Cultural Competency with Non-Binary and Genderqueer Individuals: Results from a Qualitative Participatory Action Research Pilot Study

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How can counselors and other health professionals acknowledge, include, and support non-binary (NB), genderqueer (GQ), and other gender non-conforming people? This study grew from the needs of a peer support group for non-binary and genderqueer people in Portland, Oregon, USA, and our wish to share our insights with the world. Based on our personal experiences of erasure, marginalization, invisibility, and being misunderstood and trivialized within mainstream cisheteropatriarchal culture and within the LGBTQ and trans communities, we want to make concrete recommendations for improving services for people like us[1]. This article blends an activist approach with a social science research project, with the hope that we will be able to leverage some of the power of scientific discourse in order to make change. We have tried to write for lay and professional audiences, and we hope that readers will bear with us as they navigate this hybrid text.

In the summer of 2017, we decided to conduct a participatory action research study using a qualitative thematic analysis method (Braun and Clarke

1 (Sasha Strong) am the primary author of this research report, and I am the member of our group with the most formal training in qualitative research. In this report, I use 'we' when I am talking about what I sense is the collective voice of our research group based in our findings, and 'I' when I am speaking from my personal perspective as a researcher and clinician. Because our study is community-based, yet informed by scholarship and professional practice, in this report, I try to walk the line between scholarly language and plain speech, so that our findings can be easily put to use in counseling and healthcare by people from all walks of life.

2006). From our peer support group, we recruited seven non-binary and genderqueer people ($N = 7$, including the authors) and asked them their opinions on how to improve counselors' cultural competency. In this chapter, we start by defining and contextualizing non-binary and genderqueer issues, and we review some of the literature about folks like us. Next, we explain how we collected and analyzed the data for this research project. Then we present our findings in terms of 5 themes (Validation Basics, Holding Space for Complexity, Finding Safe Spaces, Erasure, and Trauma-Informed Intersectionality) and 12 best-practices. After that, we wrap up with a discussion of the implications of these findings and the limitations of this study.

In general, we hope that these findings will be applied to counseling, and generalized to healthcare and other human service fields, in order to improve relationships, communications, and gender assumptions with non-binary, genderqueer, and other gender-nonconforming people. Hopefully, this chapter will also help non-binary, genderqueer, and other gender diverse people understand their own position better, feel appreciated and understood, and help them to advocate for meaningful change in their lived contexts, in healthcare and beyond.

Even better, we hope this chapter will inspire gender diverse folks to engage in educational and research activism. This study is an example of participatory action research that can be replicated by other oppressed groups, and by non-binary, genderqueer, and other gender non-conforming people advocating for their needs in other contexts. Participatory action research has the potential to empower communities to work for recognition and systemic change, as well as to create communities of inquiry and practice. Dear reader: We appreciate you, and we hope you will join us in this work.

Definitions and Contextualization

The terms *genderqueer* and *non-binary* refer to aspects of gender identity, expression, and performance that go beyond the strict binary division of gender into only two categories of male and female. Whereas gender diversity and different forms of transness are gaining increasing recognition as a bona fide life experience, mainstream understanding, and portrayal of transgenderism is predominantly of binary gender changes, in which a person, who was assigned a male or female gender at birth goes through a process of self-discovery, social recognition, and medical transition to the opposite (binary)

gender. While such binary trans experiences are valid and important, for us and people like us, it is clear that there are more than just two gender options. '*Non-binary*' and '*genderqueer*' are two words that some people (including the authors) choose to use to identify our lived experience, although some members of the group also sometimes use other words to describe themselves and their gender experience. (Isn't it wonderful how we're all different?)

A significant factor that shapes our lives is that our unique gender experience is routinely erased from public awareness, leading to significant social stress. For example, lavatories, clothing, medical forms, courtship customs, popular song, and most widely spoken languages and linguistic conventions constantly sort people into two (and only two) categories of male and female. For folks with a binary gender identity, there are specific life role experiences that mark and validate social identity, but non-binary and genderqueer folks do not have access to these same aspects of social approbation and understanding. Non-binary and genderqueer people can experience the same sorts of social stress and microaggression as binary trans- and cis-gender sexual minority individuals. To top it off, our experience is erased, ignored, and marginalized as we are repeatedly misgendered by strangers who automatically read us by appearance and performance, sort us into the male or female box, and blithely greet us as "sir" or "ma'am." In bathrooms, clothing stores, and health centers, we are repeatedly reminded of the gender binary and its assumption that people like us simply do not exist.

This is not to deny or ignore the other forms of pain and oppression that occur within cisheteropatriarchy, but simply to speak about our experience, as well. Clearly, cisgender women experience oppression in patriarchal culture, and cisgender men also experience constrained social roles and different kinds of marginalization. Binary trans men and trans women also experience identity-based oppression and marginalization, as attested by the epidemiological data (e.g., James et al. 2016). Non-binary, genderqueer, and other gender non-conforming people experience additional styles of social stigma, marginalization, denial of access to resources, microaggressions, and social violence due solely to our identity, experience, performance, and appearance in relation to our gender positionality. This chapter makes specific recommendations for how health professionals can provide a culturally competent experience for folks like us.

Non-Binary and Genderqueer Genders in the Literature

Non-binary, genderqueer, and other gender non-conforming experiences have received increasing attention in academic literature in the last several years, including the recent publication of an edited volume devoted to the topic (Richards, Bouman and Barker 2017). However, the topic was virtually invisible in the academic literature until recently: a 2016 PubMed[2] search for 'non-binary' and 'genderqueer' yielded a total of 59 results (54 and 5, respectively; Richards et al. 2016). At the time of writing in 2019, a similar search yields 222 results (171 for 'non-binary,' 51 for 'genderqueer'). Research into non-binary and genderqueer issues remains urgently needed.

In a basic overview for health professionals, Richards et al. (2016) defined non-binary and genderqueer genders and explored a variety of possible psychotherapeutic and biomedical interventions to affirm and support non-binary and genderqueer people in their gender experience. The medical and psychosocial intervention needs of non-binary and genderqueer individuals are diverse, and sensitivity to the needs of particular individuals is important (ibid.). Non-binary and genderqueer people routinely experience erasure in healthcare contexts, and feel forced to conform to binary gender narratives, even at specialty trans care clinics (Koehler, Eyssel and Nieder 2018; Lykens, LeBlanc and Bockting 2018; Taylor et al. 2019). The barriers to accessing gender-affirming medical care include systemic issues, incidents of bias, and insufficient medical provider education and awareness around the specific needs of trans and gender non-conforming people (Puckett et al. 2018). When clinicians misunderstand the different needs of gender diverse individuals, they risk collapsing people into binary trans identity categories, erasing their identities, and marginalizing them further. Academic research communities have committed the same error by collapsing non-binary, genderqueer, and other diverse LGBTQ identities into larger categories, thereby erasing them from data collection and analysis, despite these groups having unique health needs (Smalley, Warren and Barefoot 2016).

This erasure and marginalization occur on the wider social scale as well. Budge, Rossman, and Howard (2014) found that the genderqueer individuals they studied (N = 64) reported significantly higher anxiety and depres-

2 PubMed is an online database that aggregates health science articles and citations. It is maintained by the U.S. Library of Medicine and is visible at https://www.ncbi.nlm.nih.gov/pubmed/.

sion than in the general population and argued that this difference is due to being a stressed minority group rather than intrinsic pathology. Because non-binary and genderqueer people experience routine mis-gendering (e.g., strangers assuming a binary gender for them in speech and social assumptions), absence of media representation, pathologization, and social violence in the form of bullying and victimization, the experience of being genderqueer or non-binary can be stressful. Gender invalidation is a pervasive source of minority stress that affects non-binary individuals to a particularly significant degree (Johnson, LeBlanc, Deardorff and Bockting 2019). In addition to erasure and invalidation, victimization is a common experience for non-binary, genderqueer, and trans and gender non-conforming youth (Sterzing et al. 2017), and they report more risky behavior and experiences and fewer protective factors when compared with their cis gender peers (Eisenberg et al. 2017).

For professionals to help non-binary and genderqueer people navigate marginalizing social environments, it is helpful to provide supportive, culturally competent individual psychosocial support. In a chapter on psychotherapy with this population, Barker and Iantaffi (2017) give an overview of the challenges faced by these clients, examine the binarizing assumptions of different psychotherapeutic modalities, and enumerate likely gender-related issues that non-binary individuals may wish to examine in therapy. Rider et al. (2019) articulate a gender-affirmative lifespan approach (GALA) as a psychosocial intervention, which helps non-binary individuals build resiliency, develop gender literacy, move beyond the binary, promote positive sexuality, and move towards empowering medical interventions if desired. Interventions and therapeutic frameworks for helping non-binary and genderqueer people are beginning to appear, yet their wider dissemination and application is still very much needed.

Other authors have written clinical guides for psychotherapy with gender non-conforming children, youth and adults, with some attention to non-binary and genderqueer identities (Brill and Kenney 2016; Brill and Pepper 2008; Ehrensaft 2011; 2016; Keo-Meier and Ehrensaft 2018; Krieger 2017; Moe, Bower and Clark 2017). Others have published self-help workbooks for gender exploration and resilience (Bornstein 2006; 1998/2013; Hoffman-Fox 2017; Iantaffi and Barker 2017; Singh 2018; Testa, Coolhart and Peta 2015). Another important contribution is the publication of anthologies, first-person accounts and self-help guides that include theorized activism, such as Bornstein (1998/2013; 1994/2016), Bornstein and Bergman (2010), and Nestle, Howell and Wilchins

(2002). These short memoirs provide visibility, context, and a sense of community to those who are otherwise isolated and prevented from understanding their gender position due to an absence of narratives that explore, give words to, and validate the unique experiences of non-binary and genderqueer people.

Because social erasure and stigmatization play a key role in creating distress in non-binary individuals, it is crucial to foster cultural competence in healthcare. Interventions to support non-binary and genderqueer people are multileveled. Non-binary and genderqueer individuals need social support and help in adopting facilitative coping skills to navigate an overwhelmingly gender-binarizing world. Those who seek medical transition options need healthcare workers who can competently respond to their individual needs, rather than forcing them into a gender binarizing or trans-hostile medical paradigm. We also need to create broader change to foster a culture that acknowledges and celebrates gender diversity in all its forms, so as to counteract gender invalidation and cisheteronormativity. This chapter adds our voices to the call for greater acceptance, understanding, acknowledgement, support, and affirmation of our unique gender experiences.

Methods, Ethics, Recruitment, Data Collection

This pilot participatory action research study grew out of a non-binary/genderqueer peer support group in Portland, Oregon, USA which met twice a month from October 2016 to June 2017. The group was initially formed for community support, and as far as we know, ours was the first community group for non-binary and genderqueer people in Portland. The idea for this study came about after the group was well under way. We conducted this project as a participatory action research study (Brydon-Miller 1997), because we are all members of an oppressed group. We used a consensus-based model for making decisions, and the co-researchers were all invited to craft the shape of the research, produce data, and analyze it. Additionally, all the co-researchers have been invited to give feedback on the manuscript and include their names as co-authors.

Our aim in conducting this study was to increase cultural competency in counseling, with the specific goal of presenting our results at the Gender Odyssey Professional conference in Seattle, Washington, USA in August 2017. Because ours was a small study without institutional support, we con-

ducted an informal internal ethics review.[3] We determined to protect participant data through anonymity, and because we agreed to be co-researchers together, we sought to reduce the risk of harm stemming from power differentials. Based in our shared vision of activism, spreading awareness, and sharing power, we felt that the traditional risks of power abuses stemming from our research activities were minimal, and the potential for benefit from publishing our results outweighed the risks of harm. As a small group of participant-members of an oppressed group who experience systemic marginalization and denial of access to resources, we hope that we can be trusted with our own authority in choosing to publish the results of our findings on how to treat non-binary and genderqueer people appropriately in counseling.

We recruited a convenience sample of support group members, our non-binary and genderqueer friends, and past attendees. All past attendees were emailed an invitation to two focus groups, held two weeks apart in June and July 2017, which we held in the normal group meeting space (Sasha Strong's psychotherapy office). Most of the in-person focus group co-researchers were core members of the group; one of these individuals also participated in an in-person informal interview at their home. Two other co-researchers sent their accounts via email, and one of those individuals also participated in an informal in-person interview at a restaurant. In all, our co-researchers (N = 7) included two mental health professionals, one primary care physician, two K-12[4] educators, one educational para-professional, and one post-secondary educator. Among us, we hold two doctoral degrees and four master's degrees. Two of us are people of color, and the rest of us are white folks. Assigned gender of birth data are omitted, as they are irrelevant for our purposes.

During the two focus groups, we discussed themes and experiences that we thought were important, based on the following prompts:

> "What has worked for you in therapy as a genderqueer/non-binary person?"
> "What hasn't worked for you in therapy as a genderqueer/non-binary person?"

3 Of the two participant-researchers who had institutional affiliations at the time of the study, one worked at an institution that was hostile towards trans health issues, and the other institution had a policy not to offer institutional review board (IRB) review to students for projects not linked to doctoral theses. Due to these barriers, our study neither sought nor received formal IRB review.

4 In the U.S. education system, K-12 education refers to the compulsory educational period from kindergarten to grade 12, when students are between 5 and 18 years old.

> "What other suggestions do you have for therapists to provide competent counseling services to genderqueer/non-binary people?"

During the focus groups, each co-researcher was invited to use standard U.S. format index cards[5] and write down significant themes, suggestions, and stories. After about 30 minutes (when the supply of cards was exhausted), we each read the contents of our cards and sorted them into themes (with each co-researcher having the final say in the goodness of fit of the theme to their data, and their data to the theme). Data collection and analysis happened incrementally and simultaneously, in a spiral of sampling and analysis (Creswell 2013). This process yielded 62 unique data items. These data were subsequently transcribed for clarity and posterity.[6]

Analysis

This project used a thematic analysis approach (Braun and Clarke 2006), We did not use a preexisting coding framework, but rather sought themes within the data. During the first focus group, we generated data and sorted cards into piles, coming up with 5 major themes. In the second focus group, we identified a need for concrete recommendations to improve clinical practice with non-binary and genderqueer folks. We gathered additional data on index cards, using the prompts "What are best practices for therapists working with genderqueer/non-binary clients?" and "What are poor practices for them?" During this time, we continued to practice a consensus-based thematic analysis method and implemented memoing and coding (Creswell 2013) of themes and best practices.

All participant-members of the focus groups were invited to join the core research group, but only two or three made it to subsequent planning meetings. During a meeting in mid-July 2017, we further refined the themes and entered additional data from an interview in a typewritten and index card format. At our next meeting in August 2017, two co-researchers (Sasha Strong and Sagan Wallace) further refined the Best Practices list and determined a

5 These paper cards measured 3x5 and 4x6 inches (roughly equivalent to A6 format) and were lined on one side.

6 Transcripts and data collection images are held by Sasha and are available to qualified researchers upon request for the purposes of study validation.

presentation format. Later in August 2017, Sasha & Sagan created a synopsis of the themes and prepared a bibliography for the conference handout. We presented at Gender Odyssey Professional[7] later that month to an interested audience of mental health professionals. Sagan has developed and offered presentations on their own to local universities and LGBTQ community groups. Sasha has presented to a few audiences of health professionals[8], has continued to develop the bibliography, and wrote this research report.

Results

Our study yielded five major themes and 12 best practices. The themes were Validation Basics, Holding Space for Complexity, Finding Safe Spaces, Erasure, and Trauma-Informed Intersectionality. The best practices appear after the presentation of themes below. The narrative text for each theme and best practice was written by Sasha and was developed from a global sense of the data we elicited. These sections extrapolate from the data to articulate how professionals can better meet our needs. Our findings are couched as imperatives, asking professionals to adapt their thinking and behavior to acknowledge, understand, and support our experience.

Validation Basics

The first major theme that should be taken into consideration when working with non-binary and genderqueer people is to validate our experience. It is hard to have a lived gender experience that is outside of the social norm, and we need people in our lives who will understand, affirm, and empathize with that experience. This does not necessarily mean that professionals need to have deep expertise on our identity, but just a basic sense of understanding our position and being willing to learn more in working with us.

We need to be validated as who we are. Please do not tell us to fit into a different identity, performance, or set of norms. Rather than policing our

7 Gender Odyssey is an annual U.S. West Coast conference on gender issues, first held in Seattle in 2001. We presented these findings in 2017 and 2018, in the professional track of the conference. Learn more at http://www.genderodyssey.org/.

8 A recording of one such presentation can be viewed at https://www.brilliancycounseling.com/blog/nbgq-counseling-competency-video/.

gender, please generate curiosity and appreciation for the richness of our gender diversity. While non-binary and genderqueer genders can be a bridge to other genders, they are also a location in their own right—telling us "it's just a phase" is profoundly insulting and misguided. Therefore, please refrain from undermining our identity with your assumptions, and please do not assume anything about our wishes, our medical needs, or our transition—just ask us!

Holding Space for Complexity

Non-binary and genderqueer experience are complex, mutable, and unfolds over time. We do not fit into the typical narratives of lifespan gender and identity development, and we may need to generate, revise, revisit, and recreate our gender identity, narrative, and path throughout life. Helping professionals who accompany us on this journey need to hold space for the complexity of this unfolding journey and encourage us to do the same. Helpers and companions who fearlessly nourish and encourage us during times of uncertainty are invaluable. Professionals who make gender assumptions that do not fit our experience, or who display discomfort with the ambiguity of our gender, risk damaging the therapeutic relationship and foreclosing the space of possibility.

Non-binary and genderqueer gender identity, performance, and development are complex, vary from person to person, and change over time. Our genders are as much about becoming as they are about being, and gender creativity begins with a sense of not-knowing and being willing to explore and find out. Non-binary and genderqueer people, and the people who support and help them, need to encourage gentle exploration with plenty of time to discover and create.

Finding Safe Spaces

Because we live in a cisheteronormative, gender binarizing culture, it is crucial for non-binary and genderqueer people to find safe spaces where we can feel validated, cared for, and understood. These spaces can occur in person, online, over the phone, or through books, websites, media, and other artifacts made by people like us. Just feeling that we are not alone is a crucial ingredient in helping us accept, love, and cherish ourselves and feel that we belong.

Safe spaces are needed everywhere, but especially when accessing services, in home life, with friends, and in the community. Peer support can be

very helpful, especially in validating aspects of our experience that are misunderstood in other gendered contexts. When a safe space for our experience cannot be created, we appreciate referrals to competent counselors, community resources, and other non-binary/genderqueer-affirming groups and professionals.

Erasure

In the mainstream culture, our experience as non-binary and genderqueer people is characterized by repeated and pervasive erasure of our gender. Insomuch as gender is a core component of identity, basic facts about who we are get ignored and painted over all the time. Each time a stranger refers to us using a binary gender honorific or pronoun (e.g., Mr., Mrs., sir, madam, he, him, 'that guy'), or when a speaker addresses a group as "ladies and gentlemen," our identities are erased. People make binary gender assumptions constantly, and often, the result for us is pain and confusion. Whenever a stranger refrains from assigning us a binary gender identity in speech or manner, it can feel like a little victory of recognition—and yet it is just simple courtesy. Most of the time, strangers (and sometimes colleagues, friends, and family) erase us with their binary gender assumptions. Because this erasure is pervasive, and normative assumptions about binary genders mostly go unquestioned in mainstream social discourse, it is crucial that helpers understand this pain, and that they not recapitulate it.

Trauma-Informed Intersectionality

Crenshaw (1989) discussed how multiple intersecting aspects of identity come together to create unique configurations of social identity and oppression, in a theory that has come to be called "intersectionality." Along with an acknowledgement of the complexity of our identities (which may also include racialized identities, disability-related identities, different countries of origin, socialized genders, etc.) comes an acknowledgement that social oppression can contribute to trauma. Many of us have experienced trauma, and while our non-binary/genderqueer experience intersects with trauma and may be entangled with its aftereffects, our trauma does not cause our non-binary/genderqueer gender, and our gender does not cause our trauma. Those who claim that trauma causes gender difference, commit a profoundly pathologizing error, and they do epistemological and social violence to a person's gender location and lived experience as a survivor of trauma. That said, supportive,

trauma-informed services that are non-pathologizing and strengths-based can be helpful in addressing the biographical trauma we have experienced, as well as the repeated and pervasive social trauma we experience due to our gender difference and other oppressed social group memberships. We need competent professionals who can approach this complex interrelationship with sensitivity and discernment.

12 Best Practices

The following statements are written to address health providers, but they can also serve as points of reflection for non-binary, genderqueer, and gender diverse people to understand their own experience, as well as to advocate for their needs in healthcare and other contexts.

1. Embrace gender transition as an open-ended, lifelong process of exploration and joy. There is no timeline, correct answer, or final destination for the gender journey. Rather, it is an open field of play.

2. Be curious about NB/GQness in general and the unique experience of individuals in particular. Non-binary and genderqueer experience are improvisational, innovative, and open to constant discovery. When you bring your curiosity, it synergizes with our experience to promote optimal gender exploration and growth.

3. Don't use your clients for your professional education. Rather, read up, network with competent peers, and attend trainings. Certainly, individuals are experts on their own experience, but if you need more education on the generalities of non-binary and genderqueer issues, please consult the bibliography, engage in continuing education opportunities, or contact the authors for training and consultation.

4. Get our pronouns right (and if you mess up, apologize, and move on). Different people use different pronouns at different times for different reasons. The most polite approach is to ask a person what pronouns they use the first time you meet them, do your best to observe those preferences, and accept corrections and revisions in the future. If you erroneously misgender someone by using the wrong pronoun (or another gendered word) and notice your mistake, simply apologize sincerely, and move on to the next thing. Kindly refrain

from long-winded, over-dramatic apologies that make of us the victims and caretakers of your social anxiety and awkwardness.

5. Appreciate the rich complexity of transness. The trans umbrella is big enough to fit all the people whose gender transcends cis and/or binary genders. Please develop an appreciation for this richness, and for all the ways that people choose to live and perform their genders. Isn't it wonderful that there are so many ways to be human? Gender is a category of expression that allows for endless creativity.

6. Start from within: Analyze your own gender assumptions, limitations, and position(s). After learning to refrain from misgendering us, perhaps the next best step is to analyze and deconstruct your own gender socialization. By analyzing your own gender position and understanding the ways that power, privilege, and oppression run through it, you can reduce your discomfort when you meet someone who challenges your gender assumptions. By doing your own gender work, you reduce the risk harming others by reflexively and unreflectively enforcing cisheteropatriarchy and your gender socialization. Guidebooks to this process can be helpful (e.g., Iantaffi and Barker 2017; Bornstein 1998/2013), as can discussing your experience with competent friends.

7. Change your intake forms, policies, and processes to avoid binary gender assumptions. While insurance companies and other institutions may still require binary gender markers for reimbursement purposes, you can probably change pretty much every other aspect of your administrative environment to include and support gender non-conforming people. Donatone and Rachlin (2013) described how they created psychotherapy intake templates that are inclusive of trans identities. Remember that physical anatomy, names, pronouns, gender, romantic/affective attraction, and sexual attraction are independent dimensions that constellate differently for different people (Bornstein 1998/2013; Pan, Moore and Trans Student Educational Resources, n.d.). Please adjust your procedures and policies with those realities in mind.

8. Change your speech to avoid binary gender assumptions. The linguistic practice of assuming and imposing binary genders is only a habit, and just like any other habit, it can be unlearned and reshaped. When addressing strangers or speaking to someone about a person you don't know, refrain from assuming you know the gender of the person. For example, rather than saying "that man

over there," use a non-gendered way to clarify who you mean, such as "the person in the green shirt." This helps in practicing a new habit, and it models communication outside an assumed gender binary to those you are speaking with. Likewise, in addressing clients, patients, and students, find ways to abstain from imposing binary gender assumptions on them and on the people, you talk about (if their genders are unknown). Although English lacks clear gender-neutral honorific forms, it is possible to avoid most other gender-binarizing formulations; other languages may present different degrees of ease and challenge. These practices extend into written communications and go a long way to help non-binary and genderqueer people feel understood and respected—simply by avoiding common practices that marginalize us and erase our experience and existence.

9. Develop a relationship with the community that goes beyond learning from us. Making friends, volunteer work, and supporting artistic and cultural productions by non-binary and genderqueer people are a few ways to build full human relationships with us.

10. Understand that trauma and non-binary/genderqueer experience co-arise and are intertwined, but one does not cause the other. This major theme bears repeating as a best practice. Trauma does not make us non-binary or genderqueer, and our gender identity does not cause our psychological trauma. Just as trauma can arise and interact with any other intersectional identity, our non-binary/genderqueer gender is one among many aspects of who are.

11. Develop a critical analysis of systems of oppression and intersectionality. Gender, transphobia, cisheteronormativity, and violence against gender non-conforming people are all parts of an interlinked chain of privilege, oppression, and violence that are inseparable from capitalism, white supremacy, the military-industrial complex, and the school-to-prison pipeline. If you genuinely analyze the profound injustices of our current social system and come to understand how these injustices are created, perpetuated, and enforced, you will be able to use your positionality and privilege to interrupt these processes of injustice and promote the welfare of non-binary and genderqueer people—and indeed everyone who experiences identity-based oppression in our shared world.

12. Carry forth these principles and become a non-binary/genderqueer ally and activist! Please join us in doing this work—we need as many allies and activists as possible. If you do choose to join us, please be willing continually to examine your gender, your positionality, and your privilege, in order to reduce unintended harm and to promote the welfare of all. We want to welcome you and celebrate your creativity, contributions, resilience, and courage, as you welcome us and celebrate ours.

Limitations and Discussion

This study was conducted with a small number of participants and may not be generalizable to other populations. However, qualitative studies do not aim for statistical generalizability (Tracy 2010), and these data are an initial step in asking the experts—non-binary and genderqueer people—what they need from counselors and, by extension, other helping professionals. Our findings resonate with the clinical guidelines and qualitative results of other authors (e.g., Barker and Iantaffi 2017; Richards et al. 2016; Rider et al. 2019; Taylor et al. 2019), and such resonance lends credence to our claims. Future studies could validate and expand on our findings.

Because our project seeks to influence helping professionals to attend to our needs as non-binary and genderqueer individuals, the data we elicited is biased towards our desire to persuade helpers to meet our perceived needs and create cultural change. A desired social outcome is a feature of participatory action research (Brydon-Miller 1997). As our research group included two mental health professionals, four educators, and one primary care physician, we feel that we are relatively knowledgeable about the needs of non-binary and genderqueer people in these contexts, and what our colleagues could do to learn more to support non-binary and genderqueer individuals. I, Sasha, trust that the research group's contextually grounded understanding of our most pressing communal concerns is an appropriate guide for bringing forth the most important aspects of these data. We are the experts on our own experience.

While we have applied thematic analysis as a qualitative research method (Braun and Clarke 2006) and brought critical gender theories to bear in terms of understanding our own experiences of gender and their intersections with other oppressed social identities (e.g., Bornstein 1998/2013; Butler 1999/2006), our research strategy is fundamentally a participatory action research project

which has valorized first-person experience and expertise, consensus-based decision-making, and improved outcomes for non-binary and genderqueer people (Brydon-Miller 1997). Our overt activist goals may make our project seem less 'objective' by traditional academic standards. However, we feel that research grounded in critical emancipatory values is more appropriate for this topic than research that feigns neutrality but favors and recapitulates hidden axiological assumptions of dominance and control. Guba and Lincoln (1994) articulated competing paradigmatic assumptions of qualitative and quantitative research and critiqued the implicit values of quantitative research. Our value commitments in this study are that we matter, and we would like to help professionals to do a better job. Please do not erase or devalue our voices because the knowledge we present here does not look like the kind of science which exemplifies the 'disembodied white cis male expert' approach. That said, we welcome sincere critical engagement with our research.

We have no funders or publication requirements for tenure, so our work does not conform to those pressures. Rather, our aim is to promote the welfare and opportunities of non-binary and genderqueer people and educate professionals through this work. We hope that you, the reader, will believe that this study articulates the changes we would like you to make in your healthcare practice, so as to acknowledge and accommodate us. Our expertise on these matters comes from our own lived experience.

We recruited using a convenience and snowball sample, based on our support group members and their friends, and we did not attempt to recruit a larger sample. One could challenge our truth claims based on this sampling procedure, but we believe that our findings remain valid despite the small size of the sample. One could also critique the sample because we came together for mutual support and created friendships and camaraderie through this process. Such a critique assumes that genuine human relationships somehow hinder the acquisition of knowledge. To assume that individuals from an oppressed group need to adopt a set of values and procedures that are impersonal, disconnected, and politically neutral is to impose white cisheteropatriarchal values upon queer, non-binary, racially diverse individuals. There are many kinds of knowing and coming to know oneself through social connection is of significant value in building understanding and resilience for oppressed groups (Nieto et al. 2014). In this sense, the support group sensitized research group members to the needs discussed in the study, because for many of us, it was the first time we came together with other non-binary and genderqueer individuals in a group setting over a long period. If one has

a need that has never been met, and then one is able to meet it by spending time with alike individuals, it becomes possible to articulate that need in a way that was impossible before (ibid.). Our findings and this paper are an outcome of the resilience we built and experienced together; we are happy to share it.

Methodologically, one could challenge the validity of our results by saying that we did not achieve saturation of the categories.[9] However, we are not trying to articulate all of the ways that professional helpers should change their practices to meet our needs; rather we hope to provide good initial guidance. We also hope that interested readers will deepen their learning on this topic in the future.

Tracy (2010) articulated eight big-tent criteria for quality in qualitative research, and my sense is that this study addresses a worthy topic; achieves sincerity, credibility, resonance, and meaningful coherence; and makes a significant contribution. Tracy's (2010) criterion of rich rigor would be better supported by exposing more of the specific data points in this study. However, we have chosen not to do so in order to protect the anonymity of our co-researchers. I, Sasha, believe that the themes and best practices we elicited make sense of our experience in a way that accurately communicates information about our needs to our intended audience in a salient way. We welcome future studies that will validate, deepen, or dispute our findings.

As to Tracy's (2010) ethical criterion for qualitative research, this study conducted a semi-formal internal ethics procedure, in which we sought consent and consensus from research group members during the study. This included contextual and procedural ethics relating to the comfort and preferences of our co-researchers. While we did not seek IRB approval, our internal process has included consensual decision-making in the research process and consideration of the risk of harm and the potential for benefit in conducting and publishing this study. All seven research group members were invited to share authorship, but only four responded to emailed invitations.

While a few works in our bibliography were discovered by research group members in their search for self-understanding and affirmation prior to the study, the formal literature search was completed after data collection and analysis occurred. It simply seemed unwieldy to ask our co-researchers, most

9 Theoretical saturation was first introduced in the grounded theory method of qualitative research (Glaser & Strauss, 1967), but it is not an appropriate standard for all qualitative approaches (O'Reilly & Parker, 2013).

of whom are not academics, to conduct a literature review prior to participating in the study. As our data and categories emerged from our lived experiences foremost, they are unlikely to be predetermined or influenced by existing research findings. That said, many of the themes and best practices we discovered are echoed in the literature reviewed above, and this form of triangulation lends credence to our claims.

This study elicited suggestions for how to improve counseling for non-binary and genderqueer people, and I (Sasha) believe that these findings are generalizable to other healthcare contexts, such as medicine. While articles from those fields lend support to this argument (e.g., Koehler, Eyssel and Nieder 2018; Lykens, LeBlanc and Bockting 2018; Puckett et al. 2018; Smalley, Warren and Barefoot 2016; Sterzing et al. 2017; Taylor et al. 2019), more studies asking non-binary and genderqueer individuals about their needs in healthcare are required.

Conclusion

Counselors, mental health professionals, and other healthcare providers are uniquely poised to foster supportive environments for non-binary and genderqueer people. Our hope is that you will take our recommendations to heart and begin to change your own relationship to the gender binary so as to validate us, hold space for complexity with us as we develop, create safe spaces, erase us less, approach any trauma in our past with respect and sensitivity, and adopt the 12 best practices we recommend above. Thank you for caring about us!

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