead to multiple consequences.

> So if they're thinking "I am a trans-friendly doctor and I take good care of my trans patients", and then someone's like, "actually, my experience is not what you're saying and what you've experienced before", I think there's a risk of that disjunction or that discomfort causing some kind of backlash from the point of the doctor, not necessarily overtly. I would be concerned that it would manifest as either belittling or as a doctor assuming that their knowledge of my situation is something other than what I was saying, or trying to convince me to try to do something that I didn't want to do because that's what they'd done with other people.

In this case, Cameron's doctor's inability to understand that non-binary transgender people are real could seriously derail their relationship and leave Cameron emotionally hurt.

A provider who seemingly ignores non-binary gender without outright rejecting or questioning can also cause harm. As noted above, Devin had disclosed that they were transgender to multiple psychiatrists and therapists as non-binary transgender, but as they said, "I'll tell them the first session and

they usually forget by the third session. It's as if I didn't actually say anything." Ignoring the importance of transgender identity in Devin's mental health was harmful, and this experience made them question the value of disclosure at all. The possibility of a health care provider rejecting or ignoring their transgender identities was an emotionally painful risk for my participants.

Focus Group Results

The process of analyzing the focus group data resulted in two codes that characterize my participants' experiences with health care providers and their hopes for improving transgender health care. Note that when I interviewed Paul individually they were non-binary transgender, but when Paul later participated in the focus group he was binary transgender, specifically a transgender man.

Being transgender means often having uncomfortable experiences with health care providers

Paul, Devin and Quinn all experienced feeling uncomfortable with health care providers because of their transgender identities, but for different reasons. Paul felt uncomfortable when he went to see a physician for general health care as an out transgender person because he was "asked all these questions about surgery and stuff...I didn't want to feel like a spectacle". For him, discomfort came from health care providers knowing about his transgender identity and being inappropriately curious about his future medical decisions. Similarly, though Devin rarely disclosed their non-binary gender to health care providers, they anticipated discomfort if they were to disclose because they "don't want to risk anything being more complicated than it needs to be". They feel uncomfortable "questioning people's assumptions of who I am" because it feels too confrontational to them.

However, for Quinn, discomfort came not from disclosing that he was transgender, but from health care providers not knowing or acknowledging his transgender identity. He found it awkward when he was treated as a cisgender male by a provider who would not openly acknowledge his transgender identity, a provider asking questions that were irrelevant because of his anatomy, and not being sure if a specialist knew that he was transgender before he disrobed for an exam. In general, he believed that

awkwardness came from health care providers lacking information about his identity or ignoring his identity, and that giving them the information that he was trans could have improved the situation.

> I feel like anytime I'm dealing with a doctor or nurse or primary care physician it's always an awkward experience, and if there's anything I could do or information I could give them to make it less awkward that might be good!

Though Paul, Devin and Quinn thought very differently about uncomfortable situations with health care providers, they all highlighted as a frequent experience for them as transgender people.

Health care providers have the power to be gender experts

Paul, Devin and Quinn agreed that health care providers who prescribe medical transition see themselves as gender experts with power over the lives of transgender people. Paul described a situation with the physician who prescribes his hormone therapy in which his physician thought he "didn't look masculine enough and...should go on testosterone" and ended up raising his dose of testosterone because she wanted him to look very masculine. He thought this attitude was strange because he did not want someone else to make determinations about how his body should look.

> I found it really weird, like that should be me, like if I'm not satisfied with the way my body looks is one thing, but for her to be like, your voice doesn't sound right or you don't look right is another. And she didn't say this, but I know that it's what she was saying, like let's put you on more testosterone because you don't look how you should look at this point.

Even though Paul did not really want a higher dose of testosterone, he also did not want to ask his physician to keep the dose the same because disagreeing might compromise their relationship and he wanted her to approve him for other aspects of medical transition in the future: "I don't want to disagree with her on stuff because I want her to be really cooperative, especially because I want letters for surgery maybe or something like that". He has also had experiences when he was a non-binary transgender person in which he had acted more like a binary transgender person than he felt or crafted a story that he believed would provide evidence to his health care providers that he was transgender enough to receive medical transition: "I think as long as I like really try hard to play into the trans narrative, I'm ok...as long as I try my best to fit the stereotype I get the treatment I want". Paul's experiences show that his health care providers view themselves as gender experts who hold their transgender patients' gender expressions to

their own standards of masculinity and femininity and have the power to refuse them medical transition if they do not meet these standards.

Quinn agreed that it was not helpful for Paul's health care providers to act like authorities on masculinity, and he gave advice about how health care providers should approach making decisions about transgender people's appearances.

> But I wish they would just ask, what would really make you feel good about yourself, that seems like a really good question to ask, like what's your goal, what do you want to look like, and how do you define your gender?

He had also experienced physicians acting like authorities on sex and gender when he took part in a panel to educate health care providers on transgender health. He found that some of the physicians were convinced that "whatever your sex at birth is is your destiny", and they "thought they knew everything" and were unwilling to reconsider their opinions. Devin agreed, expressing that the medical system is constructed to make it seem like physicians know everything, and they wished that "doctors would acknowledge that they don't know everything and that they aren't omniscient, they do have biases". Paul, Quinn and Devin shared concern over the power that health care providers hold over transgender people's lives and the possibilities for the misuse of that power.

DISCUSSION

This study aims to explore how non-binary transgender people approach relationships with their health care providers and how they go about seeking care, and to investigate how binary and non-binary transgender people make decisions about disclosing that they are transgender to health care providers. The study findings offer evidence that transgender people often navigate complex decision-making processes in health care settings when determining whether or not to disclose that they are transgender to health care providers. My participants collectively cited many situation-dependent reasons to disclose that they were transgender and many reasons to avoid disclosure which they must weigh in every health care setting.

However, it should not be assumed that all transgender people are able to make choices about whether to disclose their gender or keep their gender private. For my participants, these choices were made possible by their physical appearances and the general lack of knowledge about non-binary genders. Whether they wanted to or not, many of my participants were taken to be cisgender people and so faced the decision of whether to disclose that they were transgender or let their providers assume they were cisgender. However, many transgender people choose to be visibly gender non-conforming and others' appearances do not allow them to be perceived as cisgender. Unlike most of my participants, these transgender people do not have the ability to be perceived as cisgender and to choose who knows that they are transgender. The idea that one can choose to disclose that one is transgender depends on them being perceived as cisgender at all, and if a transgender person is not perceived as cisgender, disclosure becomes less of a choice and more of an occurrence that happens without their consent. This study only touches the surface of the decisions transgender people have to make in relationship to their physical appearance when relating their identities to health care providers, but hopefully provides a fruitful first look to be followed up by more intensive study.

In most situations, patients are advised that in order to receive the best health care possible they have a responsibility to be completely honest with their health care providers. This seemingly common

sense assumption did not make sense for my participants as their transgender identities complicated their relationships with their health care providers. The best option for my participants to take care of their health could mean, in different situations, disclosing that they were transgender in order to receive health care tailored to their anatomy or identity, not disclosing their identity in order to stay safe, or for a non-binary transgender participant, saying that they were binary transgender in order to get the medical care they need without risking increased discrimination. Just trying to get their health care needs met required my participants to navigate options about how they wanted to present themselves to the world.

One of the most important factors in dealing with these options was whether their provider was a mental or physical health care provider. For many of my participants, it was much more important for their mental health care providers to know about their transgender identities than their physical health care providers. This was due to my participants perceiving that their gender identity influenced their mental health and also how important they felt it was to bring their whole selves into authentic relationships with their mental health care providers. In contrast, when their transgender identity did not directly affect how a physical health care provider understood their body, most of my participants felt that their transgender identities were irrelevant. My participants felt that their transgender identity was least relevant in interactions with physical health care providers that they would see only once and with whom they would not form and important relationship. Awareness of and respect for transgender people is necessary for all health care providers, but is especially important for mental health care providers and health care providers who see the same patients over long periods of time.

Several of my participants discussed that it was necessary for their health to find mental health care providers who would respect their transgender identities, and they specifically sought out these providers. It is certainly a privilege to be able to choose health care providers who will have predictable, positive reactions to disclosure of transgender identity. Many transgender people do not have health insurance or have limited insurance, cannot afford insurance co-pays, or live in an area where there are no health care providers who accept transgender patients. If they view their transgender identity as a crucial component of their mental or physical health, they must cope with health care that does not meet all their

needs as transgender people. Finding a transgender-accepting provider is difficult or impossible in many places, but finding a non-binary-transgender-accepting provider is even rarer. All transgender people deserve access to health care providers who will work with them respectfully, regardless of their gender identity, and inability to access affirming care is a health issue that may especially affect non-binary transgender people.

My non-binary transgender participants experienced transnormativity most explicitly when trying to access medical transition, but transnormativity ran throughout all of their health care experiences as an extra layer of complexity and uncertainty. In regards to medical transition, most of my participants expressed anxiety that their health care providers would not prescribe hormone therapy or sign letters for gender affirmation surgery because they identified outside the gender binary and might not be able to be diagnosed with gender dysphoria. In response, they had to conceal their non-binary genders or specifically seek out health care providers who they knew would allow them to access medical transition. This is the most obvious way that my non-binary transgender participants were treated like a different, less valid class of transgender people by their health care providers.

In its less obvious forms, transnormativity was present for my non-binary transgender participants as general reluctance to disclose that they were transgender for all the same reasons that binary transgender people did not want to disclose, but with extra complicating factors. My non-binary transgender participants risked their experiences being dismissed as a fad, being misdiagnosed with Borderline Personality Disorder, and expending emotional labor to educate health care providers about their genders and correct providers when they misgendered them. These small risks added up to make my non-binary transgender participants more uncertain about how they would be treated by their health care providers and whether disclosing was a good option. Thus, transnormativity played a role in my non-binary transgender participants' experiences with health care providers outside of affecting how they sought medical transition.

Of course, transnormativity does not only negatively impact non-binary transgender people, but all transgender people who are not white, middle class, able, heterosexual, or gender conforming. My

sample was too homogeneous to give data on experiences of transnormativity outside of the division between binary- and non-binary transgender identities, but it will be important for future research to treat transonormativity intersectionally, paying attention to how transgender people are marginalized along the axes of many different oppressions**.** Transgender people who face intersecting oppressions, especially transgender people of color and disabled transgender people, may have different relationships with their transgender identities than transgender people who do not experience these oppressions. Adding additional marginalized identities likely affects the ways that transgender people interact with the health care system and may add risk factors for disclosing that they are transgender, such as feeling less likely to be believed or not wanting to alienate a provider who offers the best treatment for their chronic health condition. Transnormativity operates on factors other than just gender identity and has complicated effects on transgender people's decisions around disclosing their transgender identities.

My non-binary transgender participants also often thought that their genders were irrelevant to physical health care providers because they were not always directly related to the body. Some felt it was important to correct health care providers' assumptions about their bodies by disclosing their transgender identities in general, but that did not necessarily mean discussing the specifics of being non-binary transgender. In the focus group, participants discussed awkwardness in encounters with health care professionals as coming from wrong assumptions about their anatomy, but also from inappropriate curiosity around their transgender identity. This illustrates how there can simultaneously be a practical, physical reason for disclosing transgender identity (ensuring correct knowledge of anatomy) and a less tangible, personal reason not to disclose (fear of discrimination or the emotional labor of explanation). Since non-binary gender is under the general umbrella of transgender identity, my non-binary participants could choose to only disclose that they were transgender, not non-binary transgender, to health care providers who needed to know that they were medically transitioning, separating their non-binary genders from the needs of their bodies. Because of their ability to choose which parts of their identities to reveal and which to keep private, my non-binary transgender participants could mitigate their risk of discrimination while also correcting wrong assumptions health care providers made about their bodies.

All my transgender participants navigated complex decision-making processes when deciding whether to disclose that they were transgender to health care providers, but my non-binary transgender participants also had to deal with the extra complications of an important aspect of their transgender identities that they could strategically choose to bring into conversation or leave at the door.

This study gives an excellent example of how gender accountability and transnormativity work through the medical model of transgender identity. As discussed in the literature review, West and Zimmerman's doing gender theory explains that gender is regulated through accountability processes. Transgender people are held accountable based on how transgender people do their gender, which can be through appearance and mannerisms as well by explicitly discussing their transgender identity. As Hollander claims, gender accountability processes are both external and internal. My participants experienced both types of accountability: they were held accountable externally by experiencing discrimination when they appeared to be gender non-conforming or chose to disclose that they were transgender to their health care providers**,** and they also went through complicated internal processes of considering the various ways that they might be held accountable for their transgender identity or appearance. Even if in the end they faced no external consequences for doing their gender, my participants still expended mental energy anticipating how they might be held accountable. Because transphobia and cisnormativity are systematic and ubiquitous, internal gender accountability processes take up mental space for transgender people in most situations, even those where there may be no external consequences for their gender non-normativity. The work of internal evaluation of risk and the process of decision-making around disclosure out does not end just because an individual health care provider creates a welcoming environment for transgender people, they can end only when systematic transphobia and cisnormativity are themselves uprooted.

This study was limited by its small size and the homogeneity of its sample and so is not generalizable. Additionally, the use of a single investigator and arbiter of responses introduces bias to the data analysis. However, despite its weaknesses, this study does show that transgender people have a diversity of experiences with and attitudes toward disclosing that they are transgender to health care

providers. It also illustrates some of the complex situations that non-binary transgender people find themselves in when seeking health care. These findings open a door to further study of transgender people's decision-making around disclosure of their genders to health care providers and the consequences of these decisions. The diversity of experiences in the transgender community are intertwined with other experiences of marginalization and will benefit from more careful scholarly treatment in the future.

CONCLUSION

This study does not come with a checklist of concrete steps health care providers can take to make themselves more welcoming to transgender people. My historical review and data show that transphobia and transnormativity have been deeply interwoven with our health care system, and while there are certainly ways to mitigate the harm they cause, the most important changes will not be quick or easy. For example, several of my participants brought up that they would like their health care providers to be able to admit their ignorance about transgender identities and transgender-specific health care and seek out opportunities to educate themselves. Similarly, in order for non-binary transgender people to be able to access medical transition, health care providers must be willing to learn about new genders from their patients and honor their needs. But it is not possible to universally encourage health care providers to acknowledge that they are not complete experts in a society where they are constructed as unquestionable authorities. Deconstructing how health care providers hold and exercise their power as gender experts and reconstructing the health care profession to be more open and capable of addressing the health of the transgender people is a systematic change that cannot be rushed and will be strongly resisted.

In this light, I want to reconsider the studies about LGB identity disclosure in health care settings discussed in the Background section. A great deal of this literature assumes that disclosing transgender identity to health care providers is a health-promoting activity and makes recommendations to help LGB people feel more comfortable with disclosing that they are transgender in health care settings. It would be easy to make this assumption in regard to transgender people disclosing to their health care providers, but I want to challenge the idea that outing oneself as transgender should necessarily be seen as beneficial in medical contexts. My participants believed that revealing their transgender identities to health care providers could be dangerous to their physical and mental health, and even if disclosure was not dangerous, it would still require emotional labor that they were not always willing to give. Additionally, they often found that their transgender identities were not relevant in many medical encounters and they did not feel the need to disclose them. The medical system regulates transgender identities and

expressions, and transgender people are understandably reluctant to enter themselves into this system by bringing their entire selves and the nuances of their genders into medical contexts. Strategically choosing where and how to be out is a way that both binary and non-binary transgender people survive in a system that typically flattens their identities. Health care providers should certainly work to become more knowledgeable about and welcoming to their transgender patients but should also expect that their patients will always be weighing the risks and rewards of disclosing that they are transgender and might decide that parts of their identities have no place in health care settings. The diversity of gender identities and expressions in our world is ever-growing, and health care providers must respond to these changes with flexibility and trust in the knowledge and experiences of transgender people.

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APPENDIX A

Non-Binary Transgender Experiences with Health Care Providers
Interview Guide
Elizabeth Manning
2/23/17

Interviews will be loosely structured and based on the experiences and preferences of each participant. Specific wording of questions and the order in which they are introduced will differ between participants. Here is a general guide for the questions that will be brought up in each interview.

Thank you for agreeing to participate in an interview. The interview should take around 30 minutes. Before we begin, we will go through this online consent form together (go through RedCap consent form, explaining each item and answering questions).

As a reminder, this interview is confidential and anonymous. Your name will never be associated with this thesis or with any of the notes from this interview. You have no obligation to finish the interview or answer any question, just let me know if you want to skip one.

We will start with some preliminary questions.

What pronouns should I use for you?

What is your race or ethnicity?

How do you identify or understand your gender?

Do you think you fit into either the category of binary transgender or non-binary transgender, and why?

When did you first identify as transgender?

What was that process like?

Have you transitioned in any sense of the word?

If yes, in what ways and when?

How do you use clothes, hair, mannerisms, or other outward markers to affect how other people understand your gender?

Now I am going to ask more about your experiences with health care as a transgender person.

What types of health care providers have you seen since you identified as transgender?

Tell me the story of a typical appointment with each one of these providers.

Tell me about any encounters that stand out to you as especially good.

Tell me about any encounters that stand out to you as especially bad.

When you go see your health care providers, do you change your clothes, hair, mannerisms, or other outward gender markers from how they usually are?

Which of your providers are you out to as a transgender person?

What made you want to come out or not come out to these providers? (If the participant has seen a lot of providers, I will ask them to focus on those that they felt it was most important to come out or not come out to.)

If you came out, how were you treated by the provider?

What do you think would have happened if you had not come out?

If you did not come out, what were the consequences for you in that situation?

What do you think would have happened if you had come out?

Is there anything else that you think it is important for me to know about your experiences with health care providers?

If you know anyone else who might be interested in participating in this research, I will give you a message to pass on to them (hand them a flyer with the interview e-mail recruiting script, or e-mail it to them if we are not meeting in person).

If the participant is located in the Nashville area, I will read them the recruiting script for the focus group and give them the focus group flyer:

I am also recruiting participants to participate in a focus group about the experiences of transgender people with health care providers, though you have no obligation to participate in the focus group even though you participated in the interview. The focus group will include 6-8 people, about half binary transgender people and about half non-binary transgender people, and I am inviting you to participate because you are transgender person. I will be asking you to describe, discuss and compare your experiences with health care providers. The focus group will take around 1 hour, and you will be compensated with a $20 gift certificate for your participation. Please contact me through the e-mail address on this flyer if you wish to participate.

Thank you so much for your participation. I hope that this research will be useful to the transgender community, and I am so glad that you were willing to take part in it.

APPENDIX B

Non-Binary Transgender Experiences with Health Care Providers
Focus Group Discussion Guide
Elizabeth Manning
2/23/17

Please note that this is only a guide for the discussion. Specific wording of questions and the order in which they are introduced may differ from what is written here.

Introduction:

Thank you all for agreeing to participate in this focus group, which should last about 1 hour. My name is Elizabeth Manning, and I am a Master of Arts student in Medicine, Health, and Society at Vanderbilt University, and this study is for my Master of Arts thesis.

As a reminder, your name and any other identifying information will never be associated with anything you say in the focus group. The document matching your pseudonym to your name will be kept completely separate from all of the interview notes and recording. All of the data will be kept in encrypted files on secure servers and audio files will be deleted after 1 year. You have no obligation to stay for the entire focus group or answer any question, and you can leave at any time. Do you have any questions about the interview or about the consent form?

The purpose of this study is to understand if transgender people who identify as men or women, or binary transgender people, and transgender people who do not identify as men or women, or non-binary transgender people, tend to have different experiences with health care providers. I have already conducted interviews with you one-on-one, and the point of this focus group is for you to discuss your experiences with each other in order to compare them. I have some specific questions for you to discuss, but you are welcome to share anything that you feel is helpful. Since we will be discussing a sensitive topic, I ask that you all keep anything shared here, including the identities of the people here, confidential.

Are there any questions before we get started?

Go around the group and share names, pronouns, and gender identities.

Questions:

1. In general, how do you feel like you've been treated as a transgender person by your health care providers?
2. Do you feel that you need your health care provider to know that you are transgender?
3. Since you've known that you are transgender, have you had appointments with health care providers that stood out to you as especially good?
4. Since you've known that you are transgender, have you had appointments with health care providers that stood out to you as especially bad?