

PATIENTS AS PEOPLE: ADDRESSING THE BARRIERS TO SEXUAL
AND REPRODUCTIVE HEALTHCARE FOR TRANSGENDER
AND GENDER NONCONFORMING INDIVIDUALS

by

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DEDICATION

To the children we once were, who wondered why they were different.

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ABSTRACT

Transgender and gender nonconforming individuals face obstacles throughout their lives connected to mislabeling and limitations placed on their affirmed gender identity and expression. Prior research by gender and medical scholars focuses on the stigma and discrimination these individuals face when interacting with medical professionals. However, one area that has been overlooked by sociologists is the impact of marginalization when receiving sexual and reproductive health care. This is a vital setting because it highlights the conflation of sex and gender by medical professionals and the unique challenges faced by non-binary individuals in these particular environments. Moving the discussion forward in this area, this thesis examined the sexual and reproductive health care experiences of transgender and gender nonconforming individuals, focusing on the interactions between patients and medical staff. I conducted in-depth interviews of individuals who identify as transgender or gender nonconforming and asked about their experiences when accessing sexual and reproductive health care. The findings suggest that transgender and gender nonconforming individuals encounter obstacles that mitigate opportunities to receive adequate sexual and reproductive health care, including poorly-trained medical staff, limited financial assistance, and insufficient sexual health education. To address these issues, significant attention must be given to the limitations of labels, mutual participation in medical encounters, and a restructuring of medical education and practices for health professionals.

I. INTRODUCTION

There is a new civil rights frontier being forged as individuals challenging and reconstructing gender take center stage in contemporary America. Many transgender individuals, people whose gender identity or expression does not conform to the gender assigned to them at birth, deal with obstacles in all aspects of life, facing discrimination and isolation in the home, school, workplace, justice system, and many other communal circles. Gender nonconforming individuals, whose gender identity and expression does not conform to conventional concepts of a “male” or “female” gender, also deal with similar unequal treatment (Lucal 1999, 2008; Schilt and Westbrook 2009; Pfeffer 2012; Jenness and Fenstermaker 2014).

One area that has been overlooked by sociologists is the impacts of marginalization from the healthcare system, where transgender and gender nonconforming individuals may encounter scrutiny, discrimination, and lack of appropriate contextualized medical care (CDC 2011; Grant et al. 2011; NCTE 2012; NLHEC 2016). According to the World Health Organization (2015), “when individuals do not conform to established gender norms, relations or roles, they often face stigma, discriminatory practices or social exclusion – all of which negatively impact health.” Furthermore, discrimination within the treatment setting is not uncommon, with health care providers refusing to acknowledge or regard an individual’s identity and “severely lacking in terms of provision of culturally sensitive interventions” (Lombardi 2001: 870).

Although transgender has been used in sociology as an umbrella term for any individual who does not fit into our culturally dominant “two and only two” sex and gender system (Lucal 2008), I plan to explore the sexual and reproductive health care

experiences of both transgender¹ and gender nonconforming² individuals, expanding the discourse to include individuals who do not utilize, or identify under, the term “transgender.”

Nixon (2013) writes that access to reproductive health services is not a decision solely up to the individual. She notes that reproductive health policy concerns the entire community, in how it “reflects which people are valued in our society; who is deemed worthy to bear children and capable of making decisions for themselves. Reproductive decisions are made within a social context, including inequalities of wealth and power” (Nixon 2013: 73). By focusing particularly on sexual and reproductive healthcare, this thesis also explores the notions of reproductive health, which has historically embodied normative constructs of gender roles and identities, in relation to the expressed needs of transgender and gender nonconforming individuals who fall outside the binary.

Through the employment of qualitative face-to-face interviews with transgender and gender nonconforming individuals regarding their sexual and reproductive healthcare experiences, I explored the following research questions: What issues do transgender and gender non-binary individuals face when trying to access and receive sexual and reproductive healthcare services? How do transgender and gender non-binary individuals mitigate the impacts of normative gender perceptions and discrimination in the healthcare system? In addressing these inquiries, I hope to contribute to the lack of research on transgender and gender nonconforming sexual and reproductive healthcare needs,

¹ Transgender individuals are persons whose “gender identity, expression, or behavior is different from those typically associated with their assigned sex at birth” (NCTE 2012).

² Gender nonconforming is a term that describes the gender identity of an individual which is not exclusively male or female, the “variation in gender expression or gender role from conventional norms” (NLHEC 2016).

expanding the discourse on sexual and reproductive health policy that is culturally competent and sensitive to the needs of the most vulnerable populations in the community.

II. LITERATURE REVIEW

In studying the sexual and reproductive health care experiences of transgender and gender nonconforming individuals, a review of existing literature must explore the topic holistically. First, I will discuss the use of labels in accessing social and health services, and highlight linguistic limitations which leave out the experiences of gender nonconforming individuals who might use other, more personal, terminology. Second, I will review present statistics on transgender and gender nonconforming sexual and reproductive health risks and health care services, including STI rates, sexual health education, and discrimination in the health care system. Lastly, I will briefly discuss reproductive health care, and emerging qualitative research on the reproductive experiences of transgender individuals.

Labels and the Limitations of Language

Gender is still viewed by many as occurring on a binary, where individuals are expected to fit into two strict models (masculine and feminine) of appearance, personality, and behavior (Schilt and Westbrook 2009; Westbrook and Schilt 2014). A more inclusive view sees gender occurring on a spectrum, where individuals can identify from many categories, including masculine, feminine, transgender, or gender nonconforming, to name a few (NCTE 2012; APA 2016; NLHEC 2016). These various categories can be limiting, however, when considering the unique ways individuals affirm and express their identity (Lucal 2008; Schilt and Westbrook 2009; Westbrook and Schilt 2014).

Research by Valentine (2007) on transgender identity within the realm of “gender” studied the experiences of individuals whose self-identities do not conform to

labels present in the community. He argued that none of the respondents' personal comprehensions of self are understandable within the political categories that are available due to a "gap" (Valentine 2007: 108) between this knowledge and those categories. Valentine sought to detail the "instabilities of the category transgender when it is applied to individual lives" (Valentine 2007: 108-109) and the difficulties that arise when terms are institutionalized.

The term "transgender" has been quickly adopted and promoted within the United States and across the world, used widely by individuals among various groups (e.g. the LGBTQ communities, activists, academic researchers, feminists, public health practitioners, among others). In his research, Valentine found that many persons who were labeled by outsiders as "transgender" in fact do not recognize the expression or even reject it, providing their own labels to describe their identities/expressions. He argued that the rapid adoption of an identity classification often leaves out the experiences of gender nonconforming individuals who might use other, more personal, terminology. He also reported that this issue predominantly affects persons of color, or those who are poverty-stricken.

In order for "public health-oriented social service outreach" (Valentine 2007: 134) and other related agencies to provide assistance to those whom they wish to help, Valentine argued that they must utilize the terminology and descriptions of those they seek to serve. Furthermore, he noted that limiting terminology does not allow individuals to use their own terms, in some cases forcing them to have to adopt new ways of expressing their identity if their own labels are not being recognized or validated.

Sexual and Reproductive Health Risks

Transgender and gender nonconforming individuals often face inimitable and complicated barriers when attempting to access healthcare free from prejudice and stigma. Utilizing healthcare services can include the disclosure of an individual's transgender identity to providers (Eyssel et al. 2017), potentially putting an individual at risk for harassment. Also, research has shown that some transgender individuals, due to insufficient financial or medical resources, will self-administer hormones “in an effort to attain the physical characteristics of the desired gender” (Luvuno et al. 2017: 8704); this increases the risk of exposure to disease and dangerous health complications like hyperlipidaemia or thrombosis (Luvuno et al. 2017).

The National Center for Transgender Equality (NCTE) reported on the various sexual and reproductive health issues some transgender individuals face in their lifetime, including higher risks for HIV and other STIs, unintended pregnancies, access to providers with “relevant health information” (NCTE 2012), and marginalization and abuse within the community from family, partners and colleagues which can encourage reluctance in seeking necessary health care (Grant et al. 2011; NCTE 2012; Reisner et al. 2010). These risks increase for racial-ethnic minorities, including African Americans and Latinos, and two-spirit³ individuals in Native American communities.

Transgender individuals also engage in higher rates of unprotected vaginal, anal, and oral intercourse (Nemoto et al. 2004; Sevelius 2009; Reisner et al. 2010; UNDP

³ “Two-spirit’ is a distinctly Native American category that includes individuals who are sexual minority as well as individuals who are gender-variant” (Hwahng and Nuttbrock 2014: 694). A contemporary term, many individuals in indigenous communities employ this designation to convey a gender identity or expression that falls outside of the binary categories of man and woman, and that is also “more aligned with their traditional indigenous understanding of non-female, non-male gender” (Elm et al. 2016: 353).

2010; Luvuno et al. 2017). In fact, according to the Center for Disease Control (CDC), HIV prevalence in transgender individuals is at four times the national level (CDC 2011). HIV infection rates are particularly high for transgender women, with a recent study noting that transgender women “have almost 50 times the odds of HIV infection” (Van Griensven et al. 2012: 185) compared to the general population, the high infection rates being driven by trouble accessing critical sexual and reproductive health care services due to “stigma and discrimination” (Van Griensven et al. 2012: 185). Another study by the United Nations Development Programme (UNDP) – India (2010) noted that low levels of consistent condom use, combined with barriers to social and health-related services, contributed to higher HIV rates among transgender individuals. Economic instability stemming from discrimination is also a vulnerability that can be exploited by the sex industry and human traffickers (Luvuno et al. 2017; NHTH 2018). Nemoto et al. (2004) stated that transgender women are more likely to engage in high-risk sex work, oftentimes having little power to negotiate safe sex with their partners. Increased engagement in HIV-related risk behaviors also stems from the psychological impacts of discrimination and stigma (Nemoto et al. 2004), where transgender individuals, particularly transgender women of color, are more likely to be living with depression, anxiety, and poor self-esteem (Nemoto et al. 2004; Hwahng and Nuttbrock 2014).

Transgender and gender nonconforming youth are also at higher risk for assault and sexual abuse (Herbst et al. 2008; Grant et al. 2011; Hwahng and Nuttbrock 2014; AMSA 2016), further increasing the possibilities of pregnancy and STD/STI infection. In fact, Grant et al. (2011) showed that abuse suffered by transgender individuals can start as young as the grade school years, with 12% of transgender youth reporting that they

were sexually assaulted by peers or school staff between the K-12 years. Transgender youth are a particularly vulnerable group, often facing issues such as “shame, fear, and internalized transphobia” (UNDP 2010: 4), and limitations or restrictions on individual expression. Hwahng and Nuttbrock (2014) also noted that transgender adolescents are at a higher risk for abuse by their parents and other family members due to their gender identity and expression. A lack of cultural competence by medical providers, policy makers, and family violence programs can also create barriers for transgender individuals seeking crisis intervention and assistance (Seelman 2015).

Accessing Culturally Competent Sexual and Reproductive Healthcare Services

Sexual health education provided in public schools and sexual health information found at many clinics and hospitals seldom address the bodies and individualities of transgender and gender nonconforming individuals (Grant et al. 2011; NCTE 2012; NLHEC 2016), leaving a percentage of the population without access to critical knowledge regarding their sexual and reproductive health needs. When one seeks this information, healthcare providers are unfortunately not always equipped with the knowledge to address these particular health essentials (Luvuno et al. 2017). Many transgender individuals have actually shared that when it came to addressing their personal healthcare concerns, they had to educate their healthcare providers on the appropriate provisions of care they required (Grant et al. 2011; NCTE 2012). In particular, transgender men’s sexual and reproductive health has been “understudied” (CDC 2011), and less information is available on HIV risk and sexual and reproductive health care needs for transmen than transwomen (Reisner et al. 2010).

A study by Light et al. (2014) provided qualitative insight into some of the pregnancy experiences of transgender males, highlighting issues like access to adequate healthcare, dealing with harassment and prejudice in the community, as well as how some transmales conceptualize and ascribe meaning to their pregnancies in light of their male gender identity. Some of these men stated that their healthcare providers treated them differently, often having a hard time using appropriate gender-related language (Light et al. 2014) and getting treated as “normal human beings with normal bodies” (Light et al. 2014: 5).

At times the increased health risks impacting vulnerable populations are made worse when compounded with mitigated access to adequate healthcare. Rebchook and colleagues (2017) also report that “young transgender women of color may be particularly vulnerable to HIV infection” (Rebchook et al. 2017: 225), with evidence of treatment disparities increasing in the transgender population, particularly transgender women of color living with HIV/AIDS. Furthermore, transgender youth of color “frequently face significant discrimination and prejudice in the form of transprejudice and racism” (Singh 2013: 690), further compounding societal barriers. Because of this, transgender youth, particularly young transgender women of color, are at higher risk for unemployment or under-employment and living below the poverty line (Nemoto et al. 2004), making it harder for them to access and afford quality health services.

While healthcare standards call for regular screenings of certain parts of the body, including the breast and pelvic region, some transgender and gender nonconforming individuals do not get consistent checkups on areas like the breasts and pelvic region, including pap smears and prostate exams. There are many reasons for the lack of

consistent screenings, including discomfort with self-examinations or examinations by a medical professional, lack of familiarity with the increased risk of certain types of cancer when undergoing hormone therapy, and the fear of discrimination by a healthcare provider. It is shown that around 19% to 27% of transgender individuals report that they were refused care by health care providers because of their gender identity (Grant et al. 2011; NCTE 2012). In fact, Grant et al. (2011) noted in the *National Transgender Discrimination Survey* that “if medical providers were aware of the patient’s transgender status” (Grant et al. 2011: 72), the probability of the patient experiencing discrimination *increased* by 8%.

Lack of health insurance and other economic-related issues also contribute to negative health outcomes for transgender and gender nonconforming individuals (CDC 2011; Grant et al. 2011; AMSA 2016). Compared to the roughly 60% of the general population which has employer-based health insurance coverage, only 51% of transgender individuals were covered (Grant et al. 2011). This gap is wider for transgender people of color. Also, while current health care law in the United States prohibits discrimination in insurance plans on the basis of an individual’s sex “in certain health programs and activities” (Healthcare 2016), some plans still exclude certain treatments for transgender-related health issues (Grant et al. 2011; AMSA 2016). When a transgender or gender nonconforming individual is pregnant, these reported issues not only effect the parent-to-be, but also risk harm to the child they carry.

Many researchers note that expanding current health care resources to include more inclusive sexual and reproductive health and wellness education for doctors and other medical staff can lead to many positive outcomes for transgender and gender

nonconforming individuals (Grant et al. 2011; Reisner et al. 2010, 2015; AMSA 2016). The incorporation of sexual and reproductive health information and education that is tailored to the needs of transgender and gender nonconforming individuals can assist with “addressing mood and psychological wellbeing” (Reisner et al. 2010), as well as provide support in current HIV and STI prevention programs. Programs emphasizing contextualized health care that is accommodating and adaptable for each individual can encourage receptiveness and promote understanding and empathy between the care provider and patient (Charon 2001; Carson et al. 2003).

Research Gap

How and where an individual can access and receive medical service is not only affected by their own norms, values, and behaviors, but is also dependent on the characteristics and settings of their external social environment. Sexual and reproductive healthcare concerns critical and long-lasting health needs that can permanently impact an individual’s life. How open, comfortable, and *safe* an individual feels they are when attempting to access health-related services speaks to the community that provides them. In this study, I continue the ongoing research on the sexual and reproductive healthcare needs of transgender and gender nonconforming individuals, but with a keen focus on several factors that still require further study in the sociological field.

Although healthcare experiences of transgender individuals have been explored by some health care practitioners and public health researchers, there is little sociological research on the topic that focuses on sexual and reproductive health. In my research, I concentrate specifically on the use of labels in identifying an individual’s gender identity and expression, and whether or not the limitations of language create hurdles in the

access to sexual and reproductive health information, education, and services. Second, in understanding the challenge of finding a doctor or other health care practitioners who recognize and validate the unique healthcare needs of transgender and gender nonconforming individuals, one can comprehend the hurdles transgender and gender nonconforming individuals face when looking for and receiving sexual and reproductive health care services. In this light, I draw attention to the issues surrounding access and affordability in the healthcare system. Third, I focus on the role familial and social support groups play in providing patient support, education, and resource referrals. Lastly, I focus on what improvements my respondents note would assist in making services more accessible, culturally competent, and validating, and the advice they wish to share with other transgender and gender non-conforming individuals who encounter difficulties in finding contextual and affirming health care services.

III. THEORETICAL FRAMEWORKS

Lucal's Gender Displays

First, feminist scholars in sociology have argued that sex (male or female) and gender (culturally defined masculinity and femininity) are social constructs. Further, they maintain that most cultures have rigid notions about who can be male or female, masculine or feminine. Lucal's (1999) autoethnographic work offers insightful context for individuals whose gender identity, expression and/or behavior doesn't conform to the expected behaviors of a person with the stature or body shape that they possess. A woman who has an appearance that is more socially masculine than feminine, with baggy clothes, short hair, and above-average height, Lucal is consistently mistaken for a man when she is out in the community. She describes various situations where her perceived male gender has caused her to be treated quite differently than if the stranger she interacted with knew she was a woman. This assumption by others has led to some awkward, and dangerous, encounters, from uncomfortable stares in public restrooms and going to great lengths to prove her identity, to angry confrontations in the streets by other men. Lucal has even at times gone out of her way to assert a female public display, painting her nails, growing her hair out, or even adjusting her clothing so that her breasts would be "more obvious" (Lucal 1999: 789).

From the day an individual is born they must navigate a "two-and-only-two" (Lucal 1999: 781; 2008) gender system which leaves little to no room for diverse gender expressions. "An individual's gender cues our interactions with her or him" (Lucal 1999: 782), and people are accustomed to being able to identify an individual as male or female when they appear in front of them. When someone can interpret another's gender

displays, they can assign gender specific pronouns and adjust their behaviors to correspond with the perceived gender of the person with whom they are interacting. If one tries to correct that individual, the risk can be far more hazardous than simply embarrassing that person in pointing out their mistake.

Given the pervasiveness of gender in the community, Lucal notes that it is impossible to avoid participating in it (though she can still choose to not partake in feminine expressions or behaviors). However, absent of the “decorations of femininity” (Lucal 1999: 791), Lucal will have trouble being perceived as a woman, and have to continue to endure the stares, the mistreatment, *and* be patiently attentive to the gender that she displays as much as the gender that she is. The stigma she carries as a result of society’s perceptions means that she, the one responsible for her outward expression and behavior, “will pay the price” for not appropriating indicating to people in the community that she is a woman. Furthermore, while Lucal shares that she would like to see the normative constructs of gender eradicated, she does not want to wholly discard gender. She is a woman, and would like to be perceived as one, meaning that the illustration of who a woman is needs to be expanded to include her display, and others who color outside the lines. Influenced by Lucal’s theory of *gender displays*, I will place a heavy focus upon the identification strategies of transgender and gender nonconforming individuals, highlighting instances in which they are shaped in their experiences with sexual and reproductive healthcare.

Symbolic Interactionism

Sociologist Herbert Blumer wrote that “humans act toward things on the basis of the meanings they ascribe to those things” (Blumer 1969: 5). Considered one of the

classic symbolic interactionist approaches in sociology, Blumer (1969) noted that individuals act towards each other and their surroundings based on the particular meanings and understandings they have ascribed to them. In context of transgender and gender nonconforming individuals seeking medical services, when one views this epistemological attitude through a medical sociological lens, one can see how personal reflections and interpretations of health and wellness can directly affect an individual's – and their physician's – view of their physiological condition.

Studies on the social construction of diagnosis and illness have origins in symbolic interactionism, and note the influence that gender, race, class, sexuality, culture – among other endogenous and ascribed characteristics – have on individual's negotiating their social environments, and the subsequent effects on the meaning, diagnosis, and treatment of illness. Focusing on the sociology of diagnosis, Brown observed how diagnosis is “central” (Brown 1995: 39) to a physician's occupation and can become a “tool for social control” (Brown 1995: 39) at the institutional level.

Observing the social construction of health in a symbolic interactionist fashion allows one to see how personal reflections and interpretations of health and wellbeing can directly affect an individual's view of their physiological condition. These effects also go beyond the surface of the affected, to be given their own interpretations and meaning by treating physicians, medical staff and researchers, and society-at-large. These epistemological narratives are valuable in how they present to sociologists the various ways individuals navigate day-to-day health and wellbeing, chronic illnesses, and medical distress. The experiences impose new meaning on one's sense of self and their place in the community, influencing and altering their interactions with others.

Describing health and wellness through a symbolic interactionist lens, various researchers have detailed nuanced approaches to understanding social relationships in context of individual health and wellbeing. Charmaz writes that “serious chronic illness undermines the unity between body and self and forces identity changes” (Charmaz 1995: 657). When an individual’s body experiences the changes that come with illness, whether it is long or short-term bouts of pain, fatigue, and/or impairment, these physiological effects can also take a psychological toll. Various ailments can challenge and weaken a person’s “valued image of their [body]” (Charmaz 1995: 657) and, should this be a long-term medical situation – one most likely will have to figure out a comfortable approach at daily management of not only the illness, but their sense of self. Charmaz writes that some “ignore and minimize” (Charmaz 1995: 658) the ailment, while others choose to adapt to their compromised form, “resolving the tension between body and self... [and] defining integration and wholeness of being while experience loss and suffering” (Charmaz 1995: 658). Such an approach presents to an individual the opportunity to value their body in new ways and develop a newer, deeper identity within this “unity between body and self in illness” (Charmaz 1995: 674).

Brown (1995) observes how “diagnosis represents the time and location where medical professionals and other parties determine the existence and legitimacy of a condition” (Brown 1995: 38). After confronting and sorting through a myriad of “complaints and symptoms which may be unclear, unconnected, and mysterious” (Brown 1995: 39), the medical professional can recognize and evaluate the indicators of a condition and –optimistically – arrive at a verdict. The use of diagnosis can also be abused at the institutional level, like the historical classification of homosexuality as a “mental illness”

(Brown 1995: 39). Labeling a condition allows for access to necessary provisions, and how an illness is regarded by physicians and other medical professionals can impact an individual's rights to worker's compensation, welfare, and critical medical assistance (Brown 1995).

Lastly, Conrad and Barker (2010) approach social constructivism in medicine in three central themes: the cultural significance of illness, the social construction of illness experiences, and the social construction of medical knowledge (Conrad and Barker, 2010). Taking a deeper look at culture and illness, the authors point out that illness can take on "metaphorical connotations" (Conrad and Barker 2010: 69), being compared to evilness or sin. They can also become stigmatized, as in the cases of individuals enduring leprosy, HIV/AIDS, epilepsy, and mental illness. Conrad and Barker note that "there is nothing inherent about a condition that makes it stigmatizing" (Conrad and Barker 2010: 69). What makes these experiences stigmatizing are the reactions from the surrounding community to the illness, its symptoms, side effects and sometimes permanent effects.

Queer Theory

Queer theory has been utilized only somewhat recently in sociological research, providing critical challenges to the idea of normative genders and sexualities (Warner 1991; Epstein 1994; Gamson and Moon 2004). Emerging out of gay/lesbian and women's studies in the late 1980s – early 1990s, queer theory presses "scholars to think of social categories more critically, and to be mindful of the ways in which such categories may obfuscate the very subjects they are intended to name" (Green 2007: 30). Socially-constructed categories of "sexuality and the meanings people impute to it" (Gamson and Moon 2004: 52) influence relationships of power with various institutions, "enforce[ing]

sexual boundaries and divisions” (Gamson and Moon 2007: 52). Sexuality is also often viewed as odd or unfamiliar, exiled to the “realm of the extraordinary” (Epstein 1994: 190) where it can be disconnected from everyday life. Queer theory gives a platform to “deviant” cases of identity, gender, and sexual behavior (Valocchi 2005), highlighting “how the dominant taxonomies fail to capture the complexity of individual gender and sexual subjectivities and practices even among those who may define themselves in terms of those dominant taxonomies” (Valocchi 2005: 752).

Within sociological research, queer theory is useful in pointing out the influence that heteronormative binaries (like male/female and masculine/feminine) have “as the starting assumptions on which our research is based and the major lens through which we interpret our data” (Valocchi 2005: 751) and works to challenge these deeply-rooted categories. The influence of queer theory on studies in religion, media, politics, medicine, or the family shows how queer theorists are working to deconstruct inherent biases in how gender and sexuality are institutionally framed and regulated, with the concept of “ordinary” human behavior broadening to include the multiplicity of identities and experiences found within the community and across the world (Plummer 2003; Gamson and Moon 2004).

IV. METHODS

For this study, I used qualitative research methods to examine the experiences of transgender and gender nonconforming individuals in seeking and receiving sexual and reproductive healthcare services. I conducted in-depth interviews with transgender and gender nonconforming individuals throughout the state of Texas. I began collecting data in June 2016 and completed the interviews in April 2017. In-depth interviews are an ideal method for studying this topic because they provide respondents with an open platform to share their experiences, with less restrictions than are sometimes found in surveys (Hesse-Biber and Leavy 2011). Researchers who use in-depth interviews note their utility in obtaining similar information across respondents, while at the same time providing freedom for probing about the specific experiences of each respondent (for example, Ecklund and Scheitle 2018).

Interview Protocol

Each interview involved open-ended and probing inquiries, following an interview guide which was informed by the findings of prior research into transgender and gender nonconforming sexual and reproductive healthcare services, and the theoretical framework of Lucal's *gender displays*, symbolic interactionism, and queer theory.

The semi-structured interview guide was organized into three main sections (see Appendix A). First, respondents were asked basic demographic information (age, racial/ethnic identity, sexual orientation, current marital status, city of residence, number of years in city, highest level of education, current employment status, current household income, and number of children). Second, I asked respondents about their sexual and

reproductive healthcare experiences. In this section, respondents were asked about their most important sexual and reproductive healthcare needs, and their experience in finding these services. I also inquired about their opinion of these services, barriers to treatment, and questions related to healthcare access and affordability. The third section asked questions regarding the respondent's pregnancy and parenting experiences. However, I was only able to interview one respondent for this section, as the other eight respondents either have stepchildren or no children.

All interviews were conducted in English and digitally recorded. Interviews were conducted face-to-face in private work offices, coffee shops, libraries, and parks, environments that provided respondents opportunities to share personal information in a comfortable setting. It is also important to note that though I identify as queer, I am a cis-gendered⁴ woman and therefore had "outsider interviewer status." With this in mind, I shaped my analysis around the voice of my respondents, allowing for their stories to stand on their own. Interviews lasted between 20 minutes and one hour, with the average interview taking 40 minutes.

Data Analysis

I transcribed each interview verbatim. Once transcribed, I read through each transcript while listening to the recording to verify accuracy. During the coding phase, I read through each transcript multiple times. Coding entails reading through the interview data multiple times in order to extract common themes the researcher uses to address their research questions (Hesse-Biber and Leavy 2011). I noted consistent themes across all respondents, used in the forthcoming analysis. Demographic variables (age,

⁴ Cisgender is a term used to describe an individual whose gender identity corresponds with the sex they were assigned at birth (Schilt and Westbrook 2009; Pfeffer 2012).

racial/ethnic identity, sexual orientation, current marital status, highest level of education, current employment status, current household income, and number of children) were coded on a simple table graph for comparison. From the data I created the coding categories *Identity, Expression, and Labels, Healthcare Obstacles and Medical Interactions, Support Systems, and Solutions in Their Own Voice*.

Recruitment

I enlisted participants through correspondence with transgender adult support groups and networks in Texas. As with most qualitative interview studies, the sample was a nonprobability, purposive sample, with inclusion criteria as follows: minimum 18 years of age, and identifying as a transgender individual, or an individual whose self-identity does not conform to conventional concepts of a “male” or “female” gender, but may not employ the transgender label. Respondents were located across the state of Texas, and I traveled to their locations to conduct the interviews.

To preserve the confidentiality of all the participants, I excluded all identifiable information from the transcript of each interview. Each respondent was given a pseudonym.

Participants

I interviewed a total of nine individuals (see Table 1 on page 23). The average age of respondents was 33 years, and all were enrolled in or had completed some form of post-secondary education. Four of the respondents were married, four of the respondents were single, and one respondent was divorced. Eight of the nine respondents were employed at least part-time, and the average annual household income was \$43,800⁵.

⁵ Of the nine respondents, seven reported annual incomes, one reported that they work part-time (but shared that they did not receive an income), and one reported that they were unemployed.

Seven respondents identified as white, two identified as biracial, and one identified as black. The sexual orientation of the respondents varied, with three respondents identifying as lesbian, two identifying as pansexual, two identifying as queer, one identifying as asexual, and one reporting that they were unsure of what label to use when identifying their sexual orientation.

Table 1. Selected Characteristics of the Study Sample

Respondent	Age	Race/Ethnicity	Sexual Orientation	Marital Status	Educational Attainment	Employment Status	Household Income	Number of Children
Jordan	39	White	Pansexual	Married	PhD	Full-Time	\$50,000	0
Gabe	22	White	Queer	Single	In college	Part-Time	\$0	0
Reese	34	White	Pansexual	Married	In college	Full-Time	\$120,000	0
Val	28	White	Lesbian	Married	In college	Full-Time	\$78,000	0
Rafael	23	Black	Unsure	Single	Some college	Unemployed	\$0	0
Ray	46	White/Mexican	Queer	Single	Some college	Full-Time	\$54,000	0
Sage	23	White/Cuban	Asexual	Single	In college	Part-Time	\$14,400	0
Rose	50	White	Lesbian	Married	In college	Full-Time	\$65,000	2
Paula	30	White	Lesbian	Divorced	Vocational	Full-Time	\$13,000	0

V. FINDINGS

Identity, Expression, and Labels

The findings from this research reference the obstacles that transgender and gender nonconforming individuals encounter during interactions in accessing and receiving sexual and reproductive healthcare. One of the larger subthemes that appeared in this research was how confusion or misunderstandings over the labels used to identify respondents became points of frustration between respondents and medical professionals.

Lucal (1999) addresses how a “two-and-only-two” gender system leaves little room for diverse gender expressions. A more inclusive view of gender expands it from its normative binary to a multidimensional spectrum, where individuals can identify from many categories, including masculine, feminine, transgender, or gender nonconforming, to name a few (NCTE 2012; APA 2016; NLHEC 2016). When discussing how individuals describe and express their gender identity, some respondents noted how the use of labels can provide helpful categories which one could utilize in their affirmation. While labels which have been adopted by a group within society often come equipped with well-defined boundaries, most respondents echoed Valentine’s (2007) research on the limitations of certain labels, voicing a shared preference for terminology that allows for a more personal connection between the individual and the characterization of their affirmed gender identity.

Jordan, for example, spoke about the usefulness of emerging terminology which can go beyond some of the more distinct labels, noting that “it’s important to have those broader terms because those of us who have transitioned in some way don’t fit in one nice little box.” Some individuals might prefer to use less familiar labels. Terms like

gender non-binary, gender nonconforming, gender diverse, gender queer, and gender fluid can allow individuals more opportunities for unique expression of their identity. Jordan continued: “we are fluid, we are expansive, we are creative with gender identity.” Similarly, Gabe also shared how “pre-set” labels might not embody all the characteristics that make up an individual, limiting one’s expression: “I believe every gender identity is different, and so I felt like I wasn’t being full encompassed and represented within labels that are already pre-set. And so, finding one that was a little bit different and off to the side, it fit better with who I am.”

Respondents noted the significance of modern terminology for individuals identifying their gender outside of the normative binary, and its evolution from terms like “cross-dresser,” “transsexual,” or “transvestite,” which some said were upsetting labels that limited one’s expression of their identity. When asked if certain concepts like gender nonconforming, gender queer, or gender fluid were too broad or too limiting, respondents highlighted the inclusivity of these terms. Rafael shared:

I think it’s broad, but I think it’s a good type of broad. Just because it covers all the genders. I think it’s good to have these statements and these labels, if you will, to kind of cover everybody that doesn’t feel like they have a space. They have a space somewhere.

Paula notes similar features of these terms, emphasizing their ability to be both recognizable and adaptable to an individual’s identity: “I actually really appreciate the language right now... having concepts like binary, non-binary, trans woman, trans feminine, trans masculine, trans male, all those things I felt were a much clearer road map and also offered more flexibility.”

Most respondents used more than one term to describe their affirmed identity, offering reasons for why they identify across multiple categories. One explanation is how respondents might adapt their preferred terminology for ease in explanation, with one respondent noting “if the person you’re talking to – or people – don’t understand the idea, then you have to modify the symbol – or language – so that you can get your point across... at the end of the day I’m not attached to any labels.” Another respondent shared:

I think that all those terms can be used as umbrella terms for the whole community, but they’re also a signifying term of just my one identity. So instead of having to explain my whole true identity of being non-binary trans-masculine, I can just say I’m trans. I’m non-binary. And so it identifies me within a community. (Gabe)

Respondents also noted when certain terms no longer work for them, as Ray stated: “I’ve always used transgender man. I guess I use F-to-M. I don’t like that as much anymore. Designated female at birth on occasion, but that’s such a mouthful, so I just prefer queer trans man.” There are also times when self-disclosure of identity can be dangerous, with respondents limiting the terms they use in environments which might present a safety risk. As one respondent reported: “Sometimes I feel non-binary, sometimes I feel trans. Sometimes just for the sake of my safety I have to say I’m female.” Another respondent shared: “I... use kind of differing language so that [loved ones] aren’t quite as anxious for you, as far as people you love being worried for your safety.”

Respondents also expressed preferred terms outside of the more popular non-binary categories, favoring labels like “bi-gender,” “dyke,” or “gender neutral.” Reese said: “I like the word, the term, bi-gender because it’s a mixture of both rather than

saying one or the other or neither. I represent as a mixture of both.” Some respondents shared why transgender or gender nonconforming might not be the right label for some individuals. Ray conveyed how the term transgender can be viewed in different ways and some individuals prefer not to use it. He also pointed out how the term “nonconforming” can sound to some like a negative description of one’s identity. Ray stated: “Gender nonconforming almost sounds bad. Like, ‘oh, you don’t conform’ like that’s a bad thing. So, some people use gender creative, gender expressive, gender fluid.” Another respondent, Sage, expressed their frustration at others who tried to impose labels on them that they do not identify under, stating: “It’s a very personal experience... they’re automatically like ‘no, that’s not you.’ It’s like ‘ah, I think I know.’”

Other respondents also shared the significance of highlighting their transgender identity, or simply preferring a trans or transgender label. Rose shared: “I’m very comfortable with the identification as transgender.” When asked why the use of specific terms was important, Jordan shared how using the word “trans” highlights his unique experience as a man. He explained:

It’s important for terms to open us up to more opportunities. Which is part of the reason that, even though I do sometimes say I’m a man, I much more prefer to say I’m a trans man, to get the idea across to that there is something more to my experience of being a man than just what a cis-gender man would go through.

Regarding the use of labels to convey identity and expression, respondents spoke to the need for having terminology that highlighted their unique identity but could also be understood in the broader community. These themes recall the work of Valentine (2007),

where existing labels might be too limiting when applied to non-binary individuals. Furthermore, the normative “two-and-only-two” (Lucal 1999) gender system does not allow for a more inclusive view of gender, as respondents shared that their identities spanned across many categories, including masculine, feminine, transgender, gender nonconforming, bi-gender, and gender fluid.

Healthcare Obstacles and Medical Interactions

A second subtheme that appeared in the process of interviewing respondents referred to treatment, or lack thereof, conducive to meeting the respondents’ healthcare needs. Respondents spoke to obstacles that were both non-material (i.e. difficult conversations) and material (i.e. lack of health insurance). Five common ways these obstacles manifested are in negative interactions with medical staff, having to constantly “out” oneself, access and affordability, finding culturally competent care, and reliance on medical allies to meet their healthcare needs.

Research (NCTE 2012; NLHEC 2016; Eyssel et al. 2017) on transgender and gender nonconforming individuals seeking medical treatment highlights the complicated barriers they might face when attempting to access healthcare free from prejudice and stigma. It can be difficult to locate providers who are culturally competent and medically adept at providing holistic care for transgender and gender nonconforming individuals (Luvuno 2017), with many transgender and gender nonconforming patients reporting that they had to educate their healthcare providers on the care they needed (Grant et al. 2011; NCTE 2012). Seeking health services can also entail unwanted disclosure of one’s affirmed gender identity to physicians (Eyssel et al. 2017), medical staff forgetting or

refusing to use appropriate gender-related language (Light et al. 2014), and being given erroneous or incomplete care.

Negative Interactions with Medical Staff

Respondents highlighted a variety of interactions between themselves and medical staff throughout their lifetimes, disclosing treatment narratives that ranged from “affirming” to “uncomfortable” to “unsafe.” In one medical setting, Ray noted that he had trouble feeling like his needs were going to be met, stating: “I didn’t feel safe there. I didn’t think I was in danger, I just don’t – I didn’t feel like they were taking me seriously.”

When answering questions about his sexual and reproductive health care experiences, Jordan started by sharing his journey to affirming his transgender male identity, and his interactions with medical providers during that time. He pointed out how growing up the way he performed his gender was as a tomboy, until puberty, when “everybody wanted me to start conforming to feminine standards and feminine stereotypes and feminine expectations, and I got real depressed.” Worried, Jordan’s parents took him to a doctor, who put him on testosterone blockers. “Let’s make her more girl if she’s not feeling girl enough,” Jordan said, “when I kept saying I wanted to feel more boy.” He noted that while he knew at the time that he was transgender, there really wasn’t the language for that kind of feeling or identity when he was a teenager:

Knowing anything about transitioning wasn’t a realm of experience that any of us had. Knowing that they were people in San Francisco who were “transsexual” would have been the word at that time... we knew about

drag kings and drag queens, we had seen *Rocky Horror Picture Show*, but that was fiction, that was fantasy, that was play, that was performance.

It wasn't until later in life that Jordan found he "finally had a word for what I'd been feeling my whole life, and [I] started telling people 'I'm transgender. I'm a man. I know you always thought of me as a woman, but I'm actually a man.'"

Another respondent referenced the difficulties in getting doctors and other medical staff to use their preferred name and gender pronouns. Gabe shared a "horrible" experience at the hospital where he had gone to seek emergency care for a reproductive health-related issue:

Going in I had to give my legal name, that is still my birth name, and so my sex on all my identifiers is still female. And so right off the bat the wrong pronouns were being used, wrong name was being used. A lot of the wrong assumptions were being given. And I had expressed to them "I'm transgender, call me [Gabe], use he/him pronouns," because I was going in for a procedure that I was already uncomfortable with, and so I needed my comfort level to be matched a little bit. By using the right name and pronouns, it would make me feel better about the fact that I was having to be examined in my genital area.

Gabe noted that some of the nursing staff began to acknowledge his identity, but that "they would go up to each other and whisper the word 'transgender' as if it was a dirty word or negative or something." Furthermore, Gabe shared that the physician in charge of his care was "rude" and "just like 'so, you're a girl who's trying to be a man.'" He reported that his discomfort level was "extremely high" and the experience was

distressing. “When I was laying down,” Gabe said, “my legs were up, I was wide open. I felt very exposed... it was almost like my secret was exposed for everybody... I felt unsafe.”

One respondent shared their own reproductive health-related story regarding the treatment of a yeast infection. Sage reported having a “traumatic” experience when a doctor used a vaginal speculum to perform a pap smear, the medical instrument causing them an extreme amount of pain. They said they had informed the doctor prior to the examination that they were not sexually active and did not masturbate, and said the doctor told them “you know, there shouldn’t be very much pain” when using the device. Sage noted that she wished the doctor would do more to understand gender identity and sexual identity. As an individual who identifies as asexual, Sage said that “anything sexual, it feels very invasive, traumatic, which does not go well with my lifelong depression, anxiety, suicidal episodes, because if I feel like my body is being invaded, that makes me feel dirty.” Sage also observed that when they visited another doctor and shared their experience regarding the use of the speculum and the resulting pain, that second doctor informed them that a speculum should have never been used to check for a yeast infection, instead noting that a simple, less-invasive test could have been performed.

“Out” in the Medical Office

When seeking medical services, contents and environments that cisgender individuals may take for granted become sites of contestation for those who identify outside binary gender norms, including waiting rooms, public restrooms, and patient intake forms. Respondents shared their difficulties when interacting with other

components of their medical experiences, reflecting on moments where they felt uncomfortable or unsafe, or had trouble expressing their identity on medical documents. Gabe spoke to an issue he had using public restrooms, preferring a gender neutral single-stall option. “Not that I feel at risk,” he said, “but it’s more like a personal discomfort... I don’t want to have to be hyper aware of going into a bathroom at a health center and people doing something, saying something.” Val echoed these feelings, sharing that due to the political climate in Texas and the anti-trans legislation attempting to regulate which bathrooms individuals can access, they feel scared: “I’m always afraid that someone is going to see me going into a bathroom and try to stop me because they don’t think I belong in that bathroom. I’m kinda always afraid of some dude grabbing me on the shoulder and being like ‘what the hell do you think you’re doing?!’” Val stated that they get looks when they enter a public restroom and people have told them “this is the women’s restroom,” as if they had walked into the wrong place.

Other respondents noted how their medical experiences were not only informed by their interactions with doctors, but also other patients in the waiting room. Reese shared how some strangers would react to his appearance: “Yeah, I mean definitely have had looks, had comments.” After he had begun using hormone therapy during his transition, Jordan pointed out how the physical changes in his body’s appearance led to feelings of discomfort in certain medical environments which have traditionally focused on women’s health:

The more male I became in appearance, the more awkward it became to go to the gynecologist... even though that was someone who knew me very well and supported my transition, it was uncomfortable to sit in the

waiting room of the gynecologist office once I had grown a beard. Once my hairline had started to recede. Once I had changed my name. Things like that.

Another respondent shared a similar experience at a gynecological office, noting the looks and questions they endured from other patients in the waiting room. Rafael observed how other patients, mostly older individuals, would say “what are you doing here?” or “I think you’re in the wrong place.” Rose also shared an uncomfortable interaction in the lobby outside her doctor’s office, when a male nurse, who Rose said had already been told by the receptionist that she was a transgender woman and had a preferred name, entered the waiting room and “loudly shouted my legal name... and then was very confused when I walked up there and didn’t look at all like he expected.” Rose also reflected on another experience at a different facility when the receptionist there was loudly discussing her gender transition, her name change, and other personal information in front of other patients in the waiting room: “Luckily I’m relatively comfortable with that status... I think that people need to understand, what our medical professionals and everyone needs to understand, what the consequences of outing someone who is transgender are or could potentially be.”

Patient intake forms were also an obstacle that respondents talked about, where they reported problems notating their preferred name, pronouns, gender identity, and other related information on the new patient documents completed prior to meeting with their doctor. Rafael stated:

Since I came about a new gender identity, it’s been hard for me to decide which gender marker I need to put on there. It’s important that they know,

not only to address you properly, but to know what your needs are. Like if you're born with a vagina or born with a penis, they need to know what needs to be done. So I have a little bit of difficulty in dealing with that.

Rose noted that the intake forms lacked the appropriate boxes she needed to accurately log her personal information: "I can't check or fill in gender identity and there's no room for preferred name." Other respondents disclosed that despite the limitations of the forms, they find a way to note their information. Ray shared his feelings: "I screw all over them. I don't like them, but I don't have a problem filling them out. I will write trans man." To ease the process, some respondents feel like they have to write down information that does not affirm their identity. Val reported their discomfort at writing "female" on forms, given their affirmed identity as a gender nonconforming individual, noting that it "just doesn't sit right with me... it doesn't feel right." Respondents also observed that many medical offices have begun using patient database systems installed by outside companies, and medical staff are not able to add or change categories on patient intake forms to make them more inclusive. "[The medical staff] says 'well, we can't fix the forms because it's part of the system that we bought, and the system doesn't have an option for that.'" (Jordan).

Access and Affordability

Lack of health insurance and other economic-related issues are also a barrier to receiving health care services (CDC 2011; Grant et al. 2011; AMSA 2016). Respondents noted the prohibitive cost of health care services related to their transition, stating that while some procedures might be covered by insurance, others are "considered cosmetic" and have to be paid out of pocket. Gabe reflected on some of the costs related to his

transition, noting that while he is currently getting health services like pap smears and other related “women’s health” care covered by his insurance, he is worried he will have to start paying out of pocket once he legally changes his gender marker to male: “I’ll have to start paying out of pocket for certain things, which is more than my family and I myself are capable of affording.” Other respondents also voiced their disappointment in trying to negotiate coverage for certain procedures, feeling like their health care needs are lost in a bureaucratic limbo: “There was this whole back and forth between me, the insurance provider, and the doctor, trying to, you know, get everything worked out, which definitely left a sour taste in my mouth... I definitely didn’t feel cared for” (Reese).

Some respondents disclosed the lengths that some transgender and gender nonconforming people go to for day-to-day survival, and that health care costs were an additional burden that many could not carry. “It’s just money issues,” said Rafael, “It’s expensive. And I’m currently unemployed, so I don’t really have the money or the time to be looking into these resources right now.” Jordan reflected on some of the hardships endured by transgender individuals struggling financially to transition, including participation in “black market roles” like the sex trade or drug dealing:

So many transgender people fall into poverty or take on roles in society that are considered “black market” roles because they don’t have any kind of support like that in their lives. We see transgender college students drop out of college because they can’t afford transition and college at the same time, and transition is so much more important to them.

Jordan also shared his feelings on trans health access and affordability in relation to transgender and gender nonconforming individuals who are just beginning their journey to affirmation. He noted that the present political climate in Texas makes it difficult for some transgender individuals, particular vulnerable populations within the trans and non-binary community, to ask the questions they have to get the services they need:

I think that if you're a trans person, especially a young trans person, or a trans person that hasn't had the privilege of education, and you hear Abbott, Patrick or Paxton saying the kinds of things that they're saying, that you're going to be even more afraid to go out and look for things for yourself.

At the time of the interview, which was just after the 2016 Presidential Election, Rafael also pointed out how the election of Donald Trump also added to their anxiety during their transition, noting that "people are obviously becoming more afraid because of President Elect Trump now. Everything is just getting a little more difficult to access."

Respondents from less populated cities in Texas revealed that they often had to drive to the more affluent parts of the state to receive hormone therapy and medical procedures related to their transition. Ray shared that his top surgery wasn't paid for by his health insurance and, in addition to paying \$7000.00 out of pocket for the procedure, he also had to drive to another part of the state to find a doctor that would perform a double-mastectomy on him. "I mean, driving three hours to get a surgery that so many doctors do on a daily basis... is ridiculous."

Respondents also shared the emotional toil this takes on them as they continue to encounter financial barriers to their medical transition. Paula shares that as she looks

ahead to the surgical procedures she hopes will one day be performed, the costs and prerequisites that stand in her way are distressing: “I’m finding myself more and more frustrated because the barriers are so large... it feels overwhelming, actually. At times I have trouble not giving up.” She also stated that there is “no good source” of trans-centered health information that can meet all her needs. Paula said she then “go[es] to the community and ask[s] other people’s recommendations,” but those doctors are already completely booked and aren’t accepting any new patients. “It’s exhausting,” she shared, “I spend so much time on the phone asking questions, and so much time online doing research. And it never feels that I am just confident that I know what’s going to happen before it actually happens.”

Finding Culturally Competent Medical Care

Studies show that some doctors providing care to transgender and gender nonconforming patients are lacking in the medical training or cultural competency to adeptly treat their patients (Luvuno 2017). Most respondents’ reflections echoed this research, noting moments when their doctors provided inadequate care or relied on their patients to educate *them* on their treatments. Frustrated with these interactions with their doctors, one respondent stated:

I’m not going to educate you, I’m going because I need this service. And so I don’t want to have to mess with that and mess with a physician not understanding and being rude and not validating [me], and recognizing that I can be masculine-identified, but still need female sexual health care.

When seeking sexual and reproductive health services, respondents stated that doctors were unsure about providing care contextual to their individual sexual health needs,

Jordan noting: “I find that they don’t know as much about ‘transman with woman’ or ‘woman with woman’ sex as they probably should. I’ve never had anyone recommend a dental dam, for example.” Val shared that their discussion with their doctor on sexual health and safe sex didn’t go beyond talking about birth control, the doctor moving on to another topic after they found out Val was in a relationship with a woman: “Once they find out I am a lesbian and I can’t get pregnant, that’s pretty much the end of the conversation.” Gabe shared similar experiences, noting how medical staff have trouble educating him on STD/STI prevention or what kinds of protective barriers to use during sex. “They’re just like ‘be careful,’” he said, “but don’t ever know what to tell me.” Gabe observed that the safe sex advice from medical staff is oftentimes superficial, and they don’t educate him on basic safety measures: “I’ve never had an educational moment where it’s talked about ‘if you’re using a dildo during sex, still wear a condom on a dildo for your partner’s safety and for the toy’s, cause it might absorb something.’”

Respondents noted that, despite knowing that it was in their best interest to regularly see a doctor for their preventative care, the negative experiences they encountered made it hard for them to return to medical facilities, even to receive emergency treatment. Some respondents shared that their experience “caused such great dysphoria” (Gabe) while others reflected on their lack of trust in the medical staff to care for them: “He just didn’t know what to do with me” (Paula). Reflecting on the painful pap smear she endured, Sage disclosed that it’s hard for them to go to the doctor because they don’t know where to find a physician who is understanding of their needs as a gender nonconforming individual, stating “I just don’t know who I can trust.”

Paula also shared that while her doctor's care has been fairly positive, the other medical staff "isn't always as knowledgeable." She briefly noted an encounter she had with one of her doctor's nurses, where the nurse was having trouble understanding why she had to use she/her pronouns when addressing Paula: "when I wasn't in the room she had been asking a lot of questions, including what pronouns to call me since I hadn't had surgery yet." She went on to describe her interactions with staff at a sperm bank, where she deposited and stored sperm for later reproductive use. Paula observed that staff were unsure of how to treat her, and at times used incorrect language. She also mentioned the magazines that were offered "to help you" make sperm deposits: "it was all very normative... they're just used to freezing eggs for cis-women and sperm for cis-men, and they're not used to sperm for women and eggs for men. Or anything in-between."

Allies in the Medical Field

While respondents generally framed medical interactions as overwhelmingly negative experiences, some respondents reported instances of positive interactions with medical staff. Jordan shared that the care from his primary care physician has been good, noting that when he initially came out as a transgender man his doctor was nervous, but he made the decision to learn more about Jordan's needs and continue to oversee his medical care. "He cared enough about me to learn some stuff and he wanted his practice to be known as a friendly place," Jordan said, "he now has several trans clients." Rose also related her surprise when she first showed up at the doctor's office after affirming her identity as a transgender woman. The receptionist at the front desk, recognizing that Rose's gender presentation did not match the normative presentation of the gender noted

on her medical records, immediately added her preferred name to her files at the office. Rose observed that the receptionist was “a pretty obvious ally.”

My findings highlight the importance of medical interactions as settings where conceptions of gender identity shape the treatment provided by healthcare officials to transgender and gender nonconforming individuals. Respondents’ narratives echoed prior research (NCTE 2012; NLHEC 2016; Eyssel et al. 2017) on the difficulties of receiving trans-affirming medical treatment, such as when Gabe disclosed his discomfort during a medical encounter where staff were refusing to acknowledge his affirmed identity. Respondents also pointed to the obstacles they faced outside of the exam room, like Paula’s experience with finding affordable health care and the limitations of health insurance. These findings resonate in prior studies, which found that only half of all transgender individuals were covered by some kind of health insurance plan (Grant et al. 2011). Furthermore, transgender individuals who are covered are likely to have health insurance plans which still exclude certain treatments for transgender-related health issues like hormone therapy and specific surgical procedures (Grant et al. 2011; AMSA 2016).

Support Systems

In response to the challenges that the respondents faced while seeking and receiving healthcare services, they often found support from people outside of the medical community. Respondents consistently referenced the necessity of additional support networks who provided validation and assistance. These support networks including family and friends, and trans-affirming information and education organizations.

Family and Friends

Many respondents referenced the assistance of family and friends, who in addition to financial support also provided validation, encouragement, and steadfast love throughout their journey to affirming their gender identity. “It’s important to have validation,” shared Ray, who said he is very lucky to have an “amazing support system.” He reflected on the assistance provided by close friends who went with him to the doctor when he began hormone therapy, helped fund his procedures, took care of him while he was in recovery, and be there to listen to him and talk him through the frustrating moments of his transition. “When I don’t understand things or just want to talk to somebody about all the bullshit... I pick up the phone and there are people there, like ‘yeah, it’s shitty,’” said Ray, “And I’ve had that every step of the way, [friends] that have been able to teach me how to advocate for myself, how to advocate for others.”

Recalling the financial barriers earlier in this analysis, some respondents explained how their family and friends showed their support through monetary contributions towards their transition. Gabe disclosed that his mother helped him purchase items that supported his affirmed identity, including a packer, which is “essentially a prosthetic penis that you can wear in your pants, therefore you’re “packing” in your pants,” and binders “to compress the breasts to get a more masculine chest.” He also emphasized the emotional support from his sister, “who was probably more excited than I was when I came out as trans. She’s been incredibly helpful... loving me throughout my process, throughout my transition.”

Paula shared how her parents offered to pay for her cryogenic sperm donation and storage. She said was worried about how hormone therapy would impact her ability to

have children, and hesitated starting treatment because “I didn’t want to make that choice. I couldn’t make that choice yet. I wanted to change my body, but I wasn’t loving the idea of taking that option of having biological kids away.” Paula said her parents then stepped in to pay for the sperm storage, noting “I was very fortunate to have that, cause I couldn’t afford it on my own.”

Some respondents also expressed how their families are still trying to understand their transition, or that they have not yet disclosed their affirmed gender identity to family members. For those who have not yet told their families, they spoke to the fear of a negative reaction as a reason behind why they have not shared that part of themselves with their loved ones. Val stated that while they received positive encouragement from their wife’s family in their transition, it is not something they have brought to their own family’s attention. “It took a long time for them to come to terms with the fact that I was gay, let alone that I don’t conform to the idea that I’m their daughter or granddaughter,” said Val, “Anything like that, they would just lose their minds.”

Rafael shared a similar story, noting that they were currently only “out” to close friends and coworkers, whose support they are grateful for. He stated: “I haven’t told any family. I don’t know when I’m going to tell them, it’s honestly kind of scary to think about.” While most respondents related positive responses from friends in the disclosure of their affirmed identity, one respondent said that they unfortunately lost a friend after they transitioned:

It was the most traumatic thing for me... it was my closest friend, and that was – it was just one day the friendship was over, and it was because I’m quote ‘living too

confrontational a life' for her, and she didn't want to be part of that. I'm not sure how my presenting feminine is confrontational, because all I want to do is be who I am. (Rose)

Trans-Affirming Information and Education Organizations

Respondents also expressed throughout their narratives the assistance of organizations which offer information and education to transgender and gender nonconforming individuals and their families. As observed by some respondents, there are few resources found in the medical community on the transitional process. Many discovered the answers to their health care inquiries by connecting to other transgender individuals in social circles, a process expedited now by the rapid evolution of online social media. They also connected to large national organizations like Parents, Friends, Family of Lesbians and Gays (PFFLAG).

“Going on Facebook and networking with other trans men in the state of Texas has been a huge help for finding this stuff,” noted Jordan, who found a lot of encouragement in his transition through people he met at transgender health conferences and transgender community support groups. He shared the importance of these groups as both an education tool for health and wellness resources, as well as a site of emotional support and affirmation: “I’m getting the emotional nurturance that I need for transition and for continued health and safety.”

Other respondents spoke to the help of support groups that focused on the needs of young transgender and non-binary students. They reflected on how important it was to receive support from their peer group that was also part of the marginalized group they identified within. “Going into that space knowing that if I’m struggling with something, I can talk to somebody about it, and somebody there will understand what I’m talking

about” (Gabe). Others shared how they appreciated that the group was having a shared experience, where each individual was expressing and going through their own unique affirmation and transition. “Everybody in there is somewhere along the spectrum or an ally or wants to know more,” said Rafael, “so it’s definitely a huge safe space and I appreciate them for that.”

The respondents’ experiences with developing support systems referenced the necessity of non-medical networks of family, friends, and organizations who provide validation, encouragement, and funding. While prior research does not go into detail on the positive interactions with these kinds of support systems, it does reference the bullying and abuse endured by many transgender individuals from family and peers (Hwahng and Nuttbrock 2014, UNDP 2010). Several respondents echoed this data, sharing that they had not disclosed their identity to family members yet, fearful of their loved ones’ anger, or even the rejection of their affirmed identity.

Solutions in Their Own Voice

Towards the end of our interviews I asked the respondents what they thought medical clinics and healthcare organizations could do to make the healthcare experience better for transgender and gender nonconforming individuals. Each individual offered a variety of ideas, ranging from updating documents and patient information guides to improving education and training for medical staff. Two central themes emerged: the need for more trans-affirmative healthcare and the offering of advice for other non-binary individuals seeking sexual and reproductive health services.

Towards Trans-Affirming Health Care

One of the first changes respondents suggested was the wider availability of information pamphlets that are usually found in medical office lobbies and exam rooms. “There’s lots of pamphlets in the little holders out in the lobby,” noted Val, “I think it would be helpful to have stuff out there that would apply to people outside of the [normative gender] spectrum.” Some respondents pointed out that being able to grab a pamphlet that focuses on transgender-affirming health care could be helpful for those who were still not “out” to the public regarding their affirmed identity. “Just something for people that are still in the closet that don’t have to be outward,” said Rafael, “like ‘I’m transgender, I need this, I need this’ in front of all these people.” Sage echoes this sentiment, noting her frustration at the lack of public health information for non-binary patients. “They need, you know all those stupid pamphlets they put everywhere, like maybe you can have some pamphlets about that... they just need to be more open about it and less – it needs to not be a hunt for information.”

Respondents also emphasized the need for medical providers to update their patient intake forms and other related patient records programs. Absent on many of the forms are expanded categories for sex and gender, and spaces for preferred names, especially for those individuals who have not legally updated their personal information. As one respondent shared: “When I’ve gone by a name other than my legal name... I don’t want them to call that [legal] name in front of the lobby.” In addition to safety, respondents also related how overwhelming it can be to have to disclose legal names and gender markers that do not validate their affirmed identity. Gabe shared that “it’s almost like a slight moment of defeat” when filling out patient intake forms that do not have

boxes for him to disclose his preferred name. “I recognize that I still have a legal name and a legal sex that’s different than what I like,” said Gabe, “but every time I do it... it’s another moment where I may not be recognized as who I am.”

Respondents also pointed out that the categories “male” and “female” on forms are far too limiting and do not allow patients to disclose their non-binary status, which some respondents note is critical information for medical staff:

Legally I’m a man, I’ve had all my documents changed, including my birth certificate, but that doesn’t help the doctors. The doctors need to know that I was assigned female at birth and transitioned, so that they can do the proper healthcare on me, especially around sexual and reproductive health. They need to know what surgeries I’ve had related to sexual and reproductive health, they need to know why I’ve had those surgeries, that it was related to transition, not related to some kind of medical problem. And filling in an intake form that only has “male” or “female,” or that asks for sex and not gender, or that asks for gender and not sex, complicates that. (Jordan)

Another major change that respondents suggested is updating the training for all medical personnel, including receptionists, billing, anyone who interacts with patients or their personal information. Respondents shared that medical staff need to work on their communication with non-binary patients, and also to unlearn prejudiced perceptions of transgender and gender nonconforming individuals. “Like, you’re still a human being,” said Reese, “I think a lot of it is just social stigma that comes with being a trans person. If

[medical staff] were just more accepting and understanding of that, that would go a long way.”

Respondents shared that physicians and other medical staff who treat patients should have more inclusive medical training in the healthcare needs of transgender individuals. “I wish they would step up their game and be more aware that in today’s world you can’t, as scientists, as a doctor, you can’t only look at the body, you have to consider culture and identity.” (Sage) Gabe noted that if a transgender patient comes out to their doctor, the doctor should recognize “hey, as your physician, I should know about those things,” and to do what they can as healthcare providers to recommend related information or make the appropriate referrals. Val also reflected on the bedside manner of doctors, noting that they feel a “genuine, caring” disposition is lacking in medical care for non-binary individuals. They continued: “I just want a doctor I can feel comfortable around discussing these non-normative gender questions with and not feel awkward about it.” Sage also shared their desire for doctors to check in on the emotional health of their patients: “Just taking that moment. Cause I’m sure a lot of people would say ‘I’m good.’ But every once in a while you would catch people like me who are in distress about it.”

Focusing specifically on sexual and reproductive healthcare, some respondents pointed out where they felt certain services were inadequate. Ray stated: “Everybody should be able to access sex in the way that they want to. In a way that feels good, and positive, and safe for them. And I don’t think health professionals are aware of these things.” He went on to criticize the heteronormative assumptions some doctors make when they see their patients walk in the room: “They see a male, so of course they must

be dating a woman.” Respondents shared their frustrations with medical staff assuming their sexual orientation, and then providing insufficient sexual health information or none at all. They pointed out that expanded training on non-binary patient needs should also include more sexual health education for doctors outside of birth control, including barrier methods that are directed not only at pregnancy prevention, but also STD/STI prevention:

Especially when I was younger, I think it would have been helpful for me to have at least been offered the opportunity to hear about some of that stuff, cause I definitely think I engaged in some relatively dangerous behavior. And had I had any kind of advice back then, or something like that offered by my doctor, it might’ve at least helped me make better decisions. (Val)

A few respondents also pointed to the high number of transgender individuals living with HIV/AIDS, particularly transgender women of color, and how they feel doctors need to be more upfront about these statistics with their non-binary patients. Paula said: “I didn’t even realize that we’re a very large target demographic [for HIV/AIDS].” She voiced her concern regarding organizations which focus research and funding on HIV/AIDS who do not provide some targeted outreach to the transgender population: “They mostly focus on gay men, and have all this outreach for them, and all this work towards them, and they get all their funding to go towards that demographic. They don’t have funding or knowledge about trans people.” Furthermore, respondents shared how doctors could integrate the topic of HIV/AIDS prevention into conversations on sexual health and safe

sex. “As far as sexual health, I think that we need to be talking about PrEP⁶, and getting PrEP and PEP⁷ to trans folks in an easier way,” said Ray. He continued:

PrEP is talked about as a “gay man’s pill.” It’s not just for gay men. It’s for anybody who’s sexually active who could at risk for contracting HIV. And that’s a lot of people. And where there’s so much stigma around being trans and being HIV-positive, or being a slut because you’re on PrEP, that I think we need to have these conversations and health care providers need to be talking.

Advice for Non-binary Individuals Seeking Medical Care

I also asked respondents what advice they would like to give other transgender or gender nonconforming individuals who were seeking healthcare services. Many shared how they found their information, and also took a moment to reassure those who were just starting their transition, or just coming to their understanding of their affirmed gender identity.

One piece of advice respondents shared was to reach out to other transgender or gender nonconforming individuals in the community. “Work within your network and find people who you know will provide care, cause there are trained and capable doctors out there” (Rose). Respondents said non-binary people could use social media or visit local support groups or organizations who focus on education and other social resources for LGBTQ individuals. Jordan explained how important it was for him to connect with other transgender individuals, to develop supportive mentorships and friendships, and to

⁶ “PrEP (pre-exposure prophylaxis) is when people at very high risk for HIV take HIV medicines daily to lower their chances of getting infected” (CDC 2017).

⁷ “PEP (post-exposure prophylaxis) means taking antiretroviral medicines (ART) after being potentially exposed to HIV to prevent becoming infected” (CDC 2017).

be validated by a group of individuals that also understand the transitioning experience. “Use the network. Talk to other trans people and find out who they go to so that you don’t have to be afraid to go” (Jordan).

Other respondents also suggested asking other non-binary friends, looking at what services they’ve had and who they trust to take care of their medical needs. Some even recommended that individuals ask friends to go to the doctor with them, to sit beside them in the waiting room or in the doctor’s office, to be their advocate. “It’s hard to be your own advocate. Find somebody who can help you be an advocate, find somebody to go with you,” said Ray, “Cause not only are you going to do this for yourself, you’re going to do it for somebody else, and we need that.”

Many respondents cautioned against avoiding regular check-ups. “Don’t not get your normal preventive care because of feeling uncomfortable about who you are” (Val). Respondents urged non-binary individuals who feel uncomfortable when visiting their doctor to push on and “get involved in your healthcare” (Jordan). Gabe encouraged transgender and gender non-binary individuals to have the conversations with their doctor about their unique health needs, noting that the visit could have implications beyond that one appointment: “it just takes one trans patient to tell a doctor, to tell a clinic, to say something, to make it so much better for any other trans patient.”

Furthermore, respondents shared how doing one’s research prior to meeting with their physicians could go a long way in finding medical providers who can meet their care needs. “Know before you go,” said Reese, “Do your research on who you’re going to see. Find people that are going to be supportive so you can get past a lot of the issues.” At the very least, respondents noted, non-binary individuals would be better prepared for

what questions they need to ask about their health at the appointments. Paula shared: “If you know what the medical standards are, you know what other people are going through, you can better defend yourself and also know what questions to ask.”

Some respondents also said that educating oneself about their own health needs can also empower them, helping them realize if their doctor is making poor recommendations for their care. Ray pointed out that transgender and gender nonconforming individuals shouldn’t be afraid of challenging medical staff if they are being mistreated or given inadequate medical care: “Call the doctor on their shit. If the doctor’s wrong, tell them they’re wrong. Don’t just not go back.”

One respondent cautioned against self-administration of hormones or other transition-related health care. Rose pointed out the possible negative consequences for individuals who purchase hormones off the internet. She referenced the increased risks for developing blood clots or other serious detriments to one’s health. “Do everything you can to not self-medicate.”

Lastly, respondents shared some words of encouragement for those who are still searching for healthcare services that fit their needs. “Don’t give up,” said Ray, “There will be somebody out there.” Rafael also wanted transgender and gender nonconforming people to know that even if services are out of reach at this time, they remain hopeful that their needs will eventually be met. “Just keep looking. There’s always a way. I haven’t found my way, but I’m sure there’s still a way that I can get everything I need. It’s just, like, don’t stop looking.”

Respondents’ ideas for resolving the issues non-binary individuals encountered in medical environments reflected prior studies which highlighted the benefits of inclusive

care (Grant et al. 2011; Reisner et al. 2010, 2015; AMSA 2016). Val, Rafael, and Sage's appeals for information pamphlets centered on trans-affirming health care speaks to research on the incorporation of sexual and reproductive health information that is tailored to the needs of transgender and gender nonconforming individuals (Reisner et al. 2010). Sage also pointed out the importance of establishing more inclusive training for medical staff that takes into consideration the diversity of culture and identity in the community, a sentiment reported in prior studies on contextualized health care. This research found that adaptable and comprehensive health programs are more likely to promote understanding and empathy between the care provider and patient (Charon 2001; Carson et al. 2003), leading to more positive medical encounters.

VI: DISCUSSION AND CONCLUSION

In this study I focused on addressing the following research questions: What issues do transgender and gender non-binary individuals face when trying to access and receive sexual and reproductive healthcare services? How do transgender and gender non-binary individuals mitigate the impacts of normative gender perceptions and discrimination in the healthcare system? I find that transgender and gender nonconforming individuals encounter obstacles that mitigate opportunities to receive adequate healthcare, such as confusion surrounding preferred name and pronouns, unwelcoming medical environments, poorly trained staff, and issues related to access and affordability. To counteract the challenges faced during medical encounters, transgender and gender nonconforming individuals often rely on support outside the medical community as well as engaging novel solutions, such as self-advocacy, to promote their needs and those of other non-binary patients.

During our interviews, respondents reflected on obstacles they encountered when receiving sexual and reproductive health-related care. One of the first issues respondents observed was medical staff's misunderstanding or flat-out refusal to use their preferred name or pronouns when addressing them. Respondents reported feeling invalidated and dysphoric, particularly when these situations occurred as doctors were examining an individual's lower extremities. These experiences led the respondents to questioning whether or not to continue seeing that particular physician or to seek further medical care. This finding mirrors previous research on health screenings for transgender patients, where non-binary individuals are less likely to receive regular breast and pelvic

screenings (like pap smears and prostate exams) due to discomfort or anxiety from provider mistreatment (Grant et al. 2011; NCTE 2012).

Furthermore, when seeking sexual and reproductive health services, respondents discussed their provider's failure to adequately deliver appropriate, contextualized sexual health education that went beyond pregnancy prevention to also focus on STD/STI prevention. One respondent, who was depositing and storing sperm prior to beginning her hormone treatments, also observed how medical staff at the sperm bank were not prepared to provide services for a transgender individual, and treatment was tailored to heteronormative standards of sexuality. One cannot help but be reminded of Lucal's (1999) *gender displays* research, where rigid notions of masculinity and femininity are confronted when individuals perform outside their prescribed social roles. A "two-and-only-two" (Lucal 1999: 781; 2008) gender system leaves little to no room for diverse gender expressions and, in the case of the respondents seeking sexual and reproductive health-related care, can mean that medical providers are not equipped with a more inclusive approach to sexual health and wellness. My research shows that sustained practices of assigning preconceived constructs of identity is likely to continue to foster distrust between transgender and gender nonconforming individuals and medical practitioners. Furthermore, my work highlights how the initial mislabeling and unwillingness to consider the identity needs of non-binary patients directly influences the quality of medical care available to them.

Respondents spoke to how the lack of insurance coverage for hormone treatments and expensive procedures makes it hard for many of them to receive care related to the affirmation of their gender identity. One respondent even shared the dangerous lengths

some transgender and gender nonconforming individuals will go to in order to financially support their medical transition, including participation in the sex trade or drug dealing. These findings support previous research showing non-binary individuals encountering increased health risks due to mitigated access to adequate healthcare. This theme in my study is even more surprising considering the educational level and income amongst the majority of my sample. Thus, capital and social resources that one would think might counter issues of access and affordability of healthcare still persist, indicating that issues of identity and nonconformity supersede material resources for transgender individuals.

Respondents also reflected on the emotional, educational, and financial support provided by friends, family, and transgender-serving organizations as they navigated services in the medical community. Several respondents disclosed how their family and friends provided them with the validation that was missing in their medical encounters, even going so far as to attend appointments with them and act as an advocate for their needs when addressing medical staff. Financial support from family members and friends assisted the respondents in purchasing items and treatments related to the affirmation of their identity, including packers, binders, hormone therapy, and expensive procedures like double-mastectomies, which were not always covered by insurance. Furthermore, respondents noted the support of allies found on social media and organizations which offer information and education to transgender and gender nonconforming individuals and their families. These resources assisted respondents with locating critical health services, allowing the respondents to learn from other transgender patient experiences at certain medical facilities, and receive encouragement from others who had also gone through their own medical transitions. Going back to the studies on access and

affordability, my research shows how family members, friends, allies, and social organizations attempt to mitigate some of the financial impacts transgender and gender nonconforming individuals endure while seeking sexual and reproductive healthcare.

Furthermore, my work highlights how support systems for transgender and gender nonconforming individuals become a vital source of emotional and educational support, where validation and acceptance from community members play a significant role in a non-binary individual's transition.

Implications for Future Research

There are three major implications from this study. First, I placed considerable attention on the ways in which transgender and gender nonconforming individuals affirm their identity. Lucal famously theorized the “two-and-only-two” (Lucal 1999: 781; 2008) gender issue, when male or female are the only gender options. My research exposes the problematic nature of attempting to innumerate gender identity options as evidenced by the plethora of terms and labels my respondents wished to be identified by. This research even shows that simply providing a third “transgender” option is likely to continue the marginalization and mistreatment of non-binary individuals. Labels chosen by members of this community are not static, vacillating across time and social environment. The needs of transgender and gender nonconforming individuals to express and affirm their identity in ways that do not mitigate consequential social interactions, such as receiving medical health care, require significant attention.

Second, from an interactionist perspective, the encounters between transgender and gender nonconforming patients and their doctors appear to be a one-way relationship. As one of the paradigms in this theory, relationships are reciprocal, involving exchanges

of meaningful symbols between social actors contributing to the construction of social knowledge. In context of interactionist theorem playing out in medical environments, this would entail a “mutual participation” (Szasz and Hollender 1956: 587) between the parties of the physician and the patient. For transgender and gender nonconforming individuals seeking medical services, it is the physician’s view of the patient, the physician’s perceptions, expectations, and, yes, biases, that set the stage for what kind of treatment the patient will receive. My research reveals the problem of medical providers focusing on their own idea of what treatments their patient needs, and not on the issues that the patient is presenting to them. In the case of transgender and gender nonconforming individuals, this problem becomes exasperated by the highly contextualized treatment that non-binary individuals need when seeking sexual and reproductive healthcare.

Third, from a policy standpoint, my research highlights the necessity for a restructuring of medical education and practices for health professionals. My work exposes physician’s preference for biological models that conflate biological sex with gender. Queer theorists highlight the need to deconstruct inherent biases in how gender and sexuality are institutionally framed and regulated (Plummer 2003; Gamson and Moon 2004). A refocus needs to be made to educate and instill improved treatment and consideration for individuals who do not identify within the historical and traditional concept of the male-female paradigm. I do not mean to argue that medical professionals are necessarily acting out of malice, but rather exhibit signs of ignorance or possible miseducation. I use the word education in light of the responses by several respondents who related that they found themselves having to instruct and educate their own doctors

on the kind of care they required. Therefore, it is imperative that medical professionals be subject to training that is reflexive to the needs of those whom they serve.

Limitations

A few limitations in this research warrant attention. First, it is worth noting that transgender and gender nonconforming individuals are a difficult population from which to gather information. In particular, gathering viable data from this population becomes more problematic in areas in which government officials formalize institutional barriers to further socially isolate transgender individuals, such as the recent debate over bathroom bills in the Texas legislature (Ura 2017). Since I gathered my respondents via snowball sampling, certain social characteristics, in particular educational attainment, tended to skew higher than average. Future research would do well to study transgender and gender nonconforming populations that may be economically or educationally disadvantaged, as this may further impact quality of healthcare received. Lastly, distilling all transgender or gender nonconforming into one unified group can further stereotypes and limit the scope of findings for research in this vital area. As we saw in this research, the diversity of terms and identities embraced within this broad community indicate that researchers need to give precedence to the many dimensions of affirmed identity within this population. Much as it may be problematic for a race scholar to assert that all Native Americans or all Latinos act in a uniform manner, doing the same for the transgender and gender nonconforming community is limiting as well. I lament that I was unable to locate a more diverse sample of individuals within the transgender community. Future research should build upon the findings in this paper by continuing to include a variety of non-

binary individuals who can further our understanding of the issues faced by this community when seeking sexual and reproductive healthcare.

This study highlights the obstacles that transgender and gender nonconforming individuals encounter when seeking sexual and reproductive healthcare services. Problematic issues arise when differences are focused upon rather than striving for mutual understanding and respect. Continuing to ignore or quiet the voices and experiences of people who are viewed as outsiders refusing to conform to societal standards only furthers the discourse in which differences are granted prominence over discovering shared ideals that could lead to a more inclusive society. I conclude with the following quote from Jordan:

Here I am, a trans person. I've lived in Texas most of my life. It's important to know trans people. Trans people have different stories. There are reasons we get together, that we like associating with each other, but we like associating with cis-people too. Some of the things you see on the internet are not true; we're not all cis-haters. We're not all anti-Christian. Some of us are Christian. I am Christian. Transmen and transwomen are similar but different, and it's important to know the differences. Non-binary people exist too, and here's what some of their experiences are like. Just because I don't look trans doesn't mean that the trans experience isn't very important to me.

APPENDIX SECTION

APPENDIX A: INTERVIEW GUIDE

Background/Demographic Questions

1. Demographic Questionnaire:
What is your age?
How would you classify your racial/ethnic identity?
What is your sexual orientation?
What is your current marital status?
In what city do you currently reside?
How long have you been living there?
What is the highest level of education you have completed?
What is your current employment status?
What is your current household income to the nearest thousand?
How many children do you have?
2. What are words would you use to describe your gender identity?
3. Are you using words that you learned from other people/networks, or are these words you personally use?
4. Why do you use your own personal labels/descriptions?
5. Do you find common-used terms like transgender, gender non-binary, gender nonconforming, or gender diverse to be too broad or too limiting? Please explain why you feel that way.
6. How and/or when did you realize you were transgender?
7. What are the unique ways you express this identity?

Sexual and Reproductive Healthcare Experience(s)

1. What do you consider to be your most important sexual and reproductive healthcare needs?
2. What has been your experience in finding sexual and reproductive health services?
3. What is your opinion of these services?
4. Describe any barriers that you have experienced in trying to access health care.
5. Have you had any issues when filling out patient intake forms? Please describe.

6. When visiting these facilities, have there been any issues regarding access to single occupancy or gender-neutral bathrooms? Did you address these issues with a member of the staff? How did they respond?
7. With regards to sexual and/or reproductive health, did the medical staff provide counseling on STD/STI prevention and contraceptive services?
8. How comfortable do you feel about being “out” at the doctor’s office?
9. Have you ever been discriminated against by a member of the medical staff?
10. Have you had any issues with a staff member refusing to use your preferred name or gender pronouns when addressing you?
11. Has there ever been a time when you have not felt safe at a clinic or doctor’s office? Please describe the situation(s).
12. Have you ever been denied treatment by a clinic or member of the medical staff?
13. Across the country, new laws limiting access to reproductive health services have been passed in many states, particularly in the southern United States. Have you had any difficulty accessing services that is related to the passage of these laws?
14. Have you had any difficulty accessing or affording health insurance?
15. When accessing sexual and/or reproductive healthcare services, are your visits for preventative or emergency care?
16. Is there anything you feel that clinics could do to make the healthcare experience better for transgender individuals?
17. What advice would you like to give to transgender individuals seeking healthcare and social services?
18. What do you think the Department of Health or other agencies can do to reach transgender individuals looking for a support group or referral to sexual and reproductive health services?
19. Have you gone through any part of a process (including thoughts or actions) to affirm the gender you identify with, or do you intend to? At what age did this period start?
20. Have you had to deal with any barriers throughout this process? Please describe those barriers.

21. Do you have family, friends, or colleagues offering support as you go through this process? In what ways are they providing support and/or assistance?
22. Are you aware of any networks or support groups that offer assistance for those going through a process? Are they group sessions, or one-on-one? Do you utilize any of these services? How do you feel about the assistance these services have provided?
23. Is there anything else you would like to tell me about your experiences with the healthcare system regarding sexual or reproductive healthcare services?

Family Planning

1. Do you have any children? How many? Note: Whether I ask some of the questions in this sections depends on the respondent's answer here.
2. Prior to having your children, were you engaging in any part of a process (including thoughts or actions) to affirm the gender you identify with?
3. Was there any information you wish you knew before having children?
4. How would you describe your feelings about your body as it changed during your pregnancy?
5. Did you experience any anxiety or post-partum depression after giving birth to your child(ren)?
6. Please describe your experience(s) with OB/GYN clinics and medical/administrative staff during your pregnancy.
7. Is there anything you feel that OB/GYN clinics could do to make the healthcare experience better for transgender individuals who are expecting?
8. How would you describe your parental role?
9. What is the name your children use to address you? Did you choose this name, or the children, or someone else? How does this name relate to your parental role?
10. Have you had any conversations with your children about gender identity and expression in relation to your biological and parental role?
11. Have you faced any discrimination from family, friends, colleagues, or even strangers in relation to your parental role? Please describe.
12. What advice would you like to give to transgender individuals who have, or wish to have, children?

13. Is there anything else you would like to tell me about your pregnancy experience(s)?

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