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Queering The Birth Experience: Documenting Queer Individuals' Labor & Delivery Experiences

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A project submitted in partial fulfillment of the requirements for the Degree of Bachelor of Arts in Anthropology

by

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ABSTRACT

This research developed as a qualitative analysis of the experiences of queer individuals who have given birth in Washington State. Up until very recently there has been little literature documenting the pregnancy and birth experience of transmasculine and nonbinary individuals, making this a unique project. Pregnancy and Birth are highly feminized and associated with womanhood, leaving pregnant people who do not fall under those designations marginalized. This study utilized grounded theory to analyze interviews to gain insight into the themes that emerged from the experiences of two queer individuals, and how their experiences could have better affirmed their identities. The result of this is advocating for greater education and awareness around the care for transmasculine and nonbinary birthing individuals by use of perceived control theory to ensure greater satisfaction with birth outcomes and experiences.

Keywords: Transmasculine; Nonbinary; Transgender; Labour and Delivery; Birth; Queer Parenthood.

INTRODUCTION

Gynecology, motherhood, and birth are hyperfeminized spaces, potentially leading to individuals being misgendered as their gender variance is unacknowledged or staying closeted to their providers. Research has demonstrated that misgendering causes harm to trans individuals (Swannell, 2020), it is unknown how this may impact a child in utero. The goal of this project is to collect and examine the experience of Transmasculine and Nonbinary individuals who have given birth in Washington state. This exploratory research asks, what is the current experience of transmasculine and nonbinary individuals giving birth in Washington State? To address this

retrospective research, I conducted interviews with individuals who have given birth, and with an individual that provides birth care and support. Using this information to compare the experiences of queer individuals giving birth and how those individuals feel their birth experiences could have been improved to better affirm and accommodate the identity of queer individuals who are giving birth in highly gendered environments.

BACKGROUND

Research is Lacking

While visibility and acceptance of Transgender, Nonbinary, and Gender variant populations has increased over the past few years, a trend is consistent across literature regarding pregnancy for these populations. “Research has been developed regarding the gynecological care of trans men, to date, there has been little research on the fertility of and the needs related to pregnancy and maternity/paternity among this population” (de-Castro-Peraza et al, 2019). Even less has been investigated on the birth experience specifically for these populations. What can be found offers similar information that; (1) - pregnancy is an overwhelmingly lonely and stressful experience for gender variant individuals (Ellis et al, 2014) often resulting in gender dysphoria (Besse et al, 2020), (2) - mainstream assumptions of pregnancy are cisnormative, exclusionary of trans individuals, and can result in individuals feeling the need to hide their gender identity, or rather not disclose their identity as gender variant or transmasculine, and instead attempt to pass as a cisgender woman for the safety of themselves and their unborn child (Light, 2014, Besse 2020, Ellis, 2014). (3) - Trans individuals have distrust for Health Care Providers (HCP), either preemptively or due to negative interactions.

Negative Experiences

Recent studies suggest that between 33-45% of women that have given birth described a traumatic experience or instances of Post-Traumatic Stress Disorder after giving birth. (Beck et all, 2018. Alcorn et al, 2010). While these studies do not account for or include transmasculine or nonbinary individuals, research by Wingo et al, in 2018 suggests that reproductive healthcare priorities and needs are like that of cisgender and heterosexual groups (Wingo et al, 2018). Using this assumption, Transgender and queer individuals are likely to be experiencing the same if not more instances of trauma after giving birth due to the added gender dysphoria and misgendering experienced by these individuals in their care settings (Falck, 2020. Bauer et al, 2009, Murray, 2021).

These negative experiences included erasure, inappropriate medical care, transphobia, lack of cultural competency, and refusal to treat. Many individuals felt that providers were not trained to address their needs, with providers being unable to provide information or resources relevant to transgender individuals in comparison to cisgender experiences (Hoffkling et all, 2017), as well as providers seeming to be uncomfortable treating or providing care to transmasculine and nonbinary individuals wanting to give birth (Hoffkling et al, 2017). Kaden Coleman, a transgender man who has successfully carried two pregnancies shared about his birth experience:

> "*There was a lot of trauma. Most of that came from inside the birthing world, with medical professionals. There was a lot of questioning about my identity, a lot of misgendering. Being told I should not be in spaces I was seeking care from because they were considered women's spaces. I was offered an abortion a ridiculous amount of times.*" (Murray, 2021).

Coleman's experience demonstrates the marginalization of trans men from these highly gendered spaces, as well as transphobic reactions to his identity and pregnancy.

Hoffkling et al's study listed various incidents that participants felt uncomfortable with in their care experiences including (all excerpted from Hoffkling et al, 2017):

- Addressing the patient with the wrong title or pronoun, "this one [clinic], it was always 'miss' this and 'her' that."
- Calling the patient by their legal name rather than the name they use, "she called me by my legal name, which is not the name I use."
- Presuming to know the shape of a patient's genitals by their name or face,
- Ignoring intake forms that ask patients' gender, "they even asked gender and preferred name on their intake form, but the person who called me back, and the doctor, never looked at it."
- Presuming that a patient has, or should have, a given relationship with their body "This midwife… forced me to reach inside and touch my babies head, even though I clearly didn't want to."
- And discussing gender identity as though it is sexual orientation.

Some directly transphobic experiences shared by participants were being laughed at by providers and being reported to social services as a danger to their child even prior to birth due to being transgender (Hoffkling et al, 2017).

Another common negative experience of transgender individuals is feeling that they have to offer education to their health care provider on transgender experiences and needs, and fielding overly intrusive and unwelcome questions irrelevant to the care needed, all of which was described by participants as exhausting (Asklöv et al, 2021).

Negative experiences like these described contribute to the trend of transgender and nonbinary individuals being more likely than cisgender individuals to avoid or delay seeking healthcare, (Jaffee et al, 2016) hiding their gender while receiving care, (Asklöv et al, 2021) and be more likely to opt for home births rather than in-hospital births (Hoffkling et al, 2017. Falck et al.2020, Murray, 2021.).

Positive Experiences

Positive experiences were notably less documented in literature than negative experiences. Common positive experiences described by across literature came from healthcare providers attempts to acknowledge and affirm individuals' identities, seeking consent, joint evaluation and decision making, and advocacy for individuals. Affirmation and acknowledgement of identity plays a role in improving individuals experiences, this is seen in providers other actions. The examples provided included providers asking and respecting pronouns (Ellis et. al.2014, Hoffkling et all, 2017), effort to respect patients' privacy by making use of more private spaces, asking patients consent before other providers entered the space (Hoffkling et al, 2014), asking and allowing patients to insert speculums themselves and opting for less invasive instruments as explained by Dr Alson Burke, OBGYN at University of Washington, Seattle. (Murray, 2021). By and large, positive experiences were attributed to individual healthcare providers' personal interests and actions rather than institutional or systemic approaches (Falck et al., 2020). This demonstrates a lack of central or institutional training with so much variability across healthcare providers' care approaches.

Issues with Research

When beginning this literature review, the literature was largely lacking specifically for the labour and delivery experiences of transgender and nonbinary individuals. Most literature was published prior to 2010 and utilized terminology that has been since phased out or critiqued as offensive towards members of the queer community. Examples include transgender as a noun vs adjective, Transgendered, transsexual (although used by some under the trans umbrella this should not be used to describe transgender people as a whole or without permission.), titles such

as “The Pregnant Man- an Oxymoron?” (More, 1998), transvestite or hermaphrodite instead of intersex, slurs such as Tr*nny and more.

However, over the course of 2021 and 2022, more literature has been published that contributes to the field positively and includes relevant information about labour and delivery, rather than focusing on the process of conception and the duration of pregnancy as many earlier studies did.

In the light of the ever-developing nature of language, I felt it most appropriate to include a table of terms that come up in this paper. At the time of writing in Spring 2022, the terms included on this list are most accepted and used within LGBTQ+ Community conversations and current research. However, it must be noted that these terms may fall out of favor, develop new or different meanings, or not apply to all individuals. It is with the best intention that terms are included here; however, this list is by no means exhaustive nor applicable to all people.

Table 1. Terminology

Term	**Definition**
Transgender	An umbrella term for people whose gender identity and/or gender expression differs from their assigned sex at birth. (Ellis et. al.)
Gender variant, genderqueer, or nonbinary	Umbrella terms that include all people whose gender identity varies from the traditional norm; also used to describe a subset of individuals who feel their gender identity is neither female nor male. (Ellis et. al.2014)
Gender affirmation	Umbrella term for the range of actions and possibilities involved in living, surviving, and thriving as our authentic gendered selves. (TransHub, 2021)
Gender identity	A person’s innate, deeply felt psychological identification as a man, woman, or something else, which may or may not correspond to the person’s external body or assigned sex at

	birth. (Ellis et. al.2014)
Female-to-male, FTM, transman	Someone who was assigned as female at birth but who identifies and portrays their gender as male.
Transmasculine	People who were assigned female at birth, but do not identify as female. […] A broad group of people who may identify as male, non-binary, agender, or "genderqueer." (Atkinson, 2018)
Natal sex	Male or female designation assigned at birth based on a person's anatomy (genitalia and/or reproductive organs) and/or biology (chromosomes and/or hormones). A natal female is a person who was assigned female at birth. (Ellis et. al.2014)
Passing	When people are perceived as the gender they are presenting in (e.g., a transwoman who is perceived by others as female, or a transman who is perceived as a man).
Hormone Therapy/ Hormone Replacement Therapy (HT/HRT)	The use of exogenous hormones for the purpose of gender transition or gender affirmation. (Unger, 2016)
Queer	Often used interchangeably with lesbian, gay, bisexual, and transgender. The term may have negative or derogatory connotations for some people; however, many are comfortable using it.
Certified Nurse Midwife, CNM	Healthcare provider (HCP) who provides care and practices focused on gynecological services, reproductive health, labor and delivery, postpartum care, and peri-post menopause care.
Gestational Parent	The individual who will carry the pregnancy and give birth. (Horner, 2018)
Dysphoria	The feeling of discomfort or distress that might occur in people whose gender identity differs from their sex assigned at birth or sex-related physical characteristics. The term

	focuses on one's discomfort as the problem, rather than identity.(Hoffkling, 2017)
Misgendering	Misgendering occurs when a person is addressed or described using language (name, pronouns, or title) that does not match their gender identity. (Swannell, 2020)

METHODS

One on one interviews of queer and Nonbinary individuals who have given birth in Washington state (n=2), one participant additionally had provided Labor and delivery care to Transmasculine and nonbinary populations. Interviews were coded using grounded theory (Glaser and Straus, 1990) using NVivo, qualitative analysis software, to identify emergent themes. This method is considered the most appropriate for initial exploratory research examining the social experiences and behaviors of groups that have been historically underrepresented (Crooks, 2001). This requires the openness of researchers to observe trends or patterns as they emerge from data, rather than expected data patterns (Charmaz, 2008).

Semi-structured interviews were conducted via Zoom and lasted 60+ minutes. Interviews were recorded and transcribed by a National Institutes of Health certified and approved transcription company (files are transmitted via secure connections). All Data is stored in password protected WWU Office 365 Drive. Data will be destroyed after completion of this project to allow sufficient time for publication.

Inclusion criteria were: (1) individuals who are 18 years of age or older, (2) self-identify as gender-variant (transgender, transmasculine, and/or nonbinary) or queer, (3) have previously given birth after identifying or coming out as gender variant or queer, (4) given birth in Washington state, and (5) fluency in English. Participants were selected purposefully and recruited via email or telephone.

RESULTS

In total 6 individuals were contacted to participate in the study. Of these, 2 did not respond to outreach. 2 participants were unable to meet for an interview due to lack of childcare and availability; of those 2, 1 participant did not meet all criteria by having given birth outside of Washington state. The final sample was 2 individuals that met all criteria. For anonymity pseudonyms have been used for participants.

All participants identified as white, and as members of the queer community over 40 years of age. Both participants had some degree of knowledge of medical institutions, one as a healthcare provider and the other from an administrative perspective. Both individuals were married. Daniel's partner is a transgender man of Jamaican descent. Elizabeth's partner is a lesbian woman. Daniel identified as transgender, nonbinary, and gay. Elizabeth identified as a queer, lesbian woman. Daniel had previously undergone hormone replacement therapy but had paused testosterone before pregnancy and had not yet started again. Daniel gave birth in 2019, while Elizabeth gave birth in 2018. Both participants had only a single child that had been conceived via artificial insemination in a clinic or home setting. Both participants had wanted vaginal births attended by midwives, however, Elizabeth opted for a hospital birth due to family member's objections to birth attended by a midwife. Elizabeth also had a difficult labour that required a cesarean section after attempts to induce labour failed.

Table 2. Participant demographics, Methods of Conception, Birth Settings, and Healthcare Providers. (N = 2)	
Characteristic	Value
Age at time of Interview (range) years	40-42
Relationship Status, n (%)	
Married	2 (100)
Single	0 (0)
Family Size, n (%)	
One Child	2 (100)
Two or more Children	0 (0)
Method of Conception, n (%)	
Home insemination	1 (50)
Clinic insemination	1 (50)
Birth Setting, n (%)	
Home	1 (50)
Hospital	1 (50)
Delivery Method, n (%)	
Vaginal	1 (50)
Cesarean Section	1 (50)
Care Providers, n (%) *	
Licensed midwife	0 (0)
Certified nurse-midwife	1(50)
Obstetrician-gynecologist	1(50)
Doula	2 (100)

*Participants had multiple care providers present at their birth.

Themes that arose from interviews with participants were Community & Identity, Misgendering & Microaggressions, and Expressing Needs & Birth Support. All themes are interrelated and may be expressed differently by participants. All themes fall under models of perceived control (Wallston et al, 1987) in which one's belief that one can bring about desired

outcomes through control of one's internal state and emotions, as well as exert control on external or environmental factors that contribute to these desired outcomes. This is an unconscious process whereby an individual feels more satisfied and in control of their experiences if they have observed favorable outcomes through their perceived control actions, especially within the realm of healthcare (Wallston et al, 1987). This psychological theory has also been associated with individuals' perceptions of wellbeing. Studies have shown that participants that report perceived control over their health and healthcare procedures also report greater wellbeing (Pagnini et al, 2016).

In this study nonbinary and queer gestational parents often feel a lack of perceived control in their labour and delivery environments which leads to dissatisfaction in their birth experiences. Participants who had greater perceived control reported more comfort and satisfaction in their birth experience.

Community & Identity

Under the model of perceived control, identity can refer to both an internal and external control. Identity and sense of self are deeply personal and determined by the individual, however even if an individual is confident in their gender identity and sense of self that can be impacted by external factors, like misgendering and transphobia by those around them. Within the context of labour and delivery experiences there are numerous external factors by way of healthcare providers, documentation, and other patients – if in a hospital or birth center setting. Daniel had significantly more perceived control over their birth environment and the individuals present by having a home birth. They selected their healthcare providers through their connections in the birthing and queer communities. They prioritized having a queer midwife to assist in their birth,

who had experience with queer patients, as well as prioritizing a doula of color, specifically a Black doula for birthing education classes, to act a support for Participants A's partner who is a Black trans man. For both Daniel's home insemination and home birth, all providers were members of the queer community that they had sought out through community connections. This space that felt comfortable and connected, emphasizing the perceived control of Daniel:

> *"It was a really sweet thing. We're like in my bedroom. It's me and my partner, and our friends, and there's like, everyone in the room is queer and trans or non-binary."*
>
> *"I felt really good that I was able to, um, like really shape that myself. And like I wouldn't have been able to have that many people at the hospital, even pre-COVID, I think. I can't remember, it's been so long, um, since COVID started. But-but yeah, it felt really great to know, like almost every single person in that room was-was queer and, um. And then it was just like it was a good team."*

Elizabeth felt less satisfied with their birth experience, as they experienced significantly less perceived control. Giving birth in a hospital limited the number of people that could accompany them in their room during labour and delivery. Elizabeth had only their partner, their sister, and their doula with them consistently while their obstetrician-gynecologist and nurses from the hospital would enter and exit periodically as labour progressed. With regard to community, only Elizabeth's partner was a member of the queer community, while they did try to seek out an obstetrician-gynecologist that was experienced in supporting lesbian parents, their provider was not a member of the queer community.

Misgendering & Microaggressions

Less control exerted over one's environment opens one up to unwanted interactions or events. For queer and transgender individuals that can come in the way of negative interactions that include misgendering, microaggressions or full-blown transphobia or homophobia that not only

leave individuals feeling dysphoria or uncomfortable by may pose a threat to physical safety and wellbeing. Both participants shared experiences that demonstrated discomfort arising from misgendering and microaggressions in hospital spaces. Elizabeth, had their healthcare providers make assumptions about their relationship and leave them feeling unseen as a lesbian woman:

> *"So many instances where it's kind of, like, death by a thousand papercuts. Like, just, like, little microaggressions. [...] there would be t-would be times where they would be like, "Is it okay that she's in the room?" And I'm like, "That's my wife. Yes." [...] I don't know that I necessarily felt, like, particularly seen, um, by a lotta the care team.""*

Daniel did not give birth in a hospital setting but did require a hospital visit after a minor car accident during their pregnancy. While already experiencing a loss of perceived control from this trauma, they had negative experiences in the hospital setting:

> *"The patients were just like staring at me so hard. And like when I had to be transported and brought out of the room to go to the ultrasound, um, you know, the radiology department, people were just like staring, staring, staring."*

A major part of their decision to opt for a home birth was to avoid the discomfort of microaggressions and misgendering in the hospital setting:

> *"My birth plan ended up being just about gender stuff. Like, I didn't have a birth plan for my home birth, […] but yeah, it was all about the hospital. I had, like specific rooms that I wanted to like, I specified that I wanted my midwife to be able to call and have a room assigned ahead of time, […] do not send me to triage." I had specific rooms at the very end of the hall, so the distance from the elevator to the room was very short.*
> *I asked for a pseudonym on the board, I didn't want anyone finding reasons to come into the room, when really it was just about curiosity. And I like bought a robe that had like a hood on it."*

Expressing Needs & Birth Support

Perceived control of self and perceived control of external factors and environment are independent of each other (Wallston et al, 1987). Despite differing levels of perceived control on external factors both participants felt little perceived internal control, both attempted to exercise this through external advocates in the role of their partners and doulas. Daniel felt very listened

to and cared for throughout their birth but had an expectedly fast and intense birth experience in which they felt immense pain, thought that they were dying, and experienced memories of childhood family trauma. This experience left Daniel feeling as if they were suffering, and it would be unending. They describe not being able to describe the intense emotions they felt to anyone in the space despite the love and trust they had.

> *"Oh, my God! I was like screaming, and nobody could hear me." 'Cause my memory is that I was screaming. Like, I was screaming at people, I was screaming for help. And-and like that never reached the surface; nobody ever knew that I was like really, really, really needed help that wasn't being given, because I'm so good at pretending."*

Elizabeth had advocacy through their sister, wife and doula but described a loss of internal control in that their labour was not progressing quickly enough, they were unable to have a vaginal birth like they had hoped and planned for. They had to be given medication to induce labour that made them feel extremely uncomfortable. Their contractions were very intense, described as coupling contractions (smaller rest periods between contractions) for 10 hours. They didn't want an epidural for pain as they still wanted to walk around and have the full function of their body, an effort to maintain internal control which they had largely taken away from them. Through advocacy practices recommended by their birthing instructor and support from their wife they were able to advocate for themselves to still exert a degree of internal control over the process despite needing to receive a cesarean section to ensure the safety of their child. Their most positive birth support from providers came in the way of a nurse who assisted with lactation support after birth by asking Elizabeth about their needs and using a firm approach to other providers to prioritize the wellbeing of the parent and child in bonding.

Birth support comes in asking for and advocating for the birthing individual's needs, however asking the right questions comes from knowledge or/and experience. Daniel is also certified nurse midwife who has provided care to transgender and nonbinary individuals and

feels as if there is a degree of understanding or acknowledgement of shared experience and community that assists in bridging gaps between patient and provider. This is not to say that only transgender and nonbinary providers should support transgender and nonbinary patients but that extra care and training needs to be put in place to ensure the appropriate approach from providers who may not have shared identity or community. This would be a good opportunity to speak with transgender and nonbinary patients and providers on ways to better train all providers to ensure adequate and affirming care for transgender and nonbinary birthing patients. This would not only benefit this group but open up better care and communication methods for all individuals giving birth. This could include many facets of birth care and birth care provider roles, such as obstetrician-gynecologists, midwives, doulas, and birthing instructors.

Challenges

To collect data from interviews that did not occur, the reasons for these cancellations were documented. Two individuals expressed interest in participation but ultimately were unable to because they lacked childcare to give them the time to complete an interview, even by phone. One individual stated that they were a single parent of two children that were sick. While interviews didn't occur, this is an opportunity to gather data regardless. In future interviews, offering childcare, either through a location, service or payment may be a reasonable way to secure more interviews, especially from individuals who have more than one child or remarkably busy schedules.

Finding participants was difficult as nonbinary and transgender birthing individuals make up a small portion of the population, however this does not mean that study is unnecessary, if anything representation is greatly lacking, and further research is needed to ensure best practice

and care. By nature of exploratory research, a survey was not possible at this time due to the lack of insight into the topic, however, moving forward with the insight gained from this research surveys would be invaluable in gaining more data and more interview participants through outreach. Opening the research to the United States rather than specific to one state would also allow for a greater source of information and experience.

SIGNIFICANCE OF RESEARCH

This research offers insight into the labour and delivery experiences of underrepresented populations who are impacted by lack of training, misinformation and even hatred in the forms of transphobia and homophobia. Members of the queer community already must utilize survival strategies to navigate everyday life, and even more so within healthcare settings. Kristie Seelman identified several strategies utilized by queer individuals, specifically transmasculine and nonbinary individuals, to navigate and resist stigma. These include (a) using social support; (b) persistence to meet one's own needs; (c) avoiding mainstream healthcare; (d) advocacy; (e) doing one's own research; and (f) strategic disclosure of transgender/non-binary identity. (Seelman et al, 2020). Changes to the approach to health care for transgender and nonbinary individuals would assist in mitigating the need to rely on survival strategies, hopefully improving the labour and delivery experience overall. This could offer an opportunity to partner further research with healthcare agencies and organizations to ensure better standards of care.

CONCLUSION

The major conclusions drawn from this research project is that labour and delivery care for transgender and nonbinary individuals is lacking due to the absence of providers with ties to and knowledge of the queer community, resulting in dysphoria and harm to patients, who then feel unable to communicate their needs, must educate their providers, and feel unaffirmed in their identity. This comes from society's attitude and expectations around birth, pregnancy, and identity. These understandings and expectations need to be expanded, but for now the focus on

providers will at least offer a respite in the healthcare realm. Additional training and data will improve the experiences of those in the queer community and all birthing individuals, as birth is traumatic. Birthing individuals and parents require better support across the board, and this is a small step in the right direction.

APPENDIX

EMAIL TEMPLATE

Hello!

I am a senior at Western Washington University majoring in Cultural Anthropology, completing research for my Honors Senior Capstone project. I am looking for participants to interview for my research documenting the labor and delivery experience of gender variant (specifically transmasculine or nonbinary) individuals.

I am looking to conduct 50–60-minute audio-record interviews over Zoom or telephone with individuals who are 18 years of age or older, self-identify as gender-variant (transgender, transmasculine, and/or nonbinary), and have previously given birth after identifying or coming out as gender variant, regardless of whether your care team was aware.

I have included more information for you in my attached Consent Form. Please let me know if you have any questions or are interested in participating!

I appreciate your time!

Best Regards,

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INTERVIEW GUIDE

Patient Guide

Confirm consent verbally.

1- Please tell me about yourself? Age, gender, race, ethnicity, sexuality, identification with Queer community?

2-Would you mind telling me about your experience giving birth as a Transmasc/nonbinary person (use the identity they offer in 1)?

Cesarean/vaginal birth? Care team reaction? Family support? Number of children? Number of experiences? Were they different?

3- What were you hoping for or expecting with your birth experience?

4- How & why did you choose the doctor/clinic/hospital/doula?

5- Were you out to your care team? Why/why not? How did you feel about your pregnancy and birth [as identity described in 1]/did you feel affirmed?

6-What would you change about your birth experience if you could? This can be about any aspect: care team, hospital, info received, partner presence, etc.

7- What would you not want to change about your birth experience?

8- Partner? Were they present? What is their identity? How did they support you during the birthing process?

9- What would you want to tell another nonbinary/Transmasc person before they gave birth?

10-Any thoughts or comments you want to share?

Provider Guide

1-Please tell me about yourself? Age, gender, race, ethnicity, sexuality, identification with Queer community?

2- What is your title and role in assisting someone giving birth? How long have you done this?

3- Is there a different way that you go about offering care to Transmasc and nonbinary individuals versus cisgender women? What percentage (roughly) of your patients are not cisgender women?

4- Is there an expectation or different standard of care within obstetrics for Transmasc and nonbinary individuals? Do you defy these expectations? How/why?

5- What feedback have you received from Transmasc and nonbinary patients?

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