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Accessing Gender Affirming Care from the Margins: Comparing the Strategies of Transgender People Pre-1980 and Non-Binary People Today

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Abstract

For many transgender people, gender affirming medical care is a crucial component of building identity and working towards an affirming embodiment. However, since the beginning of the development of gender related medical practices, trans people have faced barriers to accessing this care. This thesis first details the histories of trans people seeking gender affirming care before it was formally recognized in the 1980 third edition of the *Diagnostic and Statistical Manual of Mental Disorders*. Then, by comparing this history to data collected from 18 in-depth, qualitative interviews with non-binary people, this study both situates the experiences of modern-day trans people within a genealogy of trans resilience and identifies new themes and areas of struggle most relevant to non-binary people today. The nature of the challenges that transgender people face in the present differs from that of the last century because of the expansion and development of trans health systems and civil rights advances. While the standardization of trans healthcare has increased accessibility for some, it has also led to new obstacles, especially for non-binary people, whose trans experiences do not align with the transnormative narrative. As a result, non-binary people continue to rely on some of the same strategies used by trans people in the mid-20th century to access healthcare. Although their perseverance demonstrates the profound resilience that trans communities have exhibited throughout history, it is the responsibility of medical systems, including healthcare professionals, to improve so that trans people do not have to rely on individual acts of resistance and resilience in order to access their right to gender affirming healthcare.

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Introduction

Although exact definitions vary, the term *transgender* is generally used as an umbrella label that describes all people whose gender identity differs from their assigned gender at birth (Davidson, 2007). Estimates suggest that between 0.3% and 0.6% of people in the United States identify as transgender (Flores et al., 2016; Reisner et al., 2014). This category includes a diverse and ever-expanding set of gender identities, such as man, woman, non-binary, genderqueer, bigender, agender, genderfluid, etc. Notably, transgender people can generally be categorized as either binary or non-binary depending on the degree to which they identify with a gender on the male/female binary. In this thesis, *non-binary* is used as an umbrella term that includes anyone who does not identify completely as male or female. Within the categories of both binary and non-binary exists a great diversity of gender embodiment and expression. While some trans people choose to present in a way that allows them to pass, or be perceived socially as cisgender, others choose not to or are unable to. Similarly, trans people seek gender affirming medical care to varying degrees. The breadth of identities included under the transgender umbrella has been useful in consolidating trans political power (Davidson, 2007), but transgender experiences are extremely diverse and vary greatly between individuals.

Transgender people as a whole face violence and discrimination at alarmingly high rates. The 2015 US Transgender Survey found that 46% of respondents had experienced verbal harassment and 9% were physically attacked in the last year. In the same time period, 30% of respondents were fired or experienced other workplace mistreatment (James et al., 2016). Visibly trans people, whose embodied characteristics (e.g., voice range, body shape, hair growth patterns) do not align with their gender, face discrimination at especially high rates (Friedman, 2013; Lagos, 2019; Westbrook & Schilt, 2014). Sixty-three percent of those who said others could usually or always tell they were trans experienced verbal harassment, compared to 36% of those who passed as cisgender. Similarly, the rate of facing physical violence due to being transgender was 6% for those who passed as cisgender but 15% for those who were visibly trans (James et al., 2016). Transphobic violence and discrimination are well-documented problems that are an everyday reality for many trans people.

In addition to facing discrimination, transgender people also report being in worse health (e.g., greater perceived stress, worse physical health, lesser ability to partake in everyday activities due to health) than their cisgender counterparts (Fredriksen-Goldsen et al., 2014; Meyer et al., 2017). Trans people's relationships with healthcare systems have a long and complicated history. Medical settings are often the site of transphobic discrimination and violence (Davis et al., 2016; Poteat, 2013; Spade, 2003; White Hughto et al., 2015). As a result, many trans people delay or underutilize medical care, which leads to worse health outcomes (Cruz, 2014; Paine, 2018; Sledge, 2019). However, trans people are also simultaneously drawn to health systems because they are the primary providers of medical gender affirming care. For many trans people, this care can be crucial to achieving a comfortable gender embodiment (Inch, 2016; Lev, 2013; Spade, 2003). The medical system therefore gains power over trans people because of their dependence on its services. Historically, doctors have used this power to further their own agendas at the expense of providing affirming care for trans people (Gill-Peterson, 2018). Today, although more providers advertise their care as "trans-affirming," many trans people still receive inadequate healthcare or face barriers to accessing care. By comparing data from 18 in-depth interviews with non-binary people to the historical experiences of trans people within medical settings, this thesis identifies the genealogies of trans resistance and resilience in the face of enduring gatekeeping and violence towards the trans community.

Theoretical Considerations

"Doing Gender" is Candace West and Don H. Zimmerman's (1987) theory that gender is accomplished through everyday interactions rather than preprogrammed through innate biology. The framework of "doing gender," which has become a widely accepted sociological understanding of gender, distinguishes between sex, the assignment given to babies at birth based on anatomical features, and sex category, which the authors define as the ways that people display their sex in order to claim membership to male or female categories. In contrast, gender is how people respond to society's demand for adherence to these socially constructed categories through normative behaviors associated with being a man or woman. West and Zimmerman (1987) theorized that gender cannot be an intrinsic part of one's identity because it is created through relationships to other people and institutions in society. Instead, gender is a "routine, methodological, and recurring accomplishment" achieved through "doing," or social performance (West & Zimmerman, 1987, p. 126).

Scholars have noted that if gender is accomplished through doing, there must be a way for it to be undone (Deutsch, 2007). Lorber's (2005) concept of "degendering" and Risman's (1998) theory of "gender vertigo" present families and individuals who defy gendered expectations as evidence of movement towards a post-gender society. Through these frameworks, transgender and non-binary people may be seen as living examples of "undoing gender" because their sexes, sex categories, and genders do not align according to the dominant gender binary paradigm. The original "doing gender" theory examined how some binary transgender people interact with society's gendered expectations (West & Zimmerman, 1987); however, it did not consider how non-binary people problematize the theory even more. In addition to presenting incongruity between gender, sex, and sex category, non-binary genders also defy male and female categorizations on a whole.

Despite the many examples of how people challenge gendered expectations, West and Zimmerman (2009) have more recently argued that society will never reach a post-gender state because gender cannot be undone. Post-genderists seek to create a world where “sex category matters not at all beyond reproduction; economic and familial roles would be equally available to persons of any gender” (Risman, 2009, p. 84). However, even in this hypothetical situation, society would still develop gendered roles regarding reproduction responsibilities (West & Zimmerman, 2009). Thus, rather than striving for a post-gender society, West and Zimmerman (2009) argue that it is more useful to understand nonconformity to gendered expectations as movement towards a “redoing” or recreation of gender, in which society may assign new meanings to different genders (p. 118).

C. Connell (2010) has described the “redoing” of gender specific to the trans experience as “doing transgender” (p. 50). Doing transgender is not simply defying gendered expectations, as Risman (2009) and Lorber (2005) have discussed. Instead, it is the negotiation of dissonance between gender, sex, and sex category in the context of interactions with society. C. Connell (2010) suggests that simply existing while being trans is radical, because it disrupts deep socially ingrained assumptions about the interlocking nature of gender and sex. However, trans people do not have the luxury of defining their genders free from outside pressures. From structural barriers to interpersonal interactions to individual-level internalization of transphobia, trans people face stigma from society on all levels (White Hughto et al., 2015). Thus, “doing transgender” is a theoretical description of the diverse ways that trans people accomplish gender in the face of transphobia and other social restrictions.

Because the embodiment of physical gendered characteristics (e.g., voice range, physical build, and hair growth patterns) is one important aspect of gender, healthcare is a key component to how many individuals "do transgender." Trans people have had a long, complex, and often stigmatizing relationship with healthcare systems. They are more likely to underutilize or delay healthcare due to fear of discrimination in medical settings, which leads to worse health outcomes (Paine, 2018; Sledge, 2019). This is especially true of gender nonconforming people (Cruz, 2014). On the other hand, trans people have always looked to doctors to access medical interventions that could help bring their identities and bodies into congruence (Gill-Peterson, 2018). These interventions are described as medically necessary not only because they are crucial to many trans people's personal relationships with their bodies and genders (Cruz, 2014; Inch, 2016; Lev, 2013; Spade, 2003), but also because they can provide access to life altering social advantages, like greater levels of safety from transphobic violence (Dubov & Fraenkel, 2018; Grzanka et al., 2018).

As previously discussed, transgender people, especially visibly trans people, face violence and discrimination at alarmingly high rates (James et al., 2016). This is because when people perform gender, others around them categorize them into male and female categories based on both their actions and their embodied characteristics (Friedman, 2013; Lagos, 2019; Westbrook & Schilt, 2014). Most people expect certain gendered actions to accompany particular embodied characteristics, but visibly trans people's performance of gender often challenges these assumptions. In response, to reinforce traditional gender definitions, some cisgender people police gender using violence and harassment (Butler, 1999). Thus, safety has been reduced to a social privilege that is unequally awarded to those who are visibly trans, compared to those who want to and are able to access the services and resources necessary to pass as cisgender.

Binary transgender people who pass as cisgender generally enjoy greater levels of social acceptance because they are reabsorbed into the gender binary (Westbrook & Schilt, 2014). From Christine Jorgensen, a trans celebrity famous in the 1950s, to Caitlyn Jenner, one of the most famous trans people today, the extremely limited positive media coverage of trans people has been dominated by those who have fully embraced gendered beauty standards and binary gender roles. Furthermore, except for a few notable exceptions like Laverne Cox, these high profile trans celebrities are predominantly White. This repeated narrative has led to transnormativity, or the assumption that all trans people have had the following experiences: (1) fully identifying with the "opposite" gender on the gender binary, (2) knowing one is transgender from a young age, experiencing extreme dysphoria, and feeling trapped in the wrong body, and finally (3) wanting hormones and surgery in order to achieve a stereotypically beautiful body of one's gender identity (Johnson, 2016). In reality, trans people are continually pushing the boundaries of what it means to be gender diverse, so they may or may not identify with any combination of these experiences. Transnormativity centers cisgender society because it only authenticates the trans experience that least challenges society's gender binary. Meanwhile, it invalidates the identities of trans people who do not have this experience by making them feel as though they are "not trans enough" (Garrison, 2018).

The Medical Model of Transgender Identity

In addition to the intrapersonal and interpersonal discrimination that results from the validation of certain trans identities over others, transnormativity has also shaped how transgender identity is treated through institutional structures like the healthcare system (Davis et al., 2016; Johnson, 2016; Paine, 2018). While medical care like hormone therapy and surgeries are crucial for some trans people, they are just one aspect of being transgender. Despite this, overemphasis on the importance of medical transitioning has led to the adoption of "the medical model of transgender identity" in healthcare settings. This model equates transgender identity to the medical interventions that some choose to undergo, like hormone therapy and gender affirming surgery. By defining transgender identity in this way, medical systems have legitimized trans healthcare and convinced insurance companies that it is medically necessary (Davis et al., 2016; Johnson, 2015; Lev, 2013; Wiggins, 2020). However, the medical model also reinforces the hierarchy of transgender identities that places binary trans people who are on hormones and have gotten surgeries over those who have not (Johnson, 2015; Mog & Swarr, 2008). Those overlooked by the medical model include not only trans people who do not want or need medical interventions to embody their gender but also trans people who want medical care that does not have the goal of allowing them to pass as cisgender. The medical model pathologizes trans identity and situates the problem in the bodies of transgender people. It is a reductionist interpretation of the transgender experience because it fails to recognize that much of the hardship experienced by trans people is actually caused by the structural policing of non-normative gender performance (Johnson, 2015; West & Zimmerman, 1987).

In the medical system, symptoms in the body signal that there is a problem, and healthcare professionals are tasked with "fixing" the problem (Budrys, 2012). The application of this framework to transgender identity was formalized in 1980 when the American Psychological Association (APA) added "Gender Identity Disorder" to its third *Diagnostics and Statistical Manual of Mental Disorders* (DSM). The language of "Gender Identity Disorder" endured until 2013, when the APA replaced it with the term "Gender Dysphoria" in the fifth version of the

DSM. The DSM-5 also created its own section for Gender Dysphoria, rather than categorizing it with sexual dysfunctions and paraphilic disorders, as it had in the previous versions (American Psychiatric Association [APA], 2013). Some argue that these changes are a step in the right direction because they cite dysphoria rather than trans identity as the source of the problem (Lev, 2013). They also cease to directly associate trans identity with sexual perversion (Wiggins, 2020). However, others note that by maintaining any diagnosis of gender-diverse experience in the DSM, the APA continues to pathologize transgender identity by categorizing dysphoria as a mental disorder (Inch, 2016; Johnson, 2015; Lev, 2013).

The World Professional Association for Transgender Health (WPATH), the leading organization guiding those who work in transgender health, has advocated for care that affirms patients' genders without medicalizing their experiences. In 2010 it released a statement calling for the "de-psychopathologisation of gender variance worldwide" (World Professional Association for Transgender Health, 2010, para. 2). The most recent Standards of Care have taken this further by removing the recommendation that practitioners require a Gender Dysphoria diagnosis before offering affirming care (Coleman et al., 2012). The Standards of Care do, however, still list "persistent, well-documented dysphoria" as the first criterion for any hormone therapy or gender affirming surgery (Coleman et al., 2012, pp. 34, 59, 60, 104, 105, 106). The WPATH's separation from the DSM is a step away from categorizing trans identity as a psychiatric illness, but the enduring reliance on dysphoria equates the trans experience with one of internal distress (Wiggins, 2020). The Standards of Care continue to assume that the distress associated with being transgender stems only from the bodies of trans people themselves, in contrast to systemic discrimination and oppression. While dysphoria can be innate, it can also be caused by how society treats non-normative bodies (Butler, 2004). In addition to managing dysphoria, some trans people may want medical transitions so that they are better able to pass as cisgender and can thus access social advantages, as discussed previously (Dubov & Fraenkel, 2018; Grzanka et al., 2018). The Standards of Care provide guidelines to expand access to affirming healthcare, but by assuming that dysphoria is always innate, they fail to depart from the traditional assumptions of the medical model.

In practice, because the Standards of Care are not mandated, many gender affirming healthcare providers act as gatekeepers who regulate access to care based on their own outdated or biased criteria (Johnson, 2015). Medical professionals receive minimal training, if any, on how to best support trans patients (Obedin-Maliver et al., 2011; Poteat, 2013). Thus, many conduct their practice without challenging underlying assumptions that gender and sex are innately binary and must align (Butler, 2004; Davis et al., 2016). As a result, societal discrimination against trans people is recreated as interpersonal stigma between medical providers and transgender patients. This reinforces the relationship of power between doctor and patient (Poteat, 2013). Providers often use their authority to oversee transition timelines to slow down the process of granting gender affirming care (Davis et al., 2016). They frequently deny care to those whose experiences do not align with the normative trans story (Garrison, 2018; Spade, 2003) or if they believe the patient will not perform binary gender (Davis et al., 2016). Meanwhile, in other situations, doctors working with trans patients may recommend invasive procedures that are not medically necessary when the same care would never be suggested to cisgender patients. For example, Sledge (2019) found that gynecologists are quick to recommend hysterectomies to trans people who have any minimally increased risk of cervical cancer. Being trans is not a risk factor for cancer itself, yet trans patients are often suggested this procedure against evidenced-based care recommendations. Rather than trusting that trans people know what they want for their bodies, doctors assume that patients seek care that aligns their bodies with the gender binary. In doing so, they reveal that they are implicitly motivated by creating bodies that can be reabsorbed into the cultural gender and sex binary, not necessarily providing affirming care for transgender patients (Johnson, 2015; Sledge, 2019). The medical model bestows power over trans bodies to healthcare providers, and even when offering care, these medical professionals too often do so in ways that reinforce the cisgender-centric gender binary.

The adoption of the narrow definition of transgender identity outlined by the medical model has had detrimental impacts for trans people beyond just restricting access to gender affirming care. In most states, in order to get a driver's license with the correct gender listed, trans people must provide certification from a healthcare provider that they have medically transitioned to their doctor's approval. Nine states still also require proof of surgical transition (National Center for Trangender Equality, 2020). Thus, because of the intersecting nature of social structures, trans people are held accountable to the medical model in realms outside of medical spheres.

The medical model fails to provide patient-centered care because it puts social ideas of gender before patient needs (Sledge, 2019). In order to recognize the diversity of the trans experience, society must look beyond the medical model and depathologize transgender identity. The transgender experience is so much more than the dysphoria that the DSM attempts to equate it to (Wiggins, 2020). Transgender people deserve access to gender affirming care not because they have a psychiatric illness that needs curing but because it is their right (Davis et al., 2016; Lev, 2013).

The Histories of Gender Affirming Care

Gender diverse people have long looked to medical systems for care that could physically affirm their genders. The standardization of use of anesthesia and antisepsis in the early 1900s greatly increased the feasibility and safety of many medical procedures. For many gender variant people, this sparked the idea of pursuing surgery to affirm their genders (Stryker, 2017). Similarly, advances in the field of endocrinology, such as the manufacturing of synthetic estrogen to treat menstrual cramps and menopausal hot flashes in the 1940s (Kohn et al., 2019), presented a new frontier of possibilities for gender diverse people to use hormones to physically achieve bodies that would align with their gender identities. Throughout the early and mid-20th century, hospitals and medical researchers made great advances in what we would now consider trans healthcare. However, this work was almost never done with the goal of providing affirming care to gender variant patients. As a result, the burden of navigating these often-stigmatizing medical spaces was placed on patients themselves.

The term “transgender” was not widely used until the 1990s (Stryker, 2017), so using this language to describe gender variant people who lived in the many decades leading up to this is technically incorrect. However, reading these past experiences as trans in a broad sense locates them in a rich history of gender variance that directly informs the transgender experience of today (Gill-Peterson, 2018; Stryker, 2017). Thus, the application of more modern language is not intended to redefine the identities of historical figures in current terms. Rather, it is an attempt to situate the experiences of gender variant people past and present in the genealogy of transgender resilience.

The Medicalization of Gender Variance from the 1900s to the 1950s

One of the most notable early advocates for transgender medical care was Magnus Hirschfeld, a German scientist and LGBT activist working in the early 1900s. After years of organizing to end Germany's sodomy laws and targeted policing of trans people (Mildenberger, 2019; Stryker, 2017), in 1919, Hirschfeld opened the Institute for Sexual Science in Berlin. The Institute served as a research hub dedicated to studying what Hirschfeld described as "sexual intermediaries," or the millions of varieties of genders more complicated than the male/female binary (Stryker, 2017). In addition to conducting research, the Institute also offered employment opportunities, counseling, and community for these "sexual intermediaries" (Bevan, 2019; Sutton, 2018). Within this category, Hirschfeld included homosexuals, intersex people, and "transvestites," the term he coined to describe people who presented as a gender different from their assigned gender at birth. Although today "transvestite" has become a stigmatized term for cross-dressers who do not seek medical transitions, at the Institute, it was these "transvestites" who underwent the first documented gender affirming surgeries in the 1930s (Stryker, 2017).

In contrast to the Institute's research and the care provided to people of diverse gender and sexual experiences in Germany, doctors in the United States were singly focused on researching intersex conditions, or "hermaphroditism," as it was called at the time. Relying on the plasticity of gender especially in childhood, this research was a eugenic project that aimed to "fix" intersex children by forcing their bodies into the gender binary (Eder, 2018; Gill-Peterson, 2018; Karkazis, 2008; Reis, 2019). Much of the care that is today considered gender affirming healthcare was developed during this period with this goal in mind. From its opening in 1915 through the 1950s, the Brady Urological Institute at Johns Hopkins Hospital saw over one hundred intersex patients, most of whom were children. When meeting a new patient, surgeon

Hugh Hampton Young and psychologist John Money would assess their genitalia, secondary sex characteristics, and sexualities in order to determine which of the binary genders was "dominant." Young would then perform a variety of genital surgeries he had specially developed to create binary results for these patients (Gill-Peterson, 2018; Karkazis, 2008). Later, when synthetic hormones were developed, the Brady Institute combined early surgery before patients were old enough to consent, hormone therapy at puberty, and rigid gendered socialization to choose a gender and sex for intersex patients before they could even develop their own sense of identity (Reis, 2019).

Although doctors were actively developing novel medical procedures and approaches that could have been affirming for many trans people, those without intersex conditions were strictly forbidden from accessing this care. In his correspondence with a colleague, John Money distinguished between intersex conditions, or "physical disorders in which the sexual organs are improperly formed" and "nonphysical disorders, like homosexuality and transvestism, … which are subject to learning"(Gill-Peterson, 2018, p. 135). He went on to claim the following:

> A man cannot be turned into a woman. It is possible to remove all the male sexual organs surgically, but it is not possible to supply all the female reproductive organs, so that the patient ends up neither female nor male. (Cited in Gill-Peterson, 2018, p. 136)

Money's beliefs are an early version of the claims later made by trans exclusionary radical feminists that gender is purely biological, not socially constructed and performed (Gill-Peterson, 2018). His description of gender and sexuality as "subject to learning" also anticipates the arguments in favor of transphobic and homophobic conversion therapy in the decades to come. The exclusion of trans people from medical care was further cemented in 1949 when Edmund G. (Pat) Brown, California's attorney general and future governor, gave the legal opinion that gender affirming surgical operations could be criminally prosecuted (Stryker, 2017). Following this opinion, in the rare cases when doctors successfully arranged gender affirming surgeries for trans patients, local hospital boards would swiftly use legal action to prevent them from happening (Gill-Peterson, 2018).

Because of these extreme barriers, very few trans people were able to access affirming healthcare during this period. Those with the financial means, such as celebrity Christine Jorgensen, travelled outside of the United States to places like Denmark, Italy, Morocco, and Mexico for surgery (Gill-Peterson, 2018; Stryker, 2017). A few trans women were able to obtain medical support after attempting self-castration (Gill-Peterson, 2018). This dangerous choice demonstrates the dire situation that trans people found themselves in. Only by creating a medical emergency were they able to get healthcare institutions to pay attention to their needs.

Trans people during this period knew that the medical system was only willing to entertain conversations about gender variance when the goal was to eliminate it. Thus, some trans people used the language of "hermaphroditism" in order to get the attention of doctors who held the power to provide affirming care. In letters to doctors like Young and Money at Johns Hopkins, they asked for care that would "fix" the mistakes that nature had made on their bodies. Some trans people went further to claim to have intersex conditions. For example, in 1938, the Brady Institute saw a young trans man who had travelled to Baltimore from Alabama to seek care for what he described as a "congenital malformation." Although assigned female at birth, "Bernard" claimed to have an "enlarged phallus" that was "bound down," an intersex condition known as hypospadias (cited in Gill-Peterson, 2018, p. 84). In mail correspondence, he told Young that he felt a mass in his groin which he believed to be a testicle. Additionally, he explained that he shaved his facial hair weekly, his voice had dropped at a young age, and he had only ever been sexually attracted to women. After convincing Young of his intersex condition, Bernard was invited to visit the Brady Institute for an exam. During this exam, Young's colleague who saw Bernard found his claims about his physical condition to be untrue. In the end, Bernard was sent home without having accessed the gender affirming surgery he sought (Gill-Peterson, 2018).

Although Bernard was ultimately unsuccessful in accessing the care he sought, his ability to capture the attention and obtain an invitation from doctors who explicitly excluded trans patients is evidence of his ingenuity. Despite being from a small town in Alabama, he was clearly well versed on the latest work being done at the Brady Institute (Gill-Peterson, 2018). His description of his condition included not only genital irregularities but also hormonal changes and his straight sexual orientation. Bernard slyly described himself in ways that made it seem like he was simply observing his body, but this multi-level explanation demonstrates his understanding of the doctors' goals of aligning each intersex patients' sex, gender, and sexual orientation into the normative binary. Early trans people are often depicted as the passive victims of cruel medical systems, but Bernard's story is evidence of a rich history of trans people taking ownership over their pursuit of healthcare and adeptly navigating hostile systems.

In 1958, psychiatrist Robert Stoller saw a patient at the University of California, Los Angeles Medical Center who similarly used the discourse of intersex to capture the attention of doctors. "Agnes," as she came to be called in academic literature, was a nineteen-year-old trans woman who had dropped out of high school and was working as a typist (Rogers, 1992). In her medical exams, doctors found that although she had "normal male" physical anatomy, her testes seemed to produce an abnormally high level of estrogen. This was of great interest to Stoller, who sought a biological explanation for transgender identity (Gill-Peterson, 2018). Agnes was offered gender affirming surgery in exchange for her participation in not only Stoller's work but also the research of Harold Garfinkel, a sociologist studying ethnomethodology. Agnes agreed and was subjected to over 70 hours of invasive interviews with Stoller, Garfinkel, and other doctors. The doctors used these interviews to meticulously scrutinize every aspect of Agnes' life, from her physical embodiment to the way she dressed to her personal life and relationships (Garfinkel, 1967). In the end, Agnes did receive the operation promised to her. It was only in a follow-up appointment that she revealed that she had been secretly taking her mother's estrogen pills for six years. Her supposed estrogen-producing gonads, which had so excited Stoller and other doctors studying trans people, were merely a part of her strategy to access the surgery only these doctors could provide (Gill-Peterson, 2018).

Agnes is yet another example of young trans people's wit and resilience in skillfully navigating the oppressive medical system. Garfinkel's writing about his work with Agnes describes his interviews with her as "conversations," (Garfinkel, 1967), but this language overlooks the extreme power imbalance between Agnes, a transfeminine teenager at the mercy of these doctors, and Garfinkel, a White man and established academic (Rogers, 1992). Garfinkel's (1967) writing on Agnes' breast size, waist size, and physical appearance demonstrates the transmisogyny behind what was considered "science" at the time. His scrutiny of every aspect of Agnes' life was truly relentless. Despite this, Agnes succeeded in fooling the whole team of doctors into believing that her estrogen levels were natural. In the following years, transphobic writers would use Agnes's actions as evidence of trans people's manipulative tendencies (R. Connell, 2009; Vidal-Ortiz, 2009). In reality, her actions demonstrate her resilience in the face of cruel treatment from doctors and her self-taught expertise in navigating medical spaces. It was these skills that ultimately allowed Agnes to maneuver her way into the operating room.

Agnes's grit and savvy were crucial to her accessing care, but her Whiteness and the copious estrogen pills in her middle-class home were what made it possible for her to even capture the attention of the UCLA doctors. Indeed, the concept of gender plasticity was constructed as necessarily White from the start (Gill-Peterson, 2018). Lugones (2007) asserts that the binary gender system was historically introduced as a tool to maintain colonial power. Thus, when doctors attempted to mold intersex patients into male and female genders, they were motivated by upholding White, bourgeois concepts of masculinity and femininity (Malatino, 2019).

Ironically, vesicovaginal fistula, a precursor surgical procedure to the early vaginoplasty widely performed on intersex patients, was developed through experimentation on enslaved women in the preceding century. Although anesthesia was available at the time, James Marion Sims, the doctor who developed the procedure, routinely operated on these women without using it (Cronin, 2020). This torturous treatment demonstrates how Black people were only included in medical research when doctors needed completely disposable bodies. Later, when this procedure was modified for use on intersex and transgender patients, the bodies of Black, Indigenous, and other people of color (BIPOC) were rendered irrelevant. This was because doctors working in this area were motivated by the goal of creating bodies that would be absorbed into White society. Patients of color, whether they were intersex or transgender, were already eliminated from this possibility on the basis of race. Therefore, even as trans care was expanded in the coming decades, BIPOC trans people continued to be systematically excluded (Gill-Peterson, 2018).

Expanded Research with Continued Barriers to Access in the 1960s

In the 1960s, Doctor Harold Benjamin emerged as the leading authority on transgender medicine. Originally born in Berlin, Germany, Benjamin worked with Magnus Hirschfeld in his early career before settling in New York (Stryker, 2017). In 1953, he took Christine Jorgensen into his practice after her recent return from her surgery in Denmark. Jorgensen's explosion of stardom had inspired numerous trans people seeking similar gender affirming care to write to her. Before Benjamin's work had gained the level of fame it achieved in the following decade, this connection with Jorgensen was what facilitated his ability to build networks within the trans community (Gill-Peterson, 2018).

When Benjamin later established the Harry Benjamin Foundation in 1964, it was again made possible through support from trans people themselves. The year before the Foundation was established, Benjamin had provided care to a wealthy patient named Reed Erickson. Erickson was a trans man who inherited a successful family business in lead production. This wealth allowed him to establish the Erikson Educational Foundation (EEF) to fund his research interests. It was grants from the EEF that financially backed the Harry Benjamin Foundation (Stryker, 2017). Benjamin's work through his foundation greatly pushed trans medicine forward by bringing together doctors from institutions around the country. Erickson also funded Benjamin in his writing of *The Transexual Phenomenon* (Stryker, 2017). Even at the time of its publication in 1964, this book was by no standards progressive. It confusingly drew from the work of the previous decade to claim that "we are all 'intersexes'" (Benjamin, 1966, p. 8) only to later state that transsexuality "has nothing to do with hermaphroditism" (Benjamin, 1966, p. 11). Despite Benjamin's confusing explanations, *The Transexual Phenomenon* did succeed in beginning the process of legitimizing gender affirming care within medical literature (Gill-Peterson, 2018).

Harry Benjamin is often called the “founding father” of transgender medicine (Ekins, 2005, p. 306). Although there is no doubt that his work did help formalize practices and push research forward, blindly giving him so much credit erases the support and labor from trans people that was crucial to his work. In addition to his partnership with Christine Jorgensen and his funding from Reed Erickson, Benjamin relied on many other trans community organizers to get his career off the ground (Gill-Peterson, 2018). Thus, trans medicine was not developed because of the mere interest of a few cisgender doctors. Instead, trans activists strategically allied themselves with the doctors who would listen to them most in order to demand advancements in the medical field.

Ironically, although early in his career Benjamin had to rely on his relationships with well-connected trans people to build his practice, once his work became well known, he acted as an extreme gatekeeper to trans people seeking care. By the time he retired in 1979, his practice had received over 800 letters from trans people who sought his help (Ekins, 2005). Benjamin’s responses were formulaic and dismissive, often narcissistically suggesting that people buy a copy of *The Transsexual Phenomenon* (Gill-Peterson, 2018). Despite this, trans people were determined in their outreach to Benjamin. One such example, “Vicki,” was a trans child who corresponded back and forth to Benjamin’s practice for two years. Her courage to engage in conversation about body development, hormones, and surgery with the leading doctors of the field shows her commitment to doing everything she could to take ownership over her body (Gill-Peterson, 2018). In the end, Benjamin’s clinic used its gatekeeping power to refuse to help her. However, Vicki’s fortitude demonstrates that although doctors held the reputation of being experts on trans health, the real experts who knew exactly what trans people needed were trans people themselves.

The Institutionalization of Gender Affirming Healthcare in the 1970s

Building off of the research of the previous decade, gender affirming healthcare started to become more available in the 1970s. In addition to the Hopkins clinic and Benjamin’s practice, new gender clinics, many made possible by funding from the EEF, opened at University of Minnesota, Northwestern University, University of Washington, Stanford, the San Francisco Public Health Department, and the University of Texas (Gill-Peterson, 2018; Stryker, 2017). Additional private practices offering gender affirming surgeries sprung up around the country as well. In 1979, Jeanne Hoff, a psychiatrist who was trans herself, took over Benjamin’s practice. Hoff brought to her work a level of genuine care for patients that was all but missing from the trans healthcare system up until this point (Gill-Peterson, 2018). Her work introduced the possibility of trans people claiming control over the gender affirming healthcare system for themselves, a goal that many trans activists continue to work towards today.

In the 1970s, although trans people continued to face harsh transphobia in society, most White people with enough money could access hormones and gender affirming surgery without having to employ the strategies used in the prior decades to simply capture the attention of doctors. In addition to expanded medical access, trans people during this period also received greater support from newly formalized trans community organizations. One such organization was Conversion Our Goal, a trans support group operating out of San Francisco’s Glide Memorial Church. In addition to publishing a newsletter of transgender health resources, Conversion Our Goal began printing identification cards with trans people’s correct genders. With these IDs, trans people were much more likely to be able to open bank accounts and find jobs while living their true gender. In 1968, Mario Martino founded Labyrinth, a trans community organization in New York City. Labyrinth notably supported trans men in navigating growing healthcare systems that still catered mainly to trans women, who had historically been more visible due to their inability to pass as cisgender (Stryker, 2017). These emerging organizations run by and for trans people laid the foundations for decades of trans activism to come.

It is important to note that although those with racial and class privilege enjoyed increasing access to affirming care during this period, the trans healthcare system continued to operate with the goal of creating bodies that could be reassimilated into the gender binary of hegemonic White culture. Trans patients endured the burden of proving that this was their intention in order to access care. Those who deviated from this narrative were often rejected from gender clinics. For example, Lou Sullivan was a gay trans man who moved to San Francisco in pursuit of gender affirming care. When he approached the Stanford clinic, they denied him any care on the mere basis of his sexuality (Stryker, 2017). Even as gender clinics provided care for more and more trans patients, they continued to be motivated by the maintenance of binary gender roles rather than genuine care for trans patients.

Sullivan, a White man who had strong support from the trans community, was eventually able to get gender affirming care from private practices. However, for many BIPOC trans people, accessing affirming care was a structural impossibility. To make matters worse, hospital visits for these trans people often led to particularly cruel, inhumane treatment. For decades, BIPOC gender variant kids had been systematically excluded from the medical project of intersex and trans care. Doctors routinely misdiagnosed Black and brown trans people with schizophrenia, which led to their institutionalization in psychiatric facilities. Authorities cited these people's dysphoria as reason to keep them confined indefinitely (Gill-Peterson, 2018). This practice can be situated in a long history of eugenics and of healthcare systems acting as an arm of the state to pathologize Blackness. In this case, the medical system's racialized policing of gender directly pushed Black and brown trans people into carceral systems.

When trans healthcare was later expanded, BIPOC trans patients were only reluctantly given gender related care when doing so served the original eugenic goal of upholding the dominance of White bourgeois society. For example, in 1970, John Money received a letter from a doctor in Ohio seeking advice for how to treat a Black teenage trans girl who had been hospitalized after a suicide attempt. Money recommended that the doctor "rehabilitate him [*sic*] as well as possible as a homosexual." Surprisingly, Money also suggested estrogen therapy. His explanation demonstrates that his intentions were not to affirm the patient's gender but rather were motivated by racism:

> The advantage of estrogen for the extremely effeminate homosexual is it gives him [*sic*] the breasts he wants. From my point of view, the great advantage is that it's also a functional castrating agent which has tranquilizing effect on behavior in general. (Cited in Gill-Peterson, 2018, p. 186)

Money's denial of the patient's transgender identity despite the fact that she had already been diagnosed as "transsexual" demonstrates how race excluded BIPOC trans people from the mere possibility of medical recognition of their gender variance. Money had no intention of affirming this patient's gender. His suggestion of prescribing estrogen as a "castrating agent" reveals the legacy of eugenics that continued to drive his work.

While Black and brown trans people faced this hostility in hospitals, they faced violence of a different sort in the streets of American cities. Many BIPOC trans women who faced discrimination at the intersections of race, class, and gender identity found themselves living in urban areas characterized by sex-work economies and corrupt police activity. Often in violent and humiliating ways, police officers especially targeted “street queens,” as these trans women were called, because of their lack of social power to resist this maltreatment. Throughout the 1960s, tension between the police and trans communities fighting for the right to safety from state-sanctioned harassment erupted in a series of uprisings through cities across the country. The most famous of these uprisings occurred the early morning of June 28, 1969 when police began arresting patrons of New York’s Stonewall Inn. Stonewall was a popular gathering place for a diverse community of queer people, BIPOC people, and others rejected by mainstream society. Although police raids of the inn’s bar were common, on this particular night, built-up bitterness toward corrupt police activity escalated until the police were violently attacking Stonewall patrons who resisted fiercely. The people overwhelmed the police officers, causing them to have to barricade themselves inside the inn as they awaited reinforcements. The “Stonewall Riots,” as they came to be known, lasted for days and inspired countless people to mobilize in community action (Stryker, 2017; Varga et al., 2019).

Facing transphobia even within the newly galvanized gay and lesbian movements that developed after Stonewall, two community members, the famed Sylvia Rivera and Marsha P. Johnson, responded by founding Street Transvestite Action Revolutionaries (STAR), a home that provided food, safety, housing, and other basic needs for trans youth. The harassment that came with living in New York as Black and brown transfeminine people was a lived reality for Johnson and Rivera. They provided services in the streets so that they could offer trans youth the care that they did not have growing up (Gill-Peterson, 2018; Stryker, 2017). For these trans people inhabiting the streets of American cities, the gender affirming healthcare that was starting to be offered in hospitals was out of the question. However, because bodily safety was on the line, this offering of basic needs at STAR constituted a different kind of community trans health work. In reality, BIPOC trans women, who faced marginalization even in queer and trans spaces, had long been caring for each other in ways that kept each other alive and safe. Rivera and Johnson's STAR formalized this work of community healthcare run by communities themselves.

Trans Healthcare before 1980: A Story of Resilience

Although medical systems are supposed to serve the patient, the history of medicine too often reveals that they have a different agenda. The current transgender healthcare system draws its roots from the eugenic project of reinforcing the hegemonic culture of White, heterosexual society, particularly the gender binary of man/woman. As research progressed, these medical professionals were backed by extreme social power because they were the only ones able to provide the care that trans people so direly needed. Given the motivations of this medical work, it comes as no surprise that the trans people who sought gender affirming care in the early and mid-1900s faced rejection and violence.

Despite this hostility, it would be incorrect to view early trans people as mere victims of the oppressive medical system. From Bernard and Agnes, who adeptly navigated the system to demand the attention of doctors and ultimately get care, to Reed Erickson, who funded the majority of early major gender clinics, trans people have always been active in their pursuit of affirming care (Gill-Peterson, 2018; Stryker, 2017). Vicki and the multitude of others who wrote to Benjamin's practice show that the real experts on the medical needs of trans people are trans people themselves. Outside of medical institutions, BIPOC trans women, who faced intersecting marginalization, took the health of their communities into their own hands with selfless collectives like STAR. These specific trans figures stand out in history not only because of their resilience but also because there just happens to be documentation of their experiences and work in the incomplete archives, which overrepresent affluent, White patients (Gill-Peterson, 2018).

There were no doubt countless other trans people whose self-awareness, creativity, and resilience were not captured in the archives but live on in our imaginations.

In 1980, the *Diagnostic and Statistical Manual of Mental Disorders, Third Edition* listed "Gender Identity Disorder" for the first time, thus formalizing the pathologization of transgender identity and legitimization of trans medical care (APA, 1980). The subsequent formalization of care systems in the following decades has made accessing gender affirming care somewhat easier for many trans people. However, for those whose experiences do not fit the transnormative narrative, such as non-binary people and BIPOC trans people, obtaining wholistic gender recognition in medical spaces is still a challenge. These individuals continue to exist at the margins of even the transgender community. In contrast to previous research on trans health, this study specifically explores the experiences of non-binary individuals seeking gender affirming care. In particular, it illuminates how when facing barriers to care, non-binary people today are guided by the precedent of trans resilience that was set in the early and mid-20th century.

Methods

The data were obtained from 18 in-depth interviews with non-binary people from across the United States. Subjects were eligible for participation if they self-identified as a gender under the non-binary umbrella, had accessed or attempted to access gender affirming healthcare, and were 18 years old or older. A protocol (#2020-12-13883) was submitted to UC Berkeley's Institutional Review Board to ensure ethical interactions with human subjects. Due to the lack of a clear sampling frame, to identify respondents, the study employed a targeted personal network sampling technique, which combined snowball sampling and targeted sampling (Spreen & Zwaagstra, 1994). Initial participants were identified through personal networks and an online forum. In order to target respondents from different backgrounds, these initial participants were chosen from a set of diverse geographic locations. At the end of interviews, participants were asked to identify contacts who fit the study criteria from within their networks. Once consent was obtained, emails from these new contacts were shared with the principal investigator, who reached out to them directly to schedule interview times.

Figure 1: Interview Questions

- Tell me your story of accessing gender affirming care.
    - Tell me more about when you first started considering it.
    - Tell me about your decision to move forward with it.
    - Tell me how it’s going currently.
- What have your interactions with doctors been like? What about with nurses and other staff?
- Tell me more about the challenges you have had in accessing gender affirming medical care.
- Tell me more about the positive experiences you have had in accessing gender affirming medical care.
- Can you tell me about the people, systems, or strategies that were most crucial to accessing care?
    - First, tell me about your own personal strategies that were most helpful in accessing care.
    - Tell me about the people who aided you through this process.
    - Did you rely on any systems or organizations to help you access care?
- As you look to the future, how do you envision the future of your journey with gender affirming care?
    - Are there more medical interventions that you want to pursue in the future?
    - How do you plan to access them?
- What suggestions do you have on how to improve or redesign the healthcare system to provide better gender affirming care to non-binary people?

To capture the complexities of the experiences of the respondents, data were collected in the form of narrative-focused interviews. Interviews were held over Zoom and lasted between thirty minutes and one hour each. Audio and video files of the interview sessions were recorded so that they could later be transcribed by the principal investigator. The interviews were loosely guided by questions (Figure 1) but structured as a conversation. Participants were not compensated. Due to the sensitive nature of the topic, participants were informed of their right to decline to answer any question or to stop the interview at any point.

Interviews were transcribed and coded using a template analysis approach in the qualitative data analysis software MAXQDA2020. After an initial reading and cleaning of the transcripts, a code tree template was constructed. This template was applied to the first nine interview transcripts, and using information from this coding process, it was revised to create the final code tree. This code tree was then applied to all eighteen transcripts (Brooks et al., 2015).

In order to honor the diversity of experience and language used by the participants, the analysis used a thematic approach instead of statistical methods. Statistical strategies such as word frequency counts can be reductionist because they overlook how the same language can have distinct meaning depending on context (Riessman & Lee, 2005). In particular, the language used to describe non-binary experiences can be very individual. For example, even the term "non-binary" was not universally used by all participants, although this study treats it as an umbrella term to describe everyone whose gender identity does not fit the male/female binary. Even without using these statistical methods, summarizing and analyzing qualitative data can still obscure the original meaning of personal narratives because it filters it through the interpretation of the researcher (Riessman & Lee, 2005). In order to offset this effect, direct quotations from the interviews were used as the basis of the results. Quotations were minimally edited for clarity and readability (i.e., removing repeated words, “um’s,” and “like’s”).

Results: Current Barriers to Affirming Care and Responses

Eighteen non-binary participants were interviewed over the course of three months from January to March 2021. The interviews were analyzed using a template thematic analysis approach (Brooks et al., 2015), which generated a final code tree with the following four main branches: (a) *barriers to accessing affirming care* (e.g., insufficient availability of providers, unnecessary steps, cost and insurance, long wait times), (b) *facing transphobia while accessing care* (e.g., lack of research and training, transphobia in interpersonal interactions, transnormativity and the medical model), (c) *individual-level strategies* (e.g., self-advocacy, becoming a healthcare expert, performing binary identity, avoiding healthcare settings, alternative affirming care), (d) *external support* (e.g., informal support systems, institutionalized resources).

Demographics

Participant demographic information is summarized in Table 1. While all participants identified with a gender under the non-binary umbrella category, 16 (88.9%) identified with the term “non-binary.” Many participants used multiple terms to define their genders. The sample included some participants who used terms specifying their position in relation to masculinity and femininity, such as three (16.7%) transfeminine, three (16.7%) woman, two (11.1%) transmasculine, and one (5.6%) femme participants. Eight (44.4%) participants exclusively used they/them pronouns, seven (38.9%) used a mix of they/them and she/her or he/him pronouns, three (16.7%) used only she/her or he/him pronouns, and one (5.6%) participant used the

Table 1: Participant Demographics ($N = 18$)

	n (%)
Gender	
Non-binary	16 (88.9)
Transgender	5 (27.8)
Genderqueer	4 (22.2)
Transfeminine	3 (16.7)
Woman	3 (16.7)
Transmasculine	2 (11.1)
Androgynous	1 (5.6)
Femme	1 (5.6)
Genderfluid	1 (5.6)
Pronouns	
they/them	8 (44.4)
she/they	3 (16.7)
she/her	2 (11.1)
fae/femme, they/themme	1 (5.6)
he/him	1 (5.6)
he/they	1 (5.6)
they/he	1 (5.6)
they/she	1 (5.6)
Race	
White	9 (50.0)
Asian	3 (16.7)
Multiracial	3 (16.7)
Black	2 (11.1)
Middle Eastern	1 (5.6)
Age	
19-24	7 (38.9)
25-29	3 (16.7)
30-39	6 (33.3)
40+	2 (11.1)

Note: Gender, pronouns, and race reflect participants' self-descriptions. Multiple participants identified with more than one gender.

neopronouns fae/femme and they/themme. The sample included nine (50.0%) White, three (16.7%) Asian, three (16.7%) multiracial, two (11.1%) Black, and one (5.6%) Middle Eastern participant. The three multiracial participants identified as Black/White, Filipina/White, and Asian/White. The three Asian participants further identified as South Asian, Chinese, and Southeast Asian or Indonesian. The ages of participants ranged from 19 to 42 with a mean of 29.5 (*SD* = 7.8) and a median of 26.5.

Barriers to Accessing Affirming Care

All participants faced barriers to accessing gender affirming healthcare to varying degrees. Some struggled to find local providers with availability to take new patients. Others had to complete long lists of tasks before being able to see a provider. Many participants were unable to access affirming care due to high costs or insufficient insurance coverage. The result of these barriers was that many participants endured long wait times before finally being able to access crucial care.

Insufficient Availability of Providers

By the time participants sought out medical gender affirming care, even though they often reported that they knew exactly what care they needed, bureaucratic and gatekeeping medical systems made accessing this care difficult. Many participants struggled to find trans affirming care providers who were taking new patients. This was especially difficult for those living outside of urban centers. One participant, a student in Vermont seeking top surgery, exhausted the options for surgeons in the state and had to expand their search:

> There are like two surgeons that did top surgery in Vermont, and those are like super recent, and so I tried to do one there, and I hated it. It was so many red flags. I just got a really weird vibe from them. It was like a plastic surgery office that you could also get lip fillers at. Also, the other surgeon there, … you had to have three different letters, one from a PhD or higher mental health professional. I didn't have that. My therapist was just a licensed social worker, so I was like that's ridiculous because it would take me like

> three months to get that letter first of all, so I ended up like looking out of Vermont. (19-year-old White non-binary person)

Participants seeking gender affirming surgeries often had to wait many months just to have an initial consultation appointment. Another participant planning top surgery had a call with Dr. Scott Mosser, a well-known and sought after surgeon in San Francisco:

> It wasn't great just because I think he's just so busy. He's just like "I'll see you at surgery. I know what you're after." Yeah, like I talked to Mosser for like five minutes and he wished it had been three. Yeah, and good for him, like he's doing great work, and that's cool. I have no issue. It just didn't make me feel super comfortable. That's not what I needed to feel like I could go with him. (38-year-old White non-binary and genderqueer person)

Many participants echoed these sentiments of struggling to navigate a system that does not have enough available providers that offer gender affirming care. Those who felt strongly about having surgery done with experienced, well-rated doctors sometimes had to book surgery appointments years in advance with doctors far from where they lived.

Unnecessary Steps

Other participants had to navigate many tasks (e.g., acquiring multiple letters, obtaining a Gender Dysphoria diagnosis, completing orientations), which greatly slowed down the process of accessing affirming care. For some, these hoops included resolving medical abnormalities completely unrelated to the care they sought, such as one participant who was not approved for top surgery because of an irregular pap smear. Others were subjected to the arduous and costly process of obtaining multiple letters of approval to send to insurance companies. One participant had insurance through Kaiser, which required that they complete an orientation and the following process:

> The orientation should have been like, if you can prove certain knowledge that you have, it should not have been mandatory... It was more for the parents than it was for like the actual people who are getting the services. I had to do that before I could even set up a therapy appointment for my first evaluation, but they only do those once a month in

> Southern California so like, okay, well I have to wait a month for this. Then I had to wait three weeks to make a therapy appointment, and then wait another three or four weeks to see them again. Then I have to wait for the sign off. Then I can make my [surgery] appointment. So, it was like a lot of wasted weeks where I'm just waiting for the next step. (37-year-old multiracial non-binary and androgynous person)

For most participants, these extra appointments with mental health professionals did nothing but confirm what they already knew: that surgery was the next step in their healthcare journey. Some participants paid to see providers because of their PhD degree, but "it was just so obvious that she just didn't know anything about trans people because she's learning from me, and I'm like I had to get a letter from her" (22-year-old White non-binary person). The complicated and laborious process of obtaining medical approval for care presented a major obstacle for many participants.

Cost and Insurance

Many participants delayed or ruled out certain gender affirming care options because they were cost prohibitive. One participant had experienced dysphoria their whole life but was unable to transition until their 40's because care was too costly to access while uninsured. Even for those with insurance, high costs presented an extreme burden. Insurance companies often did not cover participants' appointments with letter-writing specialists, so participants had to pay between $200 and $300 out of pocket per session. Multiple insured participants had "wish lists" of procedures they knew they wanted but could not afford at the moment. Others had to save for long periods of time or rely on community financial support to afford gender affirming care. Some who were more able to deal with the dysphoria decided to not pursue care that would be affirming to them, like one participant, who shared, "I basically ruled out top surgery because, it's largely because of money." They further elaborated, "I have to feed myself. I have to maintain my car. I have to pay for somewhere to live" (22-year-old Asian non-binary, genderqueer, and genderfluid participant). For this participant, who was approaching a time in their life when they might lose insurance coverage, accessing gender affirming care was very important. However, if faced with a choice between continuing care and securing basic needs, for this participant the choice was obvious.

When making claims to insurance companies, participants often received response letters informing them that their insurance had denied coverage. Insurance companies used a variety of justifications, causing one participant to feel like they were "just trying to find reasons to get me rejected" (22-year-old White non-binary person). Many patients were denied because their care was characterized as elective and motivated by vanity rather than medical necessity:

> I had to fight with my insurance company. In the final appeal, I had a hand micro surgeon tell me that electrolysis isn't medically necessary even though I just presented tons of scientific data saying it is for transfeminine people. He said there's no way that it would even prevent any violence, and that's one of the least true things ever. And so, I've been paying for that myself. (42-year-old White non-binary, transfeminine person)

Multiple participants were similarly denied insurance coverage of permanent hair removal. As seen in this example, these denials and claims that hair removal is not medically necessary went against current medical research findings (Dubov & Fraenkel, 2018; Grzanka et al., 2018). In addition to causing financial burden, insurance denials increased gender related mental health challenges. For one participant, this experience contributed to a long history of harmful experiences of transphobia:

> There's a letter that I got from the insurance that said I got denied because "testosterone is not proven safe or effective for females." The insurance definitely contributed to that experience [of dysphoria]. It just felt like it hammered home the negative beliefs I already had about myself, which was that I was basically like this weirdo, freak show, zoo animal who is unlovable. (22-year-old White non-binary person)

Long Wait Times

The consequence of the lack of availability of care providers, unnecessary required steps, high costs, and inadequate insurance coverage was that many participants experienced extreme wait times for gender affirming care. Even participants who planned for lengthy processes were shocked by just how long systems made them wait before they could finally access care. For many, these wait times contributed to and prolonged serious mental health challenges caused by dysphoria. For example, one participant who was seeking testosterone treatment shared “I had to wait a few months later than I was hoping to, and in the throes of dysphoria I was just desperate to get on it, so it was like three months of just unnecessary suffering” (22-year-old White non-binary person). Similarly, another participant who was trying to access estradiol (i.e., the estrogen hormone taken by some trans people who seek feminizing therapy) shared, “I felt like if I don't start estradiol, then I would rather just kill myself, if I'm going to be not allowed on it” (42-year-old White non-binary, transfeminine person). As illustrated by these two participants, wait times were not just a mere inconvenience; they instead exacerbated the suffering and even suicidality caused by dysphoria.

Facing Transphobia While Accessing Care

Even once participants were able to access healthcare, this care was often not completely affirming of their genders and needs. Some found that their care was limited by the lack of medical research on trans and non-binary health. Many others felt that their providers were not properly trained on how to care for transgender patients. As a result, participants faced misgendering, deadnaming (i.e., referring to a trans person by a name they no longer use), gender essentialism, transmisogyny, and other interpersonal acts of transphobia at the doctor’s office. Participants also reported that their healthcare was limited by both transnormativity and the medical model of transgender identity, which imposed transition timelines and further requirements for care on participants.

Lack of Research and Training

Participants expressed frustration that there was not sufficient research on trans health outcomes, leaving them feeling like they were “experimenting” in “uncharted waters” (39-year-old White transmasculine, non-binary person). One participant shared her frustration at the impact of lack of research on hormones:

> The fact that spironolactone is the only testosterone blocker available in the US, even though it is terrible, and there are better testosterone blockers out there, and the US just doesn't want to approve them because it's not cost effective for the medical industrial complex is really frustrating… The only thing that providers have ever shared with me about progesterone is that there's negative health outcomes, but the negative health outcomes that they're all referring to are based on a study from the 1990s that was on postmenopausal cis women that used a completely different form of progesterone than what is prescribed to trans women. And that's been across the board. Not a single doctor has ever recommended progesterone to me. (25-year-old White non-binary, transfeminine person)

In short, participants, especially those with extensive knowledge on trans health from personal research or social networks within the trans community, were frustrated that doctors based their care recommendations on outdated studies or studies with small sample sizes. This lack of prioritization of research on trans health limited care options such as hormone choices and left participants feeling like the medical system was unequipped to care for them.

Participants also often found themselves being cared for by providers who may have read the WPATH Standards of Care but had little knowledge of the lived experiences of transgender people. Some were not even up to date on the minimal published research on trans healthcare. If providers did have experience working with other trans patients, it was often only with binary transgender patients. Thus, many participants felt that their doctors were especially ill-equipped to provide care specifically affirming their non-binary identities. One participant was able to discover her transgender identity with the help of a therapist, but because the therapist never brought in conversation about genders outside the binary, she had to independently "put two and two together to figure out" her non-binary identity (23-year-old Southeast Asian non-binary, transgender woman). As a result of this lack of proficiency in caring for non-binary patients, many participants spent appointments explaining their identities and the medical care they sought to doctors. This was especially frustrating for participants who saw doctors who called themselves "trans-affirming:"

> So much [is] me going into my doctor's office saying "hey, here's this thing that I heard from other trans folks and then thoroughly researched. What do you think about this?" And then they do their own research and realize that I'm right. But in my head, I'm like *you should have already known that if you consider yourself a trans-affirming doctor*. (25-year-old White non-binary, transfeminine person)

The burden of explaining oneself was especially heavy for participants who experienced marginalization at the intersection of gender and race. One South Asian participant shared the following:

> I also just have past trauma around doctors, mainly White doctors, so I think that definitely factors in. It's not mistrust, but definitely, you know, hesitating or understanding that if I go to the doctor's office, I want to explain my whole story, but I'm worrying if I can trust them with my whole story, if they want to understand holistically. (23-year-old South Asian non-binary, transfeminine, trans woman)

Health systems' ability to offer affirming care was hindered both by the overall lack of research on trans health and by providers' lack of training and knowledge of the diversity of trans identities. The consequences of this were especially detrimental for participants of color.

Transphobia in Interpersonal Interactions with Providers

Due to the lack of trans-affirming health professionals, participants throughout the sample faced transphobia in interactions with providers. The majority of participants experienced misgendering or deadnaming in healthcare settings. For six participants, this even occurred while they were accessing care specifically meant to affirm their genders. Although all cases of misgendering and deadnaming were harmful, participants were especially shocked and dismayed when they occurred in these situations. For example, one participant shared the following about picking up hormones:

> It just kind of feels a little bit ironic. I'll go in, and I'll be like “I'm here to get my testosterone.” Like I said the word “testosterone,” and they’re still like “she, she's here for…” I'm like, “I just said…! Did you hear what I just said?!” It's a small thing, … but at the same time there’s this sort of [feeling] like *I want to go home. I don't want to be here anymore.* It makes it difficult to keep doing it. (22-year-old Asian non-binary, genderqueer, and genderfluid participant)

As this participant explained, even though misgendering is a common microaggression that many transgender people face on a regular basis, when it occurs in medical settings, the discomfort it causes is yet another barrier to accessing affirming care.

Another setting where participants could almost predict transphobic interactions was at the gynecologist’s office. Many participants expressed extreme discomfort with the gendered nature of these clinics:

> You're sitting outside awkwardly, you know, with pregnant ladies, just like *what am I doing here?* You know that feeling that you're out of place, or that people don't take you seriously because you don't have a penis? Like it doesn't register for them that you're a dude, you know, so they keep saying “she, oh sorry, he” and then say it again. It's like, “oh, you don't have a penis I can’t compute.” (34-year-old Middle Eastern non-binary and trans person)

Because of the construction of gynecology clinics as “female health” and “women’s” clinics, many transmasculine participants entered already feeling like they did not belong. After interacting with providers, participants felt that this hesitance and wariness was warranted because gynecologists indeed often failed to recognize or affirm their trans and non-binary genders. Due to the nature of their work with the “female reproductive system,” doctors failed to overcome gender essentialism based on genitalia. Some participants, especially young participants, also expressed concern that gynecologists would not trust them to make decisions about their own bodies. For example, a 19-year-old participant feared that the gynecologist would patronizingly tell them they were too young to know they wanted a hysterectomy. The consistent misgendering and lack of recognition of trans identities made the gynecologist's office a hostile place for many participants.

When transfeminine participants accessed gender affirming care, they faced an added layer of transmisogyny in addition to general transphobia. One transfeminine participant shared the following:

> When I first went to get hormones, my doctor said something along the lines of "I never would have known you were transgender." … Then [she] asked me why I wanted hormones, and I was like "oh I just kind of want to feminize my features a little bit, get some boobs maybe." And she was like, "well, you're already so pretty." I was like, *what are we doing here?* (25-year-old White non-binary, transfeminine person)

The doctor's comments on this participant's appearances demonstrate that she was not motivated by providing care that would affirm the participant's gender. Instead, she assumed that the reason the participant sought to transition was to pass as cisgender and fulfill socially determined beauty standards. Instances of transmisogyny like this showed that transfeminine participants faced unique challenges due to their identities at the intersection of transness and femininity.

Transnormativity and the Medical Model

Even though no participants expressed having an end goal of "completely transitioning" to a new gender, many participants felt pushed towards medical transition plans that followed this transnormative narrative. In reality, some participants were content not even knowing what their transition end goal was. One participant shared "when I get to the point where I'm happy, I will know it and feel it" (37-year-old multiracial non-binary and androgynous person). However, many participants who wanted to transition on their own timeline faced challenges from medical systems that attempted to enforce binary expectations on them. For example, multiple participants who sought top surgery faced judgement and barriers from primary care doctors, surgeons, and insurance companies that told them that they did not qualify because they were not on testosterone. Other participants were not even made aware of all of the options for their transition. For example, one participant recounted the following about her experience when she started hormones:

> At the beginning of the transitioning journey, I was young and not sure what to do in terms of transitioning. Because my body dysmorphia and gender dysmorphia [*sic*] had been such a prevalent issue in my life, I [was] just like *okay I have to take hormones*. They [the doctors] immediately directed me, "yes, you have to take estrogen and anti-androgen," whereas I feel like my preferred approach looking back, I would have started with anti-androgen first and not taken estrogen to see where my hormones levels are, see what changes my body faces. But I was just immediately directed to estrogen and anti-androgen. "This is like a packet, like a done deal. Because like all trans women go through this if they're undergoing hormone replacement therapy." That's not always the case. At this point I feel like I now don't have the option to only see what my body would do if I only take the anti-androgen. (23-year-old Southeast Asian non-binary, transgender woman)

Participants like this expressed frustration that doctors encouraged transnormative binary transitions instead of giving patients the options to make decisions for themselves. This was especially harmful for participants at the beginning of their transitions when, beside medical providers, they had few sources of knowledge about care options. By limiting participants' self-determination in the transition process, doctors failed to offer care that genuinely affirmed non-binary participants' experiences and needs.

Although participants were seeking out medical gender affirming care, they resented when care providers reduced their experiences to their medical transitions. Some participants expressed that they wished for doctors to break out of the medical model of transgender identity:

> Not just giving me care but giving me *trans* care was important to me. Like, I need you to understand that this is a part of my life and not just oh yeah, you're going to give me testosterone. (37-year-old multiracial non-binary and androgynous person)

It was not enough for doctors to simply have medical knowledge and be able to write prescriptions. “Trans care” required an understanding of the importance that trans identity plays in participants’ lives outside of the medical experience of transitioning.

Other participants were frustrated by the medical model’s overemphasis and strict definition of dysphoria. One participant shared the following about her upcoming bottom surgery:

> Societal dysphoria is inflicted on us based on the years and years of gender-based trauma… Outside of that context, like I don't think that I would have the discomfort with my penis that I do. And I eventually realized that it's okay if my discomfort with my body comes from society. It doesn't have to be primarily from my own brain hole that discomfort is originating for it to be valid for me to want bottom surgery. [But] under the old rules, specifically where you had to basically say that you've always hated your penis since day one in order to get bottom surgery, I wouldn't qualify for bottom surgery, and that's bullshit. (25-year-old White non-binary, transfeminine person)

This participant recognized that a significant portion of her dysphoria was generated by interactions with oppressive social norms. The medical model of transgender identity, however, assumes that dysphoria is innate, and the participant therefore felt like traditional medical providers considered her need for bottom surgery to be less genuine. Because of the complicated nature of dysphoria and its interactions with social norms, multiple participants expressed a wish for care to focus on affirming their genders rather than treating dysphoria. For many participants, healthcare was limited by transnormativity and by the medical model of transgender identity because it failed to recognize the diversity of needs and experiences of transgender people.

Strategies and Support Systems

Despite facing challenges at various stages of interactions with medical systems, the participants all succeeded in accessing at least some level of gender affirming care. When facing barriers that were erected in front of them, they relied on both individual-level strategies and external support and resources when available. For most participants, a combination of these strategies and support systems is what ultimately led them to be able to access affirming care while also doing their best to protect their own safety.

Individual-Level Strategies

Participants modified the ways they personally interacted with healthcare systems in order to both access better care and to lessen the possibilities of violence. For some, these strategies included tirelessly advocating for themselves and becoming an expert on transgender healthcare to better be able to convince doctors to support their care. Another strategy that many participants employed was performing binary gender while at the doctor's office. Finally, some participants who felt especially unsafe in traditional healthcare settings avoided them when possible and instead sought out alternative gender affirming care. These individual-level strategies were effective to differing degrees for participants, but they all put the burden of accessing affirming care on the participants.

Self-Advocacy. Almost every participant in the sample used consistent self-advocacy to access affirming care that was not made easily accessible to them. Many participants proudly self-described themselves as "pushy" (37-year-old multiracial non-binary and androgynous person), "stubborn" (20-year-old Black non-binary, femme participant) and "hard-headed" (22-year-old White non-binary person). This ability to be a self-advocate relied on persistence that happened to come naturally for many participants. For example, one such participant described their process of scheduling surgery in this way:

> As soon as I knew that the doctor's office had sent stuff to my insurance, I called my insurance the next day and said, "I need you to fast-track this. I'm going to call you in 72 hours and make sure it's pushed through." As soon as that happened, I called the doctor's office and was like, "let's go, let's go!" Like, I was as on top of it as you can possibly be, and I'm a project manager by profession, so this was very easy for me to do. But that was very necessary to getting things done. (35-year-old White non-binary person)

This participant used their professional project management skills in order to ensure they could access the gender affirming care they needed. Other participants echoed the sentiment that if they had not forcefully made sure that care providers were completing their steps in the care process, they did not think they would have been able to access gender affirming care.

Another way that participants advocated for themselves was by refusing to settle for providers who did not affirm their genders. Many participants who experienced transphobia from care providers were quick to replace their doctors. One participant shared that after a doctor refused to prescribe hormone therapy, "I fired him" (42-year-old White non-binary, transfeminine person). By refusing to be cared for by providers like this, participants challenged the traditional power structure that places doctors over patients. Another participant vetted six primary care providers and 15 mental health specialists to make sure that they would be affirming to their gender. Self-advocacy was an effective strategy in accessing care and finding affirming providers, but it required a persistent personality and came at the high cost of additional labor and cognitive resources from participants.

Becoming a Healthcare Expert. By thoroughly researching care options and becoming an expert on transgender healthcare, participants were able to access types of affirming care not readily offered by providers. This strategy required a level of mistrust in doctors and healthcare systems that participants had to varying degrees. For participants who identified as Black and brown, this mistrust felt more innate. One Black participant knew to be wary of healthcare systems because they had grown up "hearing so many stories of being mistreated as a Black person in healthcare" (20-year-old Black non-binary, femme person). For other participants, this mistrust was learned. One White participant, explained it as follows:

> I was always taught doctors know everything, and you always trust doctors… There was this learning curve in acknowledging that I couldn't trust doctors, that they didn't know the best about trans care, and that it was okay if I found information that ran contrary to what they were telling me, and that it was more likely that they were wrong and I was right, which is not something I ever thought could be the case growing up because I just assumed that they knew everything. (25-year-old White non-binary, transfeminine person)

After developing this mistrust in healthcare professionals, participants realized that doctors would not give them the best or the most complete care options. Instead, they chose to do their own research on trans healthcare.

This research included gathering information from a variety of different sources. Almost all participants relied on anecdotal information from the trans community, but many went further to become experts in the medical field of transgender care. Participants read medical journal articles, watched conference lectures, and learned the medical terms to describe their care. Armed with this knowledge, participants were able to predict and prepare responses to the reasons that their providers used to deny care. Because of their expert knowledge, participants arrived already one step ahead of providers. This process of becoming an expert in trans healthcare and leveraging this knowledge was easier for participants who had formal educational backgrounds or career experience in healthcare. For example, one participant shared the following:

> I started talking to my primary care person about progesterone, and it took six months of fighting with her and using her own logic of how they understood evidence-based medicine against them. I'm a scholar in the health sciences, and I know how to do that

> stuff. I know all of the limitations of our literature as well. I teach this stuff. (42-year-old White non-binary, transfeminine person)

This participant held a doctorate and worked in the healthcare field, which gave femme the skills to fiercely advocate for femmeself at the doctor's office. For many others without this background or without the time to devote to researching trans medicine, this strategy of becoming a medical expert was not feasible.

Performing Binary Identity. Because of prior experiences, almost half of participants code-switched to perform binary gender identity in an attempt to access better treatment. Given that many trans healthcare systems are set up to serve binary transgender patients, a number of participants felt like allowing healthcare providers to assume they were binary transgender decreased the barriers to affirming care that they faced. Especially while accessing healthcare that was not specifically gender affirming, many hoped that performing binary gender would lead to fewer instances of violence within healthcare spaces. For example, one participant shared the following about going to the dentist:

> Every time I have to get to the dentist or those follow up visits, I always feel the pressure to present extra feminine, like wearing a dress in really cold weather and doing my makeup and hair just to go to the doctor's office. I feel like if I present hyper-feminine, then they can at least question it before deadnaming me and misgendering me. But that's not who I am, and I don't feel affirmed in that. (23-year-old Southeast Asian non-binary, transgender woman)

This strategy was uncomfortable for many who, like this participant, did not feel affirmed in binary presentation. However, for this participant, who used she/they pronouns, code-switching to binary performance was necessary to decrease the possibility of being misgendered and deadnamed. In contrast, for others who used exclusively they/them pronouns or neopronouns, performing binary identity led to more instances misgendering. Despite this, they continued to use this strategy not only to access better care but also to protect their safety. This added consideration of safety was especially important to transfeminine participants who feared being the victims of transmisogynistic violence. One participant explained “I make myself look as passively femme as possible because for me, the only thing that passing means is that it's helping to protect from violence” (42-year-old White non-binary, transfeminine person).

Avoiding Healthcare Settings. Another way that almost half of participants kept themselves safe from violence in healthcare settings was by simply avoiding care when possible. While some participants even avoided gender affirming care in order to minimize interactions with healthcare systems, more participants delayed or refused preventative healthcare or care to treat conditions unrelated to gender. Many expressed that they knew that this strategy was detrimental to their health and that they were due for certain elements of healthcare. However, especially for BIPOC participants and those with past trauma with care providers, entering healthcare spaces was sometimes not worth it. One Black participant explained:

> I have a mindset where if I'm not like on my deathbed, I just will not go to a doctor. I'm usually afraid of debt, and also nearly every Black woman’s story that I've heard in hospitals never go[es] well. And then factor in the fact that I'm queer, and how they over saturate the words like “mom,” or [words for] genitalia. And it makes me so uncomfortable! (20-year-old Black non-binary, femme person)

Alternative Gender Affirming Care. Some participants who ruled out care from medical systems accessed or expressed plans to access alternative care completely outside the medical model’s definition of gender affirming care. One participant who generally tried to minimize all engagement with healthcare systems, explained “Getting tattoos is like a gender affirming care just as much as going on hormones for me” (23-year-old multiracial trans, non-binary woman). This expanded definition of care demonstrates the diversity of ways that trans people can affirm their genders and make themselves comfortable in their bodies. Similarly, the previously described participant, who avoided healthcare systems due to their history of violence towards Black women and queer people, planned to seek care for their future pregnancy and birth outside of the hospital setting:

> I need a Black queer doula and a Black queer midwife on my team, and a Black and/or queer psychiatrist. Basically, checking off all my boxes on my birth team for when I finally decided it's time for me to have a child. (20-year-old Black non-binary, femme person)

Rather than modifying themselves to fit or fighting their way through eugenic healthcare systems, these two participants chose to pursue gender affirming care outside of the medical model of transgender identity.

External Support

In addition to employing individual-level strategies, participants also relied on external support to navigate healthcare systems. Some of these external supports were informal and based in participants' relationships with family, trans friends, and online community. Other participants had access to institutionalized resources, like queer-serving clinics, university health centers, and other health organizations operating outside of the traditional healthcare system. In contrast to individual-level strategies, which required participants to modify aspects of their behaviors to access affirming care, these external support systems facilitated access by taking some of the burden off of participants themselves.

Informal Support. In addition to working their way through bureaucratic and hostile systems on their own, participants also relied on informal support systems. Those with supportive family members leaned on them for financial support and in confrontations with insurance. This was especially true for younger participants, like one 19-year-old participant who explained the following about financing surgery:

> I was privileged in the fact that my parents would pay for it basically no matter what, like obviously not like [an] insane amount of money, but if I chose the surgeon [who] was

> more expensive, I would still be able to go to them. (19-year-old White non-binary person)

In reality, having support from family members as this participant did was rare within the sample. More participants had strained relationships with their parents, so they instead relied on support from other trans community members. In fact, all 18 participants cited the trans community as an important support system both emotionally and in accessing gender affirming care. Participants who did not already have strong connections with the trans community went out of their way to build them. For example, one participant shared the following:

> It did involve at times reaching out to people who I kind of only knew in passing, but we were Instagram friends or something. Sort of like "hello, remember that time we met five years ago? Let me ask you a very personal question." (39-year-old White transmasculine, non-binary person)

From planning care to recovering from surgeries, support from other transgender people with similar experiences was crucial to participants at all steps of medical transition processes. Some participants were not aware that they could pursue gender affirming care as a non-binary person until they had a friend who underwent it. They described thinking “you can do that?” (35-year-old White non-binary person) during this moment of realization. When exploring care options, many participants went to trans friends rather than asking healthcare providers because they felt that they could trust community members with lived experiences more than the healthcare system. This was how some participants learned about types of affirming care that differed from the transnormative plan, like micro-dosing hormones and getting top surgery without being on testosterone. One participant taking estradiol shared that while uninsured, she “turned to trans friends for extra pills that they are not using” (23-year-old Southeast Asian non-binary, transgender woman). Many participants also found care providers through recommendations from other trans people. In particular, when choosing surgeons, a number of participants relied on a website called transbucket.com:

> It's like people posting before and after results, people rating different surgeons. You can click on a surgeon's name and [see] all of the people who have written about that surgeon and how they identity and how the healing process was. It's just like swapping a lot of information that I couldn't find that concentrated anywhere else. (38-year-old White non-binary, genderqueer person)

Transbucket.com, which is powered by the posts of trans people who have accessed gender affirming care, collects testimonials and doctor recommendations so that people can easily access the resource of trans community knowledge. In sum, the trans community was crucial to participants feeling like they were not alone, obtaining hormones when they were not available, and accessing knowledge about affirming care.

Institutionalized Resources. In addition to the challenges that participants faced, many also had positive experiences with doctors and institutions that were affirming of their genders. Participants who lived in large cities or had access to university health programs were most able to find affirming care. Multiple participants in New York received healthcare from Callen-Lorde, a queer-serving health clinic in the city. One participant described her experience at Callen-Lorde as follows:

> The expectations there around sexual health or the questions during a basic checkup are always kind of already in the know in a way that no other doctor that I've ever visited was able to do or be for me, even without any explicit ask on my part. It was just inherent to the care. (38-year-old White non-binary, genderqueer person)

This participant's insurance company later rejected her top surgery claim because she was not on testosterone. Her doctor at Callen-Lorde responded by writing a new letter saying she had been prescribed testosterone, even though this was not true. Callen-Lorde providers were at times willing to lie in order to help patients get past unjustified barriers to care. Unfortunately, Callen-Lorde's popularity seemed to make it difficult for some participants to set up appointments with them. One participant expressed frustration that “the Manhattan location hasn't been taking new patients in forever because everyone wants to go there” (39-year-old White transmasculine, non-binary person). Although it was not always accessible, most participants like these who lived in large, progressive cities enjoyed somewhat greater options for affirming care.

Similarly, participants who could access care through a university where they studied or worked generally seemed pretty satisfied with the care they received there. They experienced shorter wait times, like one graduate student who shared “I got here in August, and by September I was already taking hormones” (25-year-old Black transmasculine person). Unlike in other medical settings, participants at university health centers generally felt that their providers were affirming of their non-binary identities. However, in addition to these positive attributes, a challenge that students accessing gender affirming care faced was operating within a compressed timeline. One participant expressed the following concern: “What am I going to do afterwards when I lose access to this care?” (22-year-old Asian non-binary, genderqueer, and genderfluid person). Multiple participants shared this fear that they would not be able to continue with their transition after graduating because they would lose insurance coverage and access to care providers who only serve students. Some were mentally preparing themselves for the worst-case scenario: having to stop hormone therapy after graduation due to excessive out of pocket costs. Although many participants had positive experiences with healthcare provided by universities, this was only a temporary care solution for students who graduated out of these programs.

Other participants found affirming care in health organizations outside of the standard hospital system. Many chose to seek care at Planned Parenthood rather than with a primary care doctor because they were drawn to Planned Parenthood’s commitment to providing care by the informed consent model. Some participants had used or were considering services provided by

Folx Health and Plume, two online care providers that offer lower cost hormones for those who are uninsured. One participant who was unable to access gender affirming care for decades because they were uninsured described Plume as "the easiest hormone replacement therapy that has ever been around." They further explained,

> Right away they were like, "Hey, don't worry, we're gonna write you a prescription, but we just need you to talk about your experience a little bit just [so] we have something on the books here." It's a lot easier, instead of feeling like I have something to prove. (42-year-old White genderqueer person)

Like at Callen-Lorde, providers at Plume operated with the goal of decreasing barriers to accessing gender affirming care for all trans people. Participants' non-binary identities did not at all complicate the process or pose an additional challenge. Participants trusted organizations like Planned Parenthood and Plume because they felt like, unlike hospital providers, they were driven by the goal of genuinely affirming patients' genders.

Discussion: The Genealogies of Trans Resilience

The qualitative interviews suggest that although the experience of accessing gender affirming care today is distinct from the trans experience of the last century, they are both plagued by the same histories of gatekeeping and eugenics. Many medical systems implicitly continue to structure care using the framework of White, hegemonic understandings of the gender binary. This causes medical care to be insufficient or even violent for non-binary patients, especially for those who are BIPOC. The data show that in response to these challenges, non-binary people continue to rely on some of the same strategies used by trans people pre-1980. Although this ability to navigate systemic challenges demonstrates non-binary people's resilience, it also reveals that medical systems have failed to make gender affirming care truly accessible to all patients. Additionally, affirming care continues to be unequally available to trans people depending on levels of privilege, intersecting identities, and geographical location.

Medical systems and researchers should prioritize furthering trans health research and education in order to offer more affirming care to the diverse transgender community.

Care Motivated by Upholding the Social Binary

In contrast to the 1950s, when gender related healthcare required an intersex diagnosis, today's trans healthcare system has standardized processes to specifically care for transgender patients. However, despite this clear recognition of trans medical needs (Davis et al., 2016; Johnson, 2015; Lev, 2013; Wiggins, 2020), healthcare spaces continue to operate with a narrow understanding of trans identity. This medical understanding draws from transnormativity and assumes that all trans people are binary, experience innate dysphoria, and seek a "complete" medical transition in order to fulfill the stereotypical role of their binary gender. Thus, despite greater trans health infrastructure, dependence on the medical model of transgender identity ironically has limited the ability for health systems to offer care that is affirming to the diverse trans experience. In the past, this resulted in the denial of care to people like Lou Sullivan, who was excluded from early gender clinics because he was gay (Stryker, 2017). Today, sexuality is of less concern to medical providers, but trans people who do not fit today's transnormative narrative still struggle to access affirming care. Thus, although the eligibility requirements for gender affirming care have relaxed since the 1950s, health systems continue to cater to only a subgroup of gender minorities.

As previously described, up until the 1960s, having an intersex condition was a requirement to access gender related care because doctors were motivated by molding intersex children to fit the hegemonic gender binary of male/female. To overcome this barrier, trans people such as Bernard and Agnes claimed to be intersex in order to access medical attention (Gill-Peterson, 2018). Similarly, many of the study participants code-switched to perform binary identity in order to access better care. This strategy of personifying the “standard patient” was effective for both the sample of non-binary people today and the trans figures highlighted from history. Like Agnes and Bernard, participants in the sample understood that healthcare systems were not set up to serve people like them. Instead, they recognized that providers are still implicitly motivated by upholding society’s binary definition of gender (Johnson, 2015; Sledge, 2019). The historical examples discussed in this thesis contrast with the experiences of people today because of the differing constructions of a “standard patient.” While Bernard and Agnes had to assert intersex identity because their transness would exclude them from care, this study’s participants code-switched to perform transnormativity because they expected their non-binary identities to be viewed as “not trans enough” in the eyes of medical systems (Garrison, 2018). Despite this difference, all who used the strategy of personifying the “standard patient” did so in response to barriers caused by the same social construction of binary gender.

The ability for trans people to adapt to medical spaces not built to serve them demonstrates great resilience. However, the participants’ continued reliance on this strategy today is evidence of a failure within the trans healthcare system. As previously described, the use of this strategy has historically come at high costs. Agnes was subjected to countless hours of questioning and sexist scrutiny of her body in exchange for affirming care (Garfinkel, 1967). Similarly, when seeking hormone therapy, a participant in the sample had to endure comments such as “I never would have known you were transgender” and “well, you’re already so pretty” (25-year-old White non-binary, transfeminine person). These comments demonstrate the lasting legacy of the transmisogyny that characterized Agnes’ gender affirming care experience. In addition, as a result of using binary code-switching, non-binary people still endure great psychological burden in the form of misgendering or presenting gender in a way that is not affirming to them. Trans people have long employed this code-switching strategy out of necessity, but truly affirming care would not require this level of resilience in response to inadequate care. Instead, it would provide care for people across the diversity of trans experiences with no further provisions.

While binary code-switching helps participants access better healthcare in some situations, it is unable to overcome the medical model's overemphasis on innate dysphoria. Transnormative narratives and the WPATH Standards of Care assume that internal dysphoria is the only cause for need for gender affirming medical care (Coleman et al., 2012; Johnson, 2016). However, the interview results show that while dysphoria is a primary reason that many non-binary people seek gender affirming care, they are also motivated by additional reasons. As studied by Dubov and Fraenkel (2018) and Grzanka et al. (2018), the data confirm the need for gender affirming care in order to decrease the risk of transphobic violence. This is especially the case for participants with prior experiences of transmisogynistic violence. The data similarly provide examples of how dysphoria can be caused by society's treatment of non-normative bodies, as noted by Butler (2004). The medical model of transgender identity has proved to be durable despite the work of these researchers and thinkers demonstrating the variety of valid reasons that trans people need gender affirming care. Thus, medical spheres continue to promote transnormativity by requiring innate dysphoria as a criterion for care (Coleman et al., 2012; Wiggins, 2020).

Proactive Response to Inadequate Care

Copious research has shown that medical settings are often places where trans people face discrimination and barriers to care (Cruz, 2014; Davis et al., 2016; Paine, 2018; Poteat, 2013; Sledge, 2019; Spade, 2003). The data collected in this study confirm prior research findings on the variety of the ways that this discrimination takes place. For example, as documented by Poteat (2013), many participants felt that their providers had received insufficient training, if any, on how to care for trans and non-binary patients. As a result, interpersonal instances of transphobia worsened the unequal power relationship between providers and patients. Davis et al. (2016) demonstrate how doctors use this position of power to delay granting gender affirming care. This study's data confirm that lengthy wait times are a serious concern for trans people seeking care, but the causes of these delays are complicated and can go beyond just the doctor-patient relationship. Participants found themselves navigating disjointed systems that often did not have sufficient available providers of care. They had to complete unnecessary tasks not only required by primary care doctors, but also medical specialists and the immense bureaucracy of insurance companies. In addition to these challenges, the data show that transfeminine people face an added layer of transmisogynistic discrimination. Overall, the interviews confirm previous academic work that has shown that medical spaces are not only a site of gatekeeping but also of broader transphobia.

The data suggest that transgender people today continue to use many of the same strategies employed in the last century to navigate these challenges. In the 1960s, trans people sought out leaders in the field of trans medicine like Harry Benjamin to both access gender affirming care and push research forward. For example, after receiving care from Benjamin, Reed Erickson funded much of Benjamin's pioneering work (Stryker, 2017). Today, trans people continue to carefully select their doctors in the hopes of avoiding providers who are not affirming of their genders. Unfortunately, like how Benjamin acted as a gatekeeper once he had established his career (Stryker, 2017), many providers who today call themselves "trans-affirming" fail to offer care that fulfills this description. As noted by one participant, "working with one trans person doesn't make you trans affirming. Working with a thousand trans people doesn't make you trans affirming" (25-year-old White non-binary, transfeminine person). Truly supporting trans patients requires more than mere experience. From Benjamin to the doctors seen by participants of this study, even providers who specialize in trans health have fallen short of providing genuinely affirming care. Thus, trans people are unable to guarantee that they will receive affirming care, even when proactively choosing providers.

Another historical strategy that has lasted through today is reliance on extreme self-advocacy. Since the 1960s, trans figures like Vicki, who wrote to Benjamin for years even though he refused to accept her into his practice (Gill-Peterson, 2018), have always recognized that health systems often do not willingly care for them. In response, they take it upon themselves to control as much as they can about their own health processes. One study participant had to rely on their professional project management expertise to ensure that medical systems would allow them to schedule surgery within the timeframe they needed. This self-advocacy, which involved incessantly calling insurance companies and doctor's offices, parallels Vicki's relentless letter writing. It also further demonstrates how in many cases, extreme determination continues to be a requirement for accessing gender affirming care.

Participants similarly relied on becoming an expert on current medical research, a strategy that dates back to as early as the 1930s (Gill-Peterson, 2018). In order to successfully convince doctors that they had intersex conditions, trans people like Bernard and Agnes had to get past exhaustive questioning from doctors. Their ability to provide answers accepted by doctors demonstrates their thorough knowledge of the current research of the time. Trans people today continue to become experts on trans medicine despite no longer have to hide their trans identities in order to access gender affirming care. This allows them to learn about care opportunities outside of the options offered by providers, such as surgeries or hormone regimens that do not conform to the transnormative standard. Additionally, it arms patients with the necessary knowledge to push back against doctors who refuse or discourage certain care. Similar to the use of binary code-switching, trans people who fearlessly advocate for themselves and become medical experts demonstrate resilience in the face of barriers. However, this requires subversion of the traditional doctor-patient power relationship, a feat not easily accomplished, especially when these relationships may be influenced by underlying transphobia. Those who are not predisposed to respond to barriers in this way therefore continue to receive inadequate care.

The data demonstrate that trans and non-binary people rely heavily on trans community support while seeking affirming healthcare. Participants looked to trans friends for both emotional support and assistance in planning and accessing gender affirming care. Trans support networks like this date back to long before the standardization of trans healthcare, when most people learned about medical transition opportunities through word of mouth. In the 1970s, trans community work was formalized in organizations like Mario Martino's Labyrinth and Conversion Our Goal, the trans support group at Glide Memorial Church in San Francisco (Stryker, 2017). Today, spaces like transbucket.com, the online database of surgeon reviews and procedure results, draw on this long history of trans people creating the resources they need for each other. Modern technology has allowed support networks like transbucket.com to expand their scope and reach anyone with internet access. However, in addition to the use of these more formalized community spaces, the interview data show that trans and non-binary people rely even more heavily on support from community members with whom they have personal relationships. This may be because the challenge of navigating oppressive medical systems leads to a unique need for intimate emotional support that is best provided through interpersonal relationships. Alternatively, this might also be a result of the lack of structural support for trans community spaces. Grassroots community work is often uncompensated or undercompensated, causing it to be unfeasible for many, especially considering that trans people report poverty rates that are more than twice that of the rest of the U.S. population (James et al., 2016). As a result of this heavy reliance on interpersonal support, some trans people still primarily gather knowledge about transition options through the anecdotal experiences of those around them. Thus, the trans community is able to fill in some information gaps and provide emotional support to those navigating care systems, but it is unable to make up for all of the deficiencies of trans health providers.

Unequal Access Depending on Privilege

Despite the clear expansion of trans health systems since the mid-20th century, affirming care is still unequally available to trans people depending on geographic location and levels of privilege. The data show that trans and non-binary people who live in urban centers are better able to access more affirming care. Cities like New York and San Francisco have leading queer health centers that offer care that many participants were very satisfied with. Trans people in urban centers that are not famous hubs of trans health providers are often able to still access healthcare or support from other organizations outside of the traditional medical system, such as LGBT centers or Planned Parenthood clinics. Similarly, those who see doctors through university healthcare systems also face fewer barriers to affirming care. In sum, many non-binary people gain access to quality care because of their geographical location in cities or college towns.

In contrast, trans people living outside of urban centers have fewer options for accessing affirming care. Those who do not have medical insurance or who graduate out of student healthcare programs face the added challenge of paying for care that can be extremely expensive. Some trans people overcome these geographic and financial barriers with the help of companies like Plume or Folx Health, the online healthcare providers that offer hormone therapy and virtual doctor's visits. Unfortunately, these resources are not universally available because they are limited to certain states. Additionally, although they are generally cheaper than paying for hormones out of pocket, their monthly costs can still cause financial strain. Furthermore, those seeking gender affirming care besides hormones, such as gender affirming surgeries, continue to have to travel long distances. This geographic inaccessibility parallels the 1950s, when those with the financial means would travel outside the country for gender affirming surgeries not offered to trans people in the United States (Gill-Peterson, 2018; Stryker, 2017). Although trans people today do not have to travel as far as in the past, the costs associated with travelling for surgery (e.g., medical copays, transportation, lodging during the healing period) still pose a significant barrier. These serious geographic and financial barriers have caused gender affirming care to become a privilege rather than a right guaranteed to all transgender people.

Faced with these cost barriers, while some trans people turn to crowd funding or other means to pay for their care, many instead choose to prioritize other basic needs over gender related medical care. Sylvia Rivera and Marsha P. Johnson's work with Street Transvestite Action Revolutionaries in the 1970s shows the long history of gender variant communities, especially those facing the most marginalization, supporting each other in accessing basic needs such as safety, housing, and food (Gill-Peterson, 2018; Stryker, 2017). Today, trans people continue to experience transphobic violence, homelessness, and poverty at alarmingly high rates (James et al., 2016). This is especially true for those who face oppression at the intersections of other systems of power (e.g., BIPOC trans people, undocumented trans people, disabled trans people). Participants in the sample who chose to delay or forgo medical care that would be affirming to their genders were not deprioritizing their health. Instead, they demonstrate that having basic needs met is a crucial aspect of both mental and physical health.

The data further show that the medical system's eugenic history continues to affect some Black and brown trans people's ability and willingness to access gender affirming care. Historically, BIPOC people were completely excluded from the medical predecessors to trans healthcare. This was because doctors in the field were motivated to develop gender related care by the goal of assimilating intersex kids into White, hegemonic culture. Because Black and brown people could never achieve this, care providers rejected them from their practices for decades (Gill-Peterson, 2018). The interview data suggest that BIPOC trans people today feel the legacy of this history to varying degrees. While some are able to put more trust in healthcare systems, others choose to avoid medical spaces when possible and seek alternative ways of affirming their genders. This phenomenon of avoiding and delaying healthcare was consistent throughout the sample, which affirms prior research on how trans people access care (Cruz, 2014; Paine, 2018; Sledge, 2019). However, Black and brown participants avoided care not only out of fear of transphobic discrimination but also because of the histories of medical abuse of BIPOC bodies in healthcare settings (Hoberman, 2016). Research has shown that trans health systems still implicitly operate with the goal of upholding the gender binary, which is a Western, colonial construction (Johnson, 2015; Lugones, 2007; Sledge, 2019). Thus, although providers no longer explicitly exclude patients of color, the gender affirming healthcare system continues to be motivated by the same forces as during its eugenic past.

Study Limitations

Although this study uncovers important findings regarding the continued lack of access to gender affirming care, some limitations must be considered. Limitations of this study primarily stemmed from the small sample size and the use of personal network sampling methods (Spreen & Zwaagstra, 1994). This approach was employed because of the lack of a clear sampling frame for the target population. However, because people generally have networks of social connections with others who are similar to themselves, snowball techniques often generate samples that are not representative of the entire target population. Thus, the resulting sample may overrepresent segments of the population that are demographically similar to the original respondents (Berg & Lune, 2012; Esterberg, 2001; Spreen & Zwaagstra, 1994). By targeting initial respondents in a variety of geographic locations, this effect was offset somewhat (Spreen & Zwaagstra, 1994). However, because of the scope of this exploratory study, the small sample size was still unable to adequately capture the diversity of the non-binary community. In particular, 50% of the sample was White, and other races were only represented by a few respondents each, as seen in Table 1. Thus, conclusions about intersections with race may not be generalizable to the full population because they were made using a very small sample of participants. A larger sample size and probability sampling technique would be required to draw conclusions that are more generalizable.

Implications for Further Research and Interventions

The findings of this study are consistent with prior research that shows that trans people still face barriers to access and inadequate medical care (Cruz, 2014; Davis et al., 2016; Johnson, 2015; Poteat, 2013). While the standardization of medical practices through the *Diagnostic and Statistical Manuals of Mental Disorders* and the WPATH Standards of Care has legitimized gender affirming care and made it more available for some, it has also led to the medical model of transgender identity, which overly medicalizes the trans experience (Johnson, 2015; Lev, 2013; Mog & Swarr, 2008; Wiggins, 2020). Ironically, this has created more barriers to affirming care, especially for non-binary people who seek transitions that differ from the transnormative plan. Thus, despite the developments in trans healthcare in the last decades, historical comparison demonstrates that non-binary people continue to have to rely on the same strategies used by trans people in the mid-20th century to access gender affirming care. These strategies exhibit the creativity, determination, and resilience of transgender people past and present. However, they are also evidence of the medical system's failure to provide for the diverse needs of trans people.

Although transphobic discrimination in medical settings has been well documented in prior research, certain patterns of discrimination identified in this study should be more thoroughly investigated. For example, how does the added layer of transmisogynistic discrimination experienced by transfeminine people impact their ability to access healthcare? What are the effects of misgendering and deadnaming specifically within the context of the doctor-patient power relationship? Given the small sample size of this study and the large percentage of White participants, researchers should also prioritize further study of the experiences of BIPOC trans people within health systems. In particular, how do providers seek to remedy the lasting impacts of the medical system's history of eugenics and abuse of Black and brown bodies? Overall, researchers should investigate the long-term social and health impacts of discrimination in medical settings. This greater understanding of the relationship between health outcomes and medical transphobia will inform further interventions to improve gender affirming care.

The results of this research and prior studies point to the need for care providers who are sensitive to the needs of trans and non-binary patients. In order to reduce instances of transphobia, care providers should engage in a continual process of learning how to best support trans people. Most participants wished for doctors who were trans themselves because they could put more trust into providers with the lived experience of being trans. However, although trans practitioners have existed at least since 1979, when Jeanne Hoff took over Harry Benjamin's practice, trans people today are still rarely able to find them. There are likely many reasons for the lack of trans care providers, but research has found that one critical reason may be discrimination in medical schools (Thoreson et al., 2020). In order to change this culture, these institutions should invest in programming that recruits, retains, and supports transgender students, staff, and faculty. Medical schools should also educate students on trans health issues as a part of the standard curriculum. Even though research has demonstrated that trainings on queer health are effective in cultivating better practitioners (Utamsingh et al., 2017), the median amount of time that standard four year programs spend on the topic is five hours (Obedin-Maliver et al., 2011). Trans specific training makes up only a fraction of this training time. Because trans people see all types of doctors, all medical students, not just aspiring gender affirming care specialists, should receive education on trans health.

In particular, doctors who call themselves "trans-affirming" should hold themselves to a higher standard. Rather than simply reading the WPATH Standards of Care, they must stay up to date on the literature and limitations of the field of trans medicine. They should also contribute to or advocate for more research on trans health, especially given the current lack of study on long-term transition health outcomes, hormone options, and other related topics. Finally, cisgender "trans-affirming" doctors should practice humility by continually learning from the trans community in order to gain a greater sense of the diversity of trans experience outside of medical transitions. Accountability to these measures could be achieved through greater oversight or licensure requirements for doctors who claim to be trained gender affirming medical professionals. With a system like this, patients would be able to approach healthcare settings with more confidence that their providers are driven by the intention of truly affirming patients' genders.

On a broader level, in order to offer affirming care to all transgender people, health systems must expand their understanding of transgender identity and experience beyond the medical model and the WPATH Standards of Care. Researchers should build off of the growing body of work that complicates the role of dysphoria in gender affirming care (Butler, 2004; Coleman et al., 2012; Wiggins, 2020). In particular, guiding documents such as the DSM and the Standards of Care should relax the care requirements to accommodate research demonstrating the variety of reasons people pursue gender affirming care besides innate dysphoria (Dubov & Fraenkel, 2018; Grzanka et al., 2018). Insurance providers should also expand their coverage to include trans healthcare options that are currently rarely covered, like voice surgery and therapy, permanent hair removal, and facial gender surgeries (DeVore et al., 2021; Thoreson et al., 2020). By moving beyond the narrow transnormative definitions of transition related healthcare, health providers can get one step closer to offering affirming care to all trans people.

The ubiquity of the medical model of transgender identity influences all aspects of trans life. However, gender affirming healthcare is just one facet of a network of factors that contribute to transgender health and wellness. As seen both in the sample and in the historical analysis, some trans people who struggle to meet other basic needs do not have the time, capacity, or financial means to navigate the bureaucratic healthcare system. Because trans people face homelessness, poverty, and unemployment at rates significantly higher than the rest of the U.S. population (James et al., 2016), affirming medical care has become a privilege that is inaccessible to many trans people. As a result, for those facing these challenges, health and wellness work may comprise primarily of fulfilling basic needs. The burden of fulfilling this need has historically fallen on trans individuals who take it upon themselves to care for fellow community members, such as Sylvia Rivera, Marsha P. Johnson, and the countless others not documented in history. These past and present trans icons have taken up this work despite experiencing structural transphobia themselves, both in their work and their personal lives. For institutions such as the healthcare system to claim that they serve trans people, they must support and engage with the diversity of this work that trans community members have always spearheaded. They should recognize and fight against the legacies of their eugenic pasts and work towards holistic trans wellness. Rather than distancing themselves from movements fighting trans homelessness and transphobic violence using the claim that these issues are outside of their medical domain, they must recognize that gender affirming healthcare is a just one component of the historically profound movement towards trans liberation.

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