Genderqueer Identity and Wellbeing
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ABSTRACT

For a long time, transgender experience was understood in terms of transsexual experiences, who desire to transition from one’s gender assigned at birth to the “opposite” gender. However, recent studies have shown that such binary gender models are not applicable to all transgenders. A growing group of transgenders identifies as ‘genderqueer’: they feel that their gender identity cannot be captured within the binary terminology. The current study is the first to examine the prevalence of genderqueer individuals and their wellbeing (compared to transsexuals) within a clinical setting of a gender identity clinic. We analysed data of all people who applied to the Center of Expertise on Gender Dysphoria at the VU University Medical Center during the year 2013. Furthermore, five biographical semi-structured interviews were conducted to further explore identity development in genderqueer individuals. We found that genderqueers were more likely to request partial treatment than transsexuals. Also, we found some indication that genderqueers reported lower levels of wellbeing. From the interviews, a number of important factors emerged that contributed to the current gender identity. For example, people described that when they heard about transgender people, they started to explore living in the opposite gender role, but they eventually found out that this also did not ‘fit’ them. The results of the study may help counsellors with figuring out how to provide individualized care for transgender people.
Introduction

When hearing the term “transgender” most people will probably think of someone who reports feeling “trapped in the wrong body” (Diamond, Pardo, & Buttersworth, 2011). For example, a natal male might express a strong psychological sense of being a female and desires to bring their psychological sense of gender and their physical sex into alignment: this person is considered a transsexual. Transsexuals might change their social appearance and seek for physical treatment (hormones and/or surgery) and a formal change in legal status (Diamond, et al., 2011). Transsexuals, by definition, desire to live and “pass” as the gender opposite to their gender assigned at birth. People can transition from female-to-male (FTM) or from male-to-female (MTF). For a long time the normative and healthy endpoint of transgender development was often thought to be the “adoption of a stable, integrated, unambiguous identification as 100% male or 100% female” (Diamond & Buttersworth, 2008).

However, this binary gendered view is changing; more and more scientific reports show that transgenders (a broad term for individuals whose gender identity or gender expression conflicts in some way with their natal sex, Diamond et al., 2011) have diverse, complex experiences that do not always fit the transsexual pathway (e.g., Diamond, et al., 2008, 2011; Raj, 2002; Saltzburg, 2010). Some people identify as both male and female or neither male nor female. These people can be described as having a genderqueer identity (Kozee et al., 2012). Not much is known about the development of genderqueer identities in general. Furthermore, it is currently unclear to what extent having a genderqueer identity occurs in the Netherlands (especially within a specialized Gender Identity Clinic). This study is set up to gain a greater insight in this group of individuals.

First, we will assess the (relative) number of genderqueer identified individuals who apply to the Center of Expertise on Gender Dysphoria at the VU University Medical Center. Second, we will measure the (psychological and social) wellbeing of genderqueer individuals in comparison with transsexual individuals. Third, we aim to gain more understanding of the developmental trajectories of individuals with a genderqueer identity.
Defining the Terms

Before presenting an overview of previous research, it is highly important to define the relevant concepts for this study. The first distinction that needs to be made is between *sex* and *gender*. Sex refers “only to the physical or biological status of persons as female, male, or intersexed” (Devor, 1997). Usually doctors assign a baby as either “male” or “female” based on the appearance of external genitalia (Diamond et al., 2011). This procedure of sex-assignment generally suffices, but in some babies there is a disjuncture between chromosomal sex and genital morphology¹ (Diamond et al., 2011; Fausto-Sterling, 2000). Because of conciseness, the term *natal sex* is used in this thesis to refer to the sex assigned at birth.²

*Gender*, on the other hand, is a social standard and can be defined as “the trait characteristics and behaviors culturally associated with one’s sex” (Fausto-Sterling, 2000). One’s *gender identity* is “a person’s sense of self as a boy/man or a girl/woman or another gender” (Diamond et al., 2011). In the majority of people, one’s *gender identity* and *natal sex* are largely congruent; a natal boy will most often label himself and identify as a boy (Steensma, 2013). However for some people, their *gender identity* and *natal sex* are not in line. When there is “incongruence between one’s experienced/expressed gender on the one hand, and one’s assigned sex and/or one’s congenital primary and secondary sex -characteristics on the other hand”, we can call this person *gender variant* or *gender incongruent* (Kreukels et al., 2010; Steensma, 2013). *Gender variance* or *gender incongruence* is not necessarily associated with distress. In contrast, there are individuals who do experience distress and show extreme and enduring forms of cross-gender behaviors, preferences and interests and may indicate that they want to be the other gender; these individuals are said to

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¹ This is one of the many types of intersex conditions (also known as disorders or differences of sex development, Fausto-Sterling, 2000).
² Some scholars point out that it is problematic to consider *sex* as a biological (or “natural”) phenomenon that is different from *gender* which is seen a as cultural construct (see Fausto-Sterling, 2000; Serano, 2007). They argue that *sex* (like gender) is a social construct, because “cultural expectations and assumptions play a large role in shaping how we determine and consider sex” (Serano, 2007). Ann Fausto-Sterling notes that we might just as well posit five biological “sexes” rather than two (see Fausto-Sterling, 1993; 2000). Acknowledging these points, when I use the term *natal sex* I do not mean that this is one’s “true” or “natural” sex. Following the standard terminology in the field, I will use the term *gender assigned at birth* (rather than sex assigned at birth).
be gender dysphoric (DSM-5, American Psychiatric Association, 2013; Steensma, 2013). Gender dysphoria refers to “a radical incongruence between an individual’s natal sex and their gender identity. An individual who is “gender dysphoric” feels an irrevocable disconnection between their physical body and their mental sense of gender” (Carroll, Gilroy, & Ryan, 2002). Gender expression is the “way in which a person acts to communicate gender within a given culture; for example, in terms of clothing, communication patterns and interests” (APA, 2011). The umbrella-term transgender is “a broad category typically used to denote any individual whose gender identity or gender expression conflicts in some way with their natal sex, and who therefore violates conventional standards of unequivocal “male” or “female” identity and behavior” (Diamond, et al., 2011). Many people may be considered as transgender. Often this category includes individuals who place themselves between transsexuals (individuals who desire/require medical interventions) and cross-dresses (individuals who “dress in the clothing of the opposite gender for emotional satisfaction and/or erotic pleasure [but] do not wish to permanently alter their biological sex and express little or no desire for hormones or sexual reassignment surgery”, Raj, 2002) on a gender identity continuum. It is important to note that not all transgenders experience distress about their gender identity; for example, cross-dresses are often perfectly happy with their gender identity, and enjoy dressing in clothing of the opposite gender.

(Trans)Gender Identities

Historically, transgender experience was understood in terms of desiring to transition from one’s gender assigned at birth to the “opposite” gender. The healthy endpoint of the transition was considered to be an identification as 100% male or 100% female (Denny, 2004; Diamond & Buttersworth, 2008). As a consequence, most medical services specifically catered to the needs and desires of transsexuals. For example, at the Center of Expertise on Gender Dysphoria at the VU University Medical Center, for a long time, the only treatment option was the “full”
transition in which the only healthy outcome was considered the adoption of the desired gender role and to “pass” as the preferred gender. The first versions of the Standards of Care (SOC) of the World Professional Association for Transgender Health (WPATH) also focused only on “full” sex reassignment for transsexuals (Bockting, 2008; Cohen-Kettenis & Pfäfflin, 2010). Non-transsexual transgenders were often denied of access to hormones or (partial) surgery (i.e. breast removal, removal of the uterus and ovary, and/or genital surgery).

However, recent studies show that binary gendered models are not applicable to all transgenders. For example, Devor (1997) found in an interview-study with 45 FTMs, that a third of the participants did not find that their gender identity was adequately represented within the gender binary. Also, when Bockting (2008) asked 1229 US transgender persons to describe their transgender identity, many participants chose labels that fall outside the classical binary view of transgenderism, such as: “genderqueer”, “in-between and beyond”, “shemale”, “genderless”, “gender neutral”, “gender fluid”, “dyke-tomboy”, or “I was born with a female body but I am on the male end of the gender spectrum, but I am more than just male”.

In several studies in the US, the label genderqueer was often selected by transgenders to describe their gender identity. This term proves hard to define, because an important component of it is to defy classification; genderqueers often discourage the use of labels and their motto can be summarized as “Don’t pin a label on me” (Hansbury, 2005). A practical definition, and the way we define genderqueer in this study is: “individuals who do not feel their gender [identity] can be captured within the binary terminology” (Kozee, Tylka & Bauerband, 2012). The label genderqueer has become quite popular in the US. For example, a recent online study on transgenders in the US, showed that most participants (55.1%) identified (selecting more than one category was allowed) as genderqueer (Kuper, Nussbaum & Mustanski, 2012). Furthermore, almost half (45.2%) of their participants identified as neither male nor female, and some (5.5%) identified as both male and female. Another study with FTM-identified (transmen) participants found that 60% of the participants used the label genderqueer to describe their gender identity (Saltzburg, 2010).
Evidently, there is a lot more variety in how transgender people experience their gender identity, than originally assumed. The idea that “the transsexual trajectory is not the only form of transgender experience, and [that it] may not even be the modal one” has been described as “perhaps the most important development in research on gender over the past 20 years” (Diamond, et al., 2011). In the words of a former president of the WPATH: “there is no one way of being transgender” (Bockting, 2008). In line with how ideas about transgender experience changed, Gender Identity Clinics changed the medical services that are available for transgenders. At the VUmc, for example, it has become possible to apply for a partial treatment. For example, some natal females wished to have a metaidoioplasty (a surgery which uses the clitoris, virilized as a result of testosterone treatment, to construct a micropenis, Hage, 1996), but keep their neosscrotum (created by stretching out the labia majora and later placing scrotal implants, Krueger et al., 2007) open, as they still want to use their vaginal opening for sexual contact (Cohen-Kettenis et al., 2010). This change in offered treatments is due to different demands from those who apply to gender identity clinics.

While there is increasing research-interest on transpeople who identify other than 100% male or 100% female in the US, much less is known about the variety in gender identity of Dutch transpeople. A recent large-scale study provided an estimate of the prevalence of Dutch people who have a gender identity that falls outside the gender identity dichotomy. In this population based study with over 8,000 individuals, 1.1% of the natal males and 0.8% of the natal females reported having an incongruent gender identity: they identified stronger with the opposite gender than with their gender assigned at birth (Kuyper, 2012; Kuyper & Wijsen, 2013). Interestingly, a much larger percentage reported having an ambivalent gender identity; 4.6% of the natal males and 3.2% of the natal females reported equal identification with the other gender and with their gender assigned at birth (Kuyper, 2012; Kuyper & Wijsen, 2013). This seems to indicate that a gender continuum rather than a gender dichotomy might be more appropriate to describe (trans)gender identity (Kuyper, 2012). This idea seems to be supported by another recent Dutch
In this study, 450 transgenders were asked what labels they used to describe their gender identity. They mentioned many different labels and 22% of the participants could be classified as “genderambiguous transgenders”. This category was created to describe individuals who feel both/neither male and female or who mainly (but not fully) identify as male or female. Examples of identity-labels chosen by these participants are: “androgynous girl”, “part-time woman”, “just me” or “genderqueer” (Keuzenkamp, 2011).

These previous studies present valuable information: the results indicate that gender identities come in many forms. However, not much is known about the wellbeing of genderqueer identified people, nor about how such an identity has developed over the years. Furthermore, until now, no study has assessed the number of genderqueer identified individuals who apply to a Gender Identity Clinic. In order for these clinics to provide the best care, it is important to know if and how genderqueer individuals differ from transsexual individuals. For example, genderqueer identified people might desire other treatment than transsexuals. It is plausible that genderqueer individuals are more likely than transsexual individuals to desire partial treatment. The current study is the first to examine, in a Gender Identity Clinic, the number of genderqueer individuals, their wellbeing (compared to transsexuals) and the developmental trajectories of those with a genderqueer identity.

**Wellbeing**

Until recently, transgender experience was understood in terms of a desire to live in the gender-role opposite to one’s natal sex and health-care was organized to the needs of transsexuals who required to “fully” transition (Cohen-Kettenis et al., 2010; Denny, 2004; Diamond et al., 2012). Since healthcare options were often unavailable for genderqueer transpeople, one could argue that having a genderqueer identity would make life more challenging than being transsexual. Also, the transsexual experience is better known than that of genderqueer individuals (Diamond et al., 2011). Many transgenders describe that seeing transsexuals on television and hearing their stories
was an important moment when things “clicked” (Keuzenkamp, 2011). Since genderqueer identities receive much less attention in the media, their stories are less mainstream than transsexual experiences. It is conceivable that this lack of media representation may cause longer periods of confusion about and exploration of one’s gender identity for genderqueer individuals (compared to transsexual individuals). Lastly, in many societies – including the Netherlands – one is often categorized based on gender. For example, if a baby is born, the first question most people ask is: “Is it a boy or a girl?” (Steensma, 2013). Also, the majority of individuals in the Netherlands think it is important to know the gender of the person they are interacting with (Kuyper, 2012). It might be difficult, or even impossible, to categorize (genderqueer) individuals who do not feel that their gender identity can be captured by a binary view of gender. It is thus possible some may find it uncomfortable to interact with genderqueer individuals, which may result in stressful interactions, feeling misunderstood and possibly lower wellbeing for genderqueer individuals. We expected that these three factors (that until recently health-care options were more limited for genderqueers, that experiences of genderqueers are less known, and that dichotomous gender presentations (male/female) are highly valued in society) combined, may result in a lower wellbeing of genderqueer people compared to transsexual people.

It is important to realize that the current study is a first step to gain insight into the phenomenon of genderqueer identities and does not attempt to include all genderqueer identified people. All participants in this study have applied to the Center of Expertise on Gender Dysphoria at the VU University Medical Center, and are likely to seek some type of treatment (e.g., hormones or partial surgery). Since they desire some type of intervention, our participants may have a lower wellbeing than (and may differ from) genderqueer identified people who do not desire any form of medical intervention (Raj, 2002). Since these people most likely do not want/need to go to a Gender Identity Clinic, their experiences cannot be captured in the present study.
Transgender Identity Development

The third aim of this study is to get greater insight in the developmental trajectories of genderqueer identified people. There is very limited knowledge on transgender identity development and most of the available literature is theoretical. A few scholars put forth models of transgender identity. Devor (2004), for example, proposes a 14-stage developmental model that starts with early confusion and ends with planning and undertaking complete sex reassignment surgery, resulting finally in self-acceptance and pride. One of the final stages of this model is transiting to the gender opposite to the gender assigned at birth (e.g., from male to female), which indicates that the model is specific to transsexualism rather than the full range of transgender experiences (Diamond et al., 2011). Another model, put forward by Denny (2004), leaves more space for non-binary gender identification; this model allows one to identify as both male and female. Although this model is generally seen as more inclusive than the transsexual model, the transgender model still is linear and transition-oriented (Diamond et al., 2011; Kozee et al, 2012). Another, more flexible framework is provided by Diamond et al. (2011), who propose to place change and transition at the center of analysis. The model presumes that while some individuals may have a linear development process, others may experience fluid identity development (Kozee et al, 2012). This model is based on dynamical systems theory. Dynamical systems models focus on explaining how complex patterns (in this case: transgender identities) “emerge, stabilize and restabilize over time” (Diamond et al, 2011). This theory emphasizes the interaction between the endogenous factors (e.g., genes, skills, thoughts) and exogenous factors (e.g., relationships, cultural norms, experiences, Diamond et al, 2011). Regarding transgender identity formation, this frameworks posits that dynamic interactions between these factors can create new behaviors and a sense of self; identity “outcomes” are viewed as states that are continually constructed and reconstructed over time, rather than achieved with a certain finality (Diamond et al, 2011). This approach specifically promotes understanding transgender identity development as unique, individual, diverse, dynamic and fluid.
Although theoretical work on transgender identity development is available, empirical data is scant. This is even more true for non-transsexual transgender (genderqueer) identity development. With the current study, we hoped to fill this gap by conducting semi-structured, biographical interviews with genderqueer identified people. This would allow us to get a more in-depth view of what it means for someone to be genderqueer. We will focus on their description of how their current gender identity has developed; which factors played an important role? What are important moments in their life regarding their sense of gender identity?

**The Current Study**

This study aims to answer three main questions: 1) What is the percentage of individuals who identify as genderqueer within the Center of Expertise on Gender Dysphoria at the VU University Medical Center and how can we reliably determine whether one is genderqueer or not? 2) What is the wellbeing of genderqueer people (compared to transsexual people)? 3) How does a genderqueer identity develop; which factors contribute to the current gender identity? To answer these questions, we looked at the available data of all adults who applied to the Center of Expertise on Gender Dysphoria at the VU University Medical Center during the year 2013. Since this is the first study focusing on genderqueer identities in the Netherlands, simply looking at the number of genderqueer identified individuals who applied to the Gender Identity Clinic presented valuable information.

To answer the second question, we compared the scores of genderqueer and transsexual individuals at the Center of Expertise on Gender Dysphoria at the VU University Medical Center on several instruments intended to measure wellbeing. Since, until recently, for genderqueer identified individuals health-care options were limited (Cohen-Kettenis et al., 2010) and that experiences of transsexuals are better known (Diamond et al., 2011), we expect to find lower wellbeing of genderqueer people compared to transsexual people. As one indicator of wellbeing, possible group differences in the amount of experienced gender dysphoria were examined. Since
transsexuals, by definition, desire to live and “pass” as the gender opposite to their gender assigned at birth, we expect that they experience higher intensities of gender dysphoria than genderqueer people. The latter group will likely show lower intensities of gender dysphoria, since some people will feel both female and male and thus not feel completely uncomfortable or distressed about their gender assigned at birth.

To answer the third question about the development of a genderqueer identity (or any gender identity that is not 100% female or 100% male), we conducted a number of semi-structured biographical interviews. So, in order to answer our main questions most accurately, we utilized a mixed-method approach including both quantitative and qualitative research methods. We will first report the method, results and conclusion of the first (quantitative) study and then that of the second (qualitative) study, followed by a general conclusion.
Study I: The Prevalence, Wellbeing and Treatment Requests of Transsexual and Genderqueer People

Method

Location

We collected data from adults who applied to the Center of Expertise on Gender Dysphoria of the VU Medical Center, which is the largest Gender Identity Clinic in Europe (Kreukels et al., 2012). The VUmc in Amsterdam started providing diagnosis and treatment for gender dysphoric individuals in 1975 (Kreukels, et al., 2012). The treatment provided is multidisciplinary, consisting of a mix of psychological, psychiatric, hormonal and surgical interventions. On a yearly basis, an average of 140 adults apply for gender reassignment surgery (Kreukels et al., 2012). As part of the diagnostic procedure within the Center of Expertise on Gender Dysphoria at the VU University Medical Center (which is part of the European Network for the Investigation of Gender Incongruence (ENIGI, Kreukels, et al., 2010), individuals are psychologically tested. The test battery consists of measures of psychological functioning, psychological wellbeing, the intensity of experienced gender dysphoria, body image and several other instruments.

Participants

We had access to the VUmc’s database with information of each individual referred to the Gender Identity Clinic (if they gave informed consent for data usage for clinical research). In the year 2013, a total of 386 adults applied and (at least some) data was available for 357 individuals: 231 natal males (64.7%) and 126 natal females (35.3%). Their age ranged from 18 to 76 ($M = 32.90, SD = 13.00$). For different reasons, not every applicant completed every single questionnaire: for some people Dutch was not their mother language, for others the questionnaires were too complicated (e.g., because of reading/cognitive disabilities), or the time did not allow them to complete all questionnaires.
Materials

Treatment requests

This questionnaire is used since July 2013 and aims to identify the applicant’s treatment request, categorized in the following way:

1) Full social transition to the “other” sex, with legal gender-change and with full physical sex reassignment surgery (including genital surgery).

2) Full social transition to the “other” sex, with legal gender-change, but with partial physical/medical treatment (e.g., no vaginoplasty/phalloplasty or other operations).

3) Partial social transition to the “other” sex, without legal gender-change and without full medical treatment.

If individuals expressed the desire for partial treatment (options 2 and 3) the interviewer/psychologist asked why they prefered a partial treatment. Possibilities include, but are not limited to: medical reasons (e.g., suffering from a disease, making one too vulnerable to undergo major surgeries or dissatisfaction with the quality of the outcome of surgeries), fear of surgery and/or considerations regarding gender-identity issues. See Appendix I for the total scale.

Wellbeing

Quality of Life (QoL): To assess psychological wellbeing, we used a questionnaire based on the “Life as a whole,”-questionnaire by Bradburn (1969), which measures general satisfaction with one’s life. This questionnaire consists of four questions that assesses the Quality of Life in general (e.g., “Taking everything into account, how happy do you feel lately?”) and can be scored on a 3-point scale ranging from 1 to 3. The answer-options differ, depending on the question, so that a score of 1 can mean “good”, “very happy”, “doing very well”, or “continue in the same way” and a score of 3 can mean “not good”, “not very happy”, “not doing very well”, or “like to change many things”, see Appendix II for the total questionnaire. To calculate the total score on the QoL, all items are reverse scored and summed so that a high total score indicate a high
quality of life and a low score indicates a low quality of life. The QoL had a good reliability, Cronbach’s $\alpha = .76$.

**Social Functioning:** This scale consists of 14 items measuring how well one is functioning socially for the past two weeks. An example item is: “Were you able to enjoy the daily activities?”. Participants could choose one of three options: “yes”, “more or less”, or “no”, see Appendix III. We added up the score on each item, where we counted every “yes” for 1 point, every “more or less” for 0 points and every “no” for -1 point. The total score ranges from -14 to +14; a high total score indicates that the participant felt he/she has been functioning socially well, a low total score indicates that he/she is not functioning socially well. On the social functioning scale, item 9 had to be reverse scored. Then all scores on all items were summed to create a total score. The reliability of the social functioning scale was good, Cronbach’s $\alpha = .82$.

**Health-related symptoms:** To measure the degree to which the participants experience health-related physical and psychological symptoms, the Symptom Checklist 90-R (SCL-90-R) was used. As the name suggests, the SCL-90-R consists of 90 items. It assesses self-reported psychological burden on nine symptom scales: somatisation, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoneuroticism (Derogatis, 1992). Participants indicate on a five-point scale ranging from not at all (1) to very much (5) the degree to which they felt they are hindered by several symptoms such as: headaches, palpitations, and being afraid to leave the house (for the full scale, see Appendix IV). An overall score is calculated by adding up the scores for each item. A high overall score (the maximum score is 450) indicates a high amount of symptoms. In a “normal” population, the average overall score on the SCL-90-R is 123 (Derogatis, 1992). The SCL-90-R had an excellent reliability, Cronbach’s $\alpha = .97$.

**Gender dysphoria:** We measured the degree of gender dysphoria with the Utrecht Gender Dysphoria Scale (UGDS). This scale consists of 12 questions to measure the degree of experienced gender dysphoria. An example item is: “I feel a continuous desire to be treated as a
man/woman”. Answers are given on a five-point scale ranging from agree completely (1) to disagree completely (5). The questions of the UGDS are different for natal females and natal males, see Appendix V and VI. To calculate the total score on the UGDS, all items for the UGDS-M and item 1, 2, 4, 5, 6, 10, 11, and 12 of the UGDS-F had to be reverse-scored and then summed. Higher scores indicate more gender dysphoria. The UGDS-M had good reliability, Cronbach’s $\alpha = .84$. The reliability of the UGDS-F was relatively low, Cronbach’s $\alpha = .56$. Because the UGDS is different for natal males than for natal females, the total scores cannot be compared directly between these two groups. Therefore, the UGDS was analysed separately for natal males and natal females.

**Demographic questionnaire**

Background information of the participants was retrieved from the medical charts. Information on four variables was collected: their natal sex (indicated by the psychologist), age, education and sexual orientation, see Appendix VII. For the analyses, three levels of education were created: low (lower education/lower vocational), middle (secondary education/secondary vocational/high school), and high (higher vocational/bachelor/master or PhD). Furthermore, three different groups of sexual orientation were formed: being attracted only to people with the same natal gender, attracted to both genders (ranging from “being primarily attracted to one gender and only sometimes being attracted to the other gender” to “being equally attracted to both genders”), and attracted only to people with the other natal gender. The last two response options (transsexuals and not applicable) were not included, see Appendix VII.

**Results**

**Treatment Requests**

In total, the treatment request was collected of 305 people. Of those, 214 people (70.2%) indicated the wish for a “full” social transition including all available medical treatment options,
81 people (26.6%) wanted a “full” social transition with some medical treatment options and 10 people (3.3%) wanted a partial social transition with some medial treatment options, see Figure 1.

![Figure 1](image.png)

**Treatment Requests in 2013 (N = 305)**

Type of Treatment Requested

*Figure 1. The different types of treatment requested by applicants to the Center of Expertise on Gender Dysphoria at the VU University Medical Center in the year 2013.*

The type of treatment differed for natal males and natal females, $\chi^2(2) = 22.27, p < .01$. This seems to represent the fact that, based on the odds ratio\(^3\), natal males were 3.2 times more likely than natal females to request full treatment, see Table 1.

\(^3\) As an example of how the odds-ratio is calculated, I write it out below. In the remainder of this thesis, the odds ratio is calculated in the same way, but only the result is reported.

\[
\text{Odds full request for natal males} = \frac{\text{Natal male and full treatment request} = 151}{\text{Natal male and no full treatment request} = 39} = 3.87
\]

\[
\text{Odds full request for natal females} = \frac{\text{Natal female and full treatment request} = 63}{\text{Natal female and no full treatment request} = 52} = 1.21
\]

\[
\text{Odds ratio} = \frac{\text{odds full treatment request for natal males}}{\text{odds full treatment request for natal females}} = \frac{3.87}{1.21} = 3.20
\]
Table 1.

*The Frequency and Percentage (%) of Type of Treatment Requested by Natal Males (♂) and Natal Females (♀)*

<table>
<thead>
<tr>
<th>Natal Sex</th>
<th>Treatment Request</th>
<th>Frequency</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Full</td>
<td>151</td>
<td>70.6%</td>
</tr>
<tr>
<td></td>
<td>Fully social, partly medical</td>
<td>33</td>
<td>40.7%</td>
</tr>
<tr>
<td></td>
<td>Partly social, partly medical</td>
<td>6</td>
<td>60%</td>
</tr>
<tr>
<td>♂</td>
<td>Total</td>
<td>190</td>
<td>62.3%</td>
</tr>
<tr>
<td>♂</td>
<td>33 (40.7%)</td>
<td>6 (60%)</td>
<td>190 (62.3%)</td>
</tr>
<tr>
<td>♀</td>
<td>63 (29.4%)</td>
<td>48 (59.3%)</td>
<td>115 (37.7%)</td>
</tr>
<tr>
<td>♀</td>
<td>4 (40%)</td>
<td>115 (37.7%)</td>
<td></td>
</tr>
<tr>
<td>Total N</td>
<td>214</td>
<td>81</td>
<td>10</td>
</tr>
<tr>
<td>Total N</td>
<td>305</td>
<td></td>
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</tbody>
</table>

The reported reasons for requesting a partial treatment are printed in Table 2. Four people (4.4% of those with a partial treatment request and 1.3% of all applicants) explicitly indicated that their gender identity was the reason for requesting partial treatment.

Table 2

*The Frequency and Percentage of Reported Considerations for Requesting Partial Treatment.*

<table>
<thead>
<tr>
<th>Reported Considerations</th>
<th>Frequency</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk / Outcome Operation</td>
<td>47</td>
<td>51.6</td>
</tr>
<tr>
<td>Gender Identity</td>
<td>4</td>
<td>4.4</td>
</tr>
<tr>
<td>Age</td>
<td>5</td>
<td>5.5</td>
</tr>
<tr>
<td>Social Aspects</td>
<td>2</td>
<td>2.2</td>
</tr>
<tr>
<td>No Genital Dysphoria</td>
<td>15</td>
<td>16.5</td>
</tr>
<tr>
<td>No Data / Unclear</td>
<td>18</td>
<td>19.8</td>
</tr>
<tr>
<td>Total</td>
<td>91</td>
<td>100.0</td>
</tr>
</tbody>
</table>

The majority (51.6%) of those who requested partial treatment indicated that they found the risks of the surgical procedures too grave or were unsatisfied with the outcomes of genital surgery.
Some people (16.5%) did not have genital dysphoria; they had no aversion to their genitals and therefore did not consider genital surgery necessary. Some regarded themselves to be too old for medical treatment (5.5%). For others (2.2%) social aspects played an important role; they indicated that they were afraid of others’ reactions to their transition. For the remaining people who requested partial treatment (19.8%) we were unable to collect data or the reasons were unclear, see Figure 2.

![Diagram: Why a Partial Treatment Request? (N = 91)](image)

*Figure 2.* The number of times different reasons for requesting partial treatment were reported.

**Classification of Genderqueer Individuals**

Initially we planned to use treatment requests to split the participants into two groups: people with a genderqueer identity (those who wanted a partial treatment and furthermore indicated that they wanted this because of their gender identity) and transsexuals (all others). Following these criteria, only four people (1.3% of all applicants) could be considered as genderqueer: 2 natal females (22 and 26 years old) en 2 natal males (41 and 24 years old). However, this group might
be larger for several reasons. Of a large number of people (19.8%) with a partial treatment request, no reasons were reported. Some individuals in this group may identify as genderqueer. Another substantial group (16.5%) reported that they did not have genital dysphoria and felt no need for sex reassignment surgery. However, we do not know why no genital dysphoria is experienced; the underlying reason may be a gender identity that is not binary. Furthermore, the treatment requests were collected in an indirect way; the psychologist asked the patient about their considerations. With a self-report measure, we might get a different picture of the underlying reasons for partial treatments. Even though times have changed, for some people, the stereotype may still exists that gender identity clinics (such as the Center of Expertise on Gender Dysphoria of the VU Medical Centre) are not used to counseling people with non-binary gender identities or people with partial treatment requests (as was the case decades ago, see Cohen-Kettenis et al., 2010; Denny, 2004; Diamond et al., 2012). Some people might have feared to run into difficulties with, or to be denied access of care and therefore may not have been open about their actual considerations (i.e., gender identity).

Since the original criteria turned out to be too strict, we decided to use another way of categorizing people into a genderqueer and transsexual group. The Center of Expertise on Gender Dysphoria of the VU Medical Centre recently developed a new questionnaire to assess the degree to which people identify as genderqueer: the Genderqueer Identity Scale (GQI). The GQI consists of 24 statements. The participant reports how much they agree with each statement on a 5-point scale ranging from 0 (totally disagree) to 4 (totally agree), see Appendix VIII for the full scale.

Because the GQI had not been validated yet, it was important to look the internal consistency and decide if the scale was reliable and useful. A total of 6 items of the GQI had to be reverse scored (item 6, 7, 8, 9, 12 and 13). The reliability of the total scale (N = 219) was good, Cronbach’s $\alpha = .79$. To improve its reliability the 24-item scale was reduced to a 20-item scale (items 6, 14, 17 and 19 were removed). The final reliability of this scale was good, Cronbach’s $\alpha$
Because the instrument was developed to measure the degree to which one has a genderqueer identity, the first item on the GQI (“I consider myself to be “genderqueer” (other than male or female, or third gender”) is a key item and should correlate strongly with the total scale. The correlation between this item and the total scale indeed is strong, $r = .52 (p < .01)$. All items correlated reasonably well with the total scale (all item-total correlations $> .2$) and the reliability could not be improved by deleting any of the other items (see Appendix IX for the item-total correlation and Cronbach’s alpha for the scale if an item was deleted). The scores on these 20 items were added to calculate the total GQI score ($N = 220$). The total GQI scores ranged from 0 to 54 ($M = 20.99$, $SD = 10.79$).

In the further analyses, the GQI was used in two ways:

1. Based on their responses to the first item (“I consider myself to be “genderqueer” (other than male or female, or third gender’), individuals were split into two groups: transsexual participants who scored a 0 or 1 (disagree totally or disagree somewhat respectively) and genderqueer participants who scored a 2, 3, or 4 (neutral, agree somewhat, or agree totally, respectively) on this item.
2. The GQI was used as a total scale; in this case, genderqueerness was included as a continuous variable instead of a dichotomous one.

Below, the results of the first approach (dividing the groups based on item 1 of the GQI) are discussed for each outcome variable. Then the results of the second approach (using the total GQI) are discussed.

**Results Using Item 1 of the Genderqueer Identity Scale**

In total 237 people gave a response to the first item of the GQI, see Table 3. Most transsexuals, individuals who express a strong psychological sense of being either male/female (the opposite of their birth gender) and desire to bring their psychological sense of gender and their physical
sex into alignment, will most likely disagree with this statement. They consider themselves to be either male or female. What to make of the people who scored “neutral”? We decided to include people who were neutral in the genderqueer group, since they did not disagree with the statement, which indicates that their gender identity is probably not 100% male or 100% female. Based on the first item of the GQI, we categorized 43 people (18.1%) as genderqueer and 194 people (81.9%) as transsexual. We used these two groups to analyze the data further.

Table 3
The Frequency and Percentage of the Response Options on the First Item of the GQI

<table>
<thead>
<tr>
<th>Response on GQI-1</th>
<th>Frequency</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Totally Agree</td>
<td>174</td>
<td>73.42</td>
</tr>
<tr>
<td>Somewhat Disagree</td>
<td>20</td>
<td>8.44</td>
</tr>
<tr>
<td>Neutral</td>
<td>11</td>
<td>4.64</td>
</tr>
<tr>
<td>Somewhat Agree</td>
<td>22</td>
<td>9.28</td>
</tr>
<tr>
<td>Totally Agree</td>
<td>10</td>
<td>4.22</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>237</strong></td>
<td><strong>100.00</strong></td>
</tr>
</tbody>
</table>

Background Variables

There were no differences between genderqueer and transsexual participants on the background variables natal sex, age, sexual orientation, and on level of education (see Table 4 on the next page).
Table 4
Summary of Background Variables, Including the Test Statistic and Significance.

<table>
<thead>
<tr>
<th>Background Variable</th>
<th>Transsexual</th>
<th>Genderqueer</th>
<th>Total N</th>
<th>Test Statistic and Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Natal Sex (N)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>✈</td>
<td>117</td>
<td>29</td>
<td>146</td>
<td>$\chi^2(1) = 0.76, \text{ ns}$</td>
</tr>
<tr>
<td>✉</td>
<td>77</td>
<td>14</td>
<td>91</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>194</td>
<td>43</td>
<td>237</td>
<td></td>
</tr>
<tr>
<td>Age (Mean, SD)</td>
<td>32.13 (13.12)</td>
<td>32.30 (11.05)</td>
<td>237</td>
<td>$t(235) = -0.08, \text{ ns}$</td>
</tr>
<tr>
<td>Sexual Orientation (N)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Same as Natal Sex</td>
<td>72</td>
<td>13</td>
<td>85</td>
<td>$\chi^2(2) = 1.89, \text{ ns}$</td>
</tr>
<tr>
<td>Both Sexes</td>
<td>71</td>
<td>20</td>
<td>91</td>
<td></td>
</tr>
<tr>
<td>Other Than Natal Sex</td>
<td>37</td>
<td>6</td>
<td>43</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>180</td>
<td>39</td>
<td>219</td>
<td></td>
</tr>
<tr>
<td>Level of Education (N)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td>29</td>
<td>5</td>
<td>34</td>
<td>$\chi^2(2) = 1.04, \text{ ns}$</td>
</tr>
<tr>
<td>Middle</td>
<td>118</td>
<td>23</td>
<td>141</td>
<td></td>
</tr>
</tbody>
</table>
Do Genderqueer People Differ from Others with Regard to Treatment Requests?

In total, there were 234 people from whom we were able to collect both their treatment request and their answer on the first item of the GQI, see Table 5.

Table 5
The Frequency and Percentage of Requested Treatment by Transsexual and Genderqueer People

<table>
<thead>
<tr>
<th>Treatment Request</th>
<th>Transsexual</th>
<th>Genderqueer</th>
<th>Total N</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N (%)</td>
<td>N (%)</td>
<td>N (%)</td>
</tr>
<tr>
<td>Full Social, Full Medical</td>
<td>146 (93.6%)</td>
<td>42 (60.9%)</td>
<td>191</td>
</tr>
<tr>
<td>Part Social, Part Medical</td>
<td>3 (33.3%)</td>
<td>6 (66.7%)</td>
<td>43</td>
</tr>
<tr>
<td></td>
<td>156</td>
<td>69</td>
<td>234</td>
</tr>
</tbody>
</table>

It turned out there was an association between gender identity (whether some is genderqueer or not) and the treatment requested, $\chi^2 (2) = 48.70, p < .01$, see Figure 3.

Figure 3. Type of treatment requested (in percentages) by transsexual ($N = 191$) and genderqueer people ($N = 43$).
However, with a 2x3 table it is unclear where the exact differences are; we can only calculate the odds ratio within a 2x2 table. In order to get a clearer idea of where this association lies, we grouped both categories of partial treatment requests (full social/part medical and part social/part medical) and compared them to the full treatment requests. It turned out that the type of treatment requested depended on people’s gender identity, $\chi^2 (1) = 44.68$, $p < .01$. This seems to represent the fact that, based on the odds ratio, the odds of requesting a partial treatment were 10.71 times more likely if people were genderqueer than if people were transsexual. If we leave out all full medical and full social requests and look only at those who requested partial medical treatment (so the difference is whether one wants to fully or partly transition socially), there was no significant result, Fischer’s exact test\(^4\) was not significant, $p = .15$. Based on the odds ratio, genderqueer people were 3.23 times more likely than transsexuals to desire a partial social transition. However, this difference in likelihood was not significant, which might be due to the small cell sizes. Taken these findings together, it seems that someone who is genderqueer is much more likely to request partial treatment than transsexuals.

**Wellbeing**

We conducted several ANOVA’s to assess whether there was a relationship between gender identity and wellbeing. Natal sex was included as an independent variable, since it is suggested that natal females and natal males might have different developmental paths (see for example, Burke, 2014 who found some indication that the developmental trajectories of gender identity might be different for natal males and natal females). The assumptions for conducting an ANOVA were met, unless reported otherwise.

\(^4\) Fischer's exact test is reported here instead of Pearson's Chi-square test, because the cell sizes are small for those who want to partly transition socially, and the expected count < 5 in one of the four (25% of the) cells.
Quality of Life

We conducted a 2 (natal sex: M/F) X 2 (gender identity: GQ/TS) factorial-ANOVA on the data from the ‘Quality of Life’ scale. There was no main effect of natal sex on the quality of life, $F(1,216) = 2.70, p = .10$. Nor was there a main effect of gender identity (genderqueer versus transsexual) on quality of life, $F(1,216) < 0.01, p = .99$. Furthermore, there was no interaction effect between the natal sex and gender identity on the quality of life, $F(1,216) = 0.03, p = .86$. Thus the scores on the “Quality of Life”-scale did not seem to differ between natal males and natal females, nor between genderqueer people and transsexual people, see Table 6.

Table 6

The Mean Scores (and Standard Deviations) of Transsexual and Genderqueer People on the Wellbeing Scales

<table>
<thead>
<tr>
<th>Natal Sex</th>
<th>Quality of Life</th>
<th>Social Functioning</th>
<th>SCL-90-R</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$N$</td>
<td>$M$ (SD)</td>
<td>$N$</td>
</tr>
<tr>
<td>Transsexual</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>♂</td>
<td>109</td>
<td>7.94 (2.02)</td>
<td>106</td>
</tr>
<tr>
<td>♀</td>
<td>72</td>
<td>8.47 (1.68)</td>
<td>70</td>
</tr>
<tr>
<td>Total</td>
<td>181</td>
<td>8.15 (1.91)</td>
<td>176</td>
</tr>
<tr>
<td>Genderqueer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>♂</td>
<td>26</td>
<td>7.88 (2.22)</td>
<td>24</td>
</tr>
<tr>
<td>♀</td>
<td>13</td>
<td>8.54 (1.85)</td>
<td>13</td>
</tr>
<tr>
<td>Total</td>
<td>39</td>
<td>8.10 (2.10)</td>
<td>37</td>
</tr>
<tr>
<td>Total</td>
<td>135</td>
<td>7.93 (2.05)</td>
<td>130</td>
</tr>
<tr>
<td>♂</td>
<td>85</td>
<td>8.48 (1.70)</td>
<td>83</td>
</tr>
<tr>
<td>Total</td>
<td>220</td>
<td>8.15 (1.94)</td>
<td>213</td>
</tr>
</tbody>
</table>

Social Functioning

A 2 (natal sex: M/F) X 2 (gender identity: GQ/TS) factorial-ANOVA was conducted on the data from the ‘Social Functioning’ scale. The assumption of normality was violated; in natal males and natal females as well as in the transsexual group, social functioning was negatively skewed.
(indicating a build-up of high scores) and significantly not normal (for all three Kolmogorov-Smirnov tests, \( p < .01 \)). The assumption of equal variances was tenable. Even though the assumption of normality was not met in all groups, we conducted an ANOVA, since this test is considered to be robust to violation of the assumption of normality (see for example: Glass, Peckham, & Sanders, 1972; Harwell, Rubinstein, Hayes, & Olds, 1992; Lix, Keselman, & Keselman, 1996; Schmidner, Ziegler, Danay, Beyer, & Bühner, 2010).

There was no main effect of natal sex on the social functioning score, \( F(1,209) = 0.43 \), \( p = .51 \). Nor was there a main effect of gender identity (genderqueer versus transsexual) on social functioning score, \( F(1,209) = 0.01 \), \( p = .98 \). Furthermore, there was no interaction effect between the natal sex and gender identity on social functioning, \( F(1,209) = 0.18 \), \( p = .67 \). The social functioning scores did not differ between natal males and natal females, nor between genderqueer people and transsexual people, see Table 6.

**SCL-90-R overall score**

We conducted a 2 (natal sex: M/F) X 2 (gender identity: GQ/TS) factorial-ANOVA on the data from the SCL-90-R. In all groups, the SCL-90-R data were not normally distributed (for all four Kolmogrov-Smirnov tests, \( p < .01 \)). There was both positive skew (a build-up of low scores) as well as positive kurtosis (indicating a pointy and heavy-tailed distribution). The assumption of equal variances was tenable. Even though the assumption of normality was not met, we conducted an ANOVA, again relying on the fact that the ANOVA is robust against violations to the assumption of normality.

There was no main effect of natal sex on the total score on the symptoms checklist, \( F(1,207) = 1.01 \), \( p = .32 \). The scores were similar in natal males and natal females, see Table 6. However, there was a significant main effect of gender identity (genderqueer versus transsexual) on the total score of the symptoms checklist, \( F(1,207) = 5.32 \), \( p = .02 \). Genderqueer people reported significantly more health-related symptoms than transsexual people, see Table 6. There was no
significant interaction effect between the natal sex and gender identity on social functioning, $F(1,207) = 1.64, p = .20$.

However, before drawing conclusions, it is important to mention that there were 4 outliers with extremely positive (high) values on the SCL-90-R; their total scores were higher than the third quartile plus 3 times the interquartile range (as calculated by IBM SPSS, version 21). Their SCL-90-R scores were 292 (genderqueer, natal female), 257 (genderqueer, natal male), 290 (transsexual, natal female) and 263 (transsexual, natal male). After removing these outliers, there were no more significant effects: there was no main effect of natal sex on the total score on the symptoms checklist, $F(1,203) = 0.15, p = .70$. The scores were similar in natal males ($M = 122.29, SD = 26.66$) and natal females ($M = 120.54, SD = 30.30$). Also, there was no longer a significant main effect of gender identity (genderqueer versus transsexual) on the total score on the symptoms checklist, $F(1,203) = 2.06, p = .15$. Genderqueer people ($M = 126.75, SD = 29.22$) reported similar amounts of health-related symptoms to transsexual people ($M = 120.54, SD = 27.76$). Without removing the outliers, this difference was significant and thus seems to be driven by outliers\(^5\). Lastly, there was no significant interaction effect between the natal sex and gender identity on social functioning, $F(1,203) = 0.87, p = .35$.

**Is the SCL-90-R overall score in Clinical Range?**

With a chi-squared test, we tested whether the frequency of individuals with a clinical SCL-90 score differed between genderqueer or transsexual participants, see Table 7.

<table>
<thead>
<tr>
<th>Table 7. Frequencies and Percentages (%) of SCL-90-R Scores of Genderqueer and Transsexual Participants that are Inside or Outside the Clinical Range for Natal Males and Natal Females and the Total scores</th>
</tr>
</thead>
</table>

\(^5\) In line with this result: when we conducted two non-parametric Mann-Whitney Tests (as a check since we violated the assumption of normality) for natal females and natal males separately, there were no differences found on the total SCL scores between transsexual and genderqueer participants: for natal males, $U = 1237, z = -0.660, ns$ and for natal females $U = 287, z = -1.689, ns$. 

Is the SCL-90-R score within the clinical range?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th></th>
<th>No</th>
<th></th>
<th>Total</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>♂</td>
<td>♂♀</td>
<td>♂</td>
<td>♂♀</td>
<td>♂♀</td>
<td>♂♀</td>
</tr>
<tr>
<td>Transsexual</td>
<td>43</td>
<td>19</td>
<td>62</td>
<td>61</td>
<td>111</td>
<td>104</td>
</tr>
<tr>
<td></td>
<td>(79.6%)</td>
<td>(76.5%)</td>
<td>(80.3%)</td>
<td>(92.6%)</td>
<td>(85.4%)</td>
<td>(80%)</td>
</tr>
<tr>
<td>Genderqueer</td>
<td>11</td>
<td>8</td>
<td>19</td>
<td>15</td>
<td>4</td>
<td>19</td>
</tr>
<tr>
<td></td>
<td>(20.4%)</td>
<td>(23.5%)</td>
<td>(19.7%)</td>
<td>(7.4%)</td>
<td>(14.6%)</td>
<td>(20%)</td>
</tr>
<tr>
<td>Total</td>
<td>54</td>
<td>27</td>
<td>81</td>
<td>76</td>
<td>54</td>
<td>130</td>
</tr>
</tbody>
</table>

There was no significant association between gender identity and whether people had a SCL-90-score within the clinical range, \( \chi^2(1) = 2.64, p = .10 \). Based on the odds ratio, genderqueer people were 1.79 times more likely to have an SCL-score within the clinical range than transsexual people. Although this was not a significant likelihood, there seems to be a trend. To get a better idea of where the potential difference lies, we exploratively conducted chi-square tests for natal males and natal females separately.

For natal males there was no significant association between gender identity and whether their SCL-90 score was within the clinical range, \( \chi^2(1) = 0.01, p = .93 \), see Table 7. For natal females, there was a significant association between gender identity and whether their SCL-90 score was within the clinical range, \( \chi^2(1) = 7.04, p < .01 \), see Table 7. This seems to represent the fact that, based on the odds ratio, the odds of falling within the clinical range were 5.26 times more likely if natal females were genderqueer than if natal females were transsexual.
Gender dysphoria

Since the UGDS items differ for natal males and natal females, we cannot directly compare these two groups. Therefore, we conducted two $t$-tests (one for natal females, one for natal males) where we looked at whether the mean gender dysphoria scores differed between genderqueer and transsexual people.

UGDS-F

According to the Kolmogorov-Smirnov test, the UGDS-F scores were not normally distributed in the transsexual group, $D(70) = .16, p < .01$; there was a negative skew (indicating a pile-up of high scores). The assumption of equal variances was tenable. Because not all assumptions were met, we conducted a $t$-test as well as a non-parametric test to compare the gender dysphoria scores between transsexual and genderqueer people. There was no significant difference in experienced gender dysphoria between transsexual and genderqueer natal females, $t(82) = 1.76, p = .08$, see Table 8. A non-parametric Mann-Whitney test confirmed these results: there was no indication that gender dysphoria differs between genderqueer people ($Mdn = 54.00$) and transsexual natal females ($Mdn = 56.60$), $U = 368, z = -1.47, ns$.

Table 8. The Mean Scores and Standard Deviations on the UGDS-F and UGDS-M for Transsexual and Genderqueer People.

<table>
<thead>
<tr>
<th></th>
<th>UGDS-F</th>
<th></th>
<th>UGDS-M</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>M (SD)</td>
<td>N</td>
</tr>
<tr>
<td>Transsexual</td>
<td>70</td>
<td>55.77 (3.82)</td>
<td>103</td>
</tr>
<tr>
<td>Genderqueer</td>
<td>14</td>
<td>53.71 (4.84)</td>
<td>26</td>
</tr>
</tbody>
</table>

*Since the Mann Whitney test is based on ranks, for this test it makes more sense to report the median instead of the mean. Which we do here.*
UGDS-M

In both the transsexual and the genderqueer group, the data was not normally distributed (the Kolmogorov-Smirnov tests, \( p < .05 \)). For both groups, the UGDS-M scores were negatively skewed, indicating a pile-up of high scores. The assumption of equal variances was tenable. Because not all assumptions were met, we conducted a \( t \)-test as well as a non-parametric test to compare the gender dysphoria scores between transsexual and genderqueer natal males. There was a significant difference in experienced gender dysphoria; transsexual natal males experienced more gender dysphoria (\( M = 50.97, SD = 6.15 \)) than genderqueer (\( M = 44.92, SD = 9.11 \)) natal males, \( t (127) = 4.03, p < .01 \), see Table 8. Because we did not meet all assumptions for conducting a \( t \)-test, again, we conducted a non-parametric Mann-Whitney test to see if the conclusions would be different. The Mann Whitney test confirmed our \( t \)-test results: natal male transsexuals experienced significantly more gender dysphoria (\( Md = 52.00 \)) than natal male genderqueer (\( Md = 47.00 \)) participants, \( U = 763.5, z = -3.39, p < .01 \).

Results Using the Total GQI-Scale

As mentioned above, the GQI was used in two ways to analyse our data; based on the first item and also based on the total scale. Here, the results of the analyses of when the total GQI-scale was included are reported. Since the reliability of the total GQI-scale was good we decided to use the total scale as well as the responses to the first key item. Using the total score on the GQI as a continuous ‘genderqueerness’ measure would lead to more statistical possibilities and more power to detect possible effects. First potential differences in background variables are discussed and afterwards the results of each test are described. All assumptions for conducting the analyses were met, unless specified otherwise.
Background Variables

**Natal sex:** With a *t*-test, we found there was a significant difference in genderqueerness between natal males and natal females; natal males (*M* = 22.22, *SD* = 10.56) scored higher on genderqueerness than natal females (*M* = 19.06, *SD* = 10.92) participants, *t*(218) = 2.14, *p* < .05. Therefore, we included natal sex as a predictor in our models.

**Age:** The relationship between age and genderqueerness (*N* = 220) was not significant, *r* = −.01, *p* = .86. Therefore, we did not include age as a predictor in our models.

**Sexual Orientation:** Sexual orientation and genderqueerness (*N* = 204) were not related, *F*(2,201) = 2.54, *p* = .08. Sexual orientation was therefore not included in our models.

**Education:** Level of education and genderqueerness (*N* = 213) were not related; *F*(2,210) = 3.01, *p* = .97. Level of education was therefore not included as a predictor in our models.

The Association Between Treatment Request and the ‘Genderqueerness’

We conducted a two-way ANOVA with natal sex and treatment request as independent variables and genderqueerness as a dependent variable. The GQI scores were normally distributed across all groups, except for the natal males, *D*(132) = .09, *p* < .05. The data was positively skewed (indicating a pile-up of low scores). With a Levene’s test we saw that the assumption of equal variances was tenable, *F* (5,212), *p* = .22. Because ANOVAs are considered robust against violation the assumption of normality, an ANOVA was conducted with natal sex and treatment request as independent variables and genderqueerness as a dependent variable. There was no main effect of natal sex on the GQI scale, *F*(1,212) = 1.16, *p* = .28. The GQI-scores were similar for natal males (*M* = 22.08, *SD* = 10.54) and natal females (*M* = 19.06, *SD* = 10.92), see Figure 4.

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7 Since the assumption of normality was violated, as a check we conducted a non-parametric Kruskal-Wallis test to see if this would yield the same results. We left out natal sex as a predictor, because it was not significant. The conclusions were the same: Genderqueerness was significantly affected by the treatment requested, *H*(2) = 27.98, *p* < .01. Mann-Whitney tests were used to follow up this finding. Those with a partial social and partial medical request had higher GQI-scores than those with a full social and partial medical request. This latter group again had higher scores than those with a full social and full medical request, all *p*-values < .05. Thus, the conclusions of the ANOVA are the same as those of the non-parametric tests.
However, there was a main effect of treatment request on genderqueerness, $F(1,212) = 23.735, p < .01$. Post hoc tests\textsuperscript{8} indicated that the genderqueerness scores were higher for people with a full social and partly medical request ($M = 24.98, SD = 11.80, N = 64$) than for people with a full social and full medical request ($M = 18.21, SD = 8.81, N = 146$), $p < .01$. Furthermore, this latter group had significantly lower GQI scored than people with a partial social and partial medical ($M = 37.00, SD = 11.63, N = 8$), $p < .01$, see Figure 4. There was no interaction effect between the natal sex and treatment request on genderqueerness, $F(1,212) = 0.66, p = .52$.

\textit{Figure 4.} The relationship between treatment request and mean genderqueerness score for natal females and natal males

Next, we conducted three multiple regressions in which genderqueerness and natal sex were used as predictors for each of three wellbeing outcome measures (quality of life, social functioning, and health related symptoms). Again, only when assumptions for conducting a multiple regression were not met, they are reported here.

\textsuperscript{8} A Hochberg’s GT2 was used for the post hoc tests which is the preferred method for unequal sample sizes (Field, 2009, pg. 375). I used this test since the sample sizes differed with regard to treatment request.
Quality of Life

The assumptions were met. Using the enter method, the model with Genderqueerness and natal sex as predictors for Quality of Life had a good fit, $F(2, 202) = 5.32, p < .01$. Genderqueerness was a significant predictor in the model, see Table 9. As people scored higher on genderqueerness, their quality of life score decreased. Also, natal sex was a significant predictor in the model, with natal women generally reporting higher quality of life, see Table 9. Together, genderqueerness and natal sex explained 5.0% of the variance in quality of life.

Table 9. Results of the Multiple Regression: The Beta Values (Unstandardized and Standardized), Standard Errors of the Constant and the Predictors Genderqueerness and Natal Sex on the Quality of Life

<table>
<thead>
<tr>
<th></th>
<th>B</th>
<th>SE B</th>
<th>β</th>
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</thead>
<tbody>
<tr>
<td>Constant</td>
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<td>.32</td>
<td></td>
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<tr>
<td>Genderqueerness</td>
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<td>.01</td>
<td>-.16*</td>
</tr>
<tr>
<td>Natal Sex</td>
<td>.56</td>
<td>.27</td>
<td>.14*</td>
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</tbody>
</table>

* $p < .05$

Social Functioning

A multiple regression was conducted with genderqueerness and natal sex as predictors of social functioning. This model fits significantly well. Using the enter method, a significant model emerged $F(2, 197) = 3.77, p < .05$. The predictors explained 3.7% of the variance in social functioning. It turned out only GQI was a significant predictor in this model, see Table 10. As people scored higher on genderqueerness, their social functioning score decreased. Natal sex was not a significant predictor in this model, see Table 10.

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9 For clarity, the assumptions for the multiple regression were assessed in the following way: the Durbin-Watson statistic was 1.94, so the assumption of independent errors (independence of observations) was tenable. The assumption of no multicollinearity was tenable; the VIF and tolerance statistic were very close to 1. The errors are normally distributed; the pp-plots showed a straight line. The assumption of homoscedasticity is met; the plot of standardized residuals against standardized predicted values looks like a random array of dots evenly dispersed around zero. The mean Cook’s distance was < 2, so there were no influential data points. For the other multiple regressions, the assumptions were tested in the same way.
Table 10. Results of the Multiple Regression: The Beta Values (Unstandardized and Standardized), Standard Errors of the Constant and the Predictors Genderqueerness and Natal Sex on the Social Functioning.

<table>
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<tr>
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<tbody>
<tr>
<td>Constant</td>
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<tr>
<td>Genderqueerness</td>
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<td>-.16*</td>
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<tr>
<td>Natal Sex</td>
<td>.94</td>
<td>.77</td>
<td>.09</td>
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</table>

* p < .05

Health Related Symptoms (SCL-90-R)

All but one assumption for conducting a multiple regression were met; there were four outliers (the same cases that were identified when the ANOVA with genderqueers were identified based on their GQI-1 score, see page 29). These four cases with extreme high SCL-90-R scores were removed. Then a multiple regression was conducted with genderqueerness and social functioning as predictors of health-related symptoms. Using the enter method, a significant model emerged $F(2,190) = 7.82$, $p < .001$. The predictors explained 7.6% of the variance in health related symptoms. Only GQI was a significant predictor in this model, see Table 11. As people scored higher on genderqueerness they had more health related symptoms. Natal sex was not a significant predictor in this model, see Table 11.

Table 11. Results of the Multiple Regression: The Beta Values (Unstandardized and Standardized), Standard Errors of the Constant and the Predictors Genderqueerness and Natal Sex on the Health Related Symptoms.

<table>
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<tr>
<th></th>
<th>B</th>
<th>SE B</th>
<th>β</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constant</td>
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<td>4.85</td>
<td></td>
</tr>
<tr>
<td>Genderqueerness</td>
<td>.75</td>
<td>.19</td>
<td>.28*</td>
</tr>
<tr>
<td>Natal Sex</td>
<td>.43</td>
<td>4.07</td>
<td>.01</td>
</tr>
</tbody>
</table>

* p < .001
To examine if genderqueerness predicted levels of gender dysphoria, we conducted two simple regression analyses. As noted earlier, the UGDS-F and UGDS-M are not identical measures and should therefore not be analyzed together. So instead of a multiple regression with natal sex as a predictor, we conducted two simple regressions: one for natal females (with the UGDS-F scores as outcome variables) and one for natal males (with the UGDS-M scores as outcome variables).

**Gender dysphoria – Natal Females**

The model was not significant, $F(1,78) = 2.49, p = .12$. The amount of genderqueerness explained 3.1% of the variance in gender dysphoria in natal females (and was not a significant predictor, beta = -.18, $p = .12$).

**Gender dysphoria – Natal Males**

The model was significant, $F(1,116) = 4.81, p < .05$. The amount of genderqueerness explained 4.0% of the variance in gender dysphoria in natal males and was a significant predictor, beta = -.20, $p < .05$). Higher scores on genderqueerness predicted lower gender dysphoria in natal males.

**Conclusions Study I: The Prevalence, Wellbeing and Treatment Requests of Transsexual and Genderqueer People**

The answer to the question: ‘how many genderqueer (non-binary) individuals apply yearly to the VUmc?’ is not straightforward and depends on how people are categorized as genderqueer or not. Since no direct self-report measure is used at the VUmc, there are different approaches possible. I have already discussed the fact that the original method of classifying genderqueer versus transsexual people – namely by looking at their reasons for requesting a partial treatment – was too strict. So the most conservative estimate of the number of genderqueer people who apply yearly to the Center of Expertise on Gender Dysphoria at the VU University Medical Center is 4
of the 305 (1.3%). However, this method was probably too strict and left us unable to accurately identify all genderqueer individuals, “individuals who do not feel their gender [identity] can be captured within the binary terminology” (Kozee, et al., 2012). When using a more lenient classification criterion, namely, everyone who does not disagree with the statement “I consider myself to be “genderqueer” (other than male or female, or third gender)”, the estimate increases drastically to 42 out of 234 people (18.1%).

In order to provide the best care, it is important for the VU to know whether genderqueer people differ from the “typical” transsexual people. We used two approaches to achieve this goal: we used both a categorical (transsexual vs. genderqueer) and continuous (degree of ‘genderqueerness’) approach. We found that overall, there were not many differences on background variables. Both approaches showed that age, sexual orientation and level of education were not related to being genderqueer. Only when genderqueerness was treated as a continuous variable we found that natal males generally scored higher on genderqueerness than natal females. This finding was not predicted, and cannot be explained easily. Perhaps natal males, who generally have more difficulty “passing” (if they have the desire to do so) as women due to the drastic bodily effects of androgens (i.e., body hair, square jaw, large hand, Adam’s apple, etc.) find it more difficult to fully accept themselves as female and therefore as some sort of compromise – because achieving their ideal body image is not possible – identify as genderqueer instead of as female. However, this is speculation and more research is necessary. In the first place, future research could test if our results will replicate and in the second place examine why there is more genderqueerness in natal males than in natal females. For the current study this difference between natal males and natal females was corrected for by including natal sex in the models.

Regarding treatment requests, we found, using both the categorical (yes/no) and continuous approach, an association between genderqueerness and treatment request: genderqueers were more likely to request partial treatment than transsexuals. Furthermore, we found that people
who requested partial social and partial medical treatment were more genderqueer than people who requested full social and partial medical treatment (who in turn were more genderqueer than people who requested the full social and full medical treatment). This finding is in line with our expectations: if people do not have a strong cross-gender identification (as is the case with genderqueer people), they are less likely to request all medical treatment options available; they do not want to live and ‘pass’ as someone of the other gender (as most transsexuals desire).

Next, we found some associations between wellbeing and gender identity. We predicted that genderqueer people would have lower wellbeing compared to transsexual people, because of three factors: health-care options have historically been more limited for genderqueers, experiences of genderqueers are less known, and that dichotomous gender presentations (male/female) are highly valued in society. When using the categorical approach, we did not find any indication that there are differences between the two groups in quality of life, social functioning and in the amount of health-related symptoms. However, when we used the continuous genderqueer scale, we found that – although the explained variance was not large - genderqueerness was a significant predictor for all three wellbeing measures. Higher genderqueerness was associated with lower quality of life, lower social functioning and more health-related symptoms. This was in line with our predictions. At the same time, we did not find support for our hypothesis with the categorical approach. This may be due to a small sample size of genderqueer people, resulting in an underpowered study. With the categorical approach, we did find that natal women who were genderqueer were much more likely to have health-related symptoms that fall in a clinical range than natal females who were transsexual. This is in line with our prediction that genderqueer individuals would have lower wellbeing than transsexual individuals. However, this finding was not significant for natal males.

Natal sex, included in the regression models because it was a possible confound, was only significant in predicting quality of life scores; generally, natal females reported a higher quality of life than natal males. This finding was not expected and may have been due to the fact that for
natal women it is socially more accepted to present in a more typical masculine way (e.g., wearing trousers, short hair) than it is for natal men to present in a more typical feminine way (e.g., wear make-up, dresses, see for example: Feinman, 1981). When it comes to gender presentation, natal woman generally have more leeway to express themselves than natal males, which may result in a higher quality of life for natal females than for natal males.

Next, we hypothesized that gender dysphoria would be higher in transsexuals than in genderqueer people. Since transsexuals, by definition, desire to live and “pass” as the gender opposite to their gender assigned at birth, we expected that transsexuals would experience higher intensity of gender dysphoria than genderqueer individuals. The latter group would most likely show less gender dysphoria, since some people will feel both female and male and thus not feel completely uncomfortable in their gender assigned at birth. Using both analytic approaches, this hypothesis was confirmed for natal males. However, we found no indication that for natal females gender dysphoria was related to being genderqueer or transsexual. This may be due to the small number of genderqueer natal females included in our study \( N = 16 \) resulting in a lack of power to reveal the true difference that may exist. Another possibility of this non-finding might be the relatively poor reliability of the UGDS-F in our sample (Cronbach’s alpha was .56), which may have prevented us of accurately measuring gender dysphoria and as a result, not finding a difference in experienced gender dysphoria between transsexual and genderqueer natal females. A possible problem with the UGDS-F is that there are a few items (item 3, 6, and 7) that seem to assume that someone is living as a female, while they may already present as male. For example, regarding item 6 (“I feel unhappy because I have to behave like a female”)

\[ r = .08, \text{ns.} \]
their gender dysphoria is so strong, they start living and presenting as males. This is speculation, and not supported with data. Furthermore, it should be noted that, on the other hand, the UGDS-F has shown to be a reliable instrument with satisfactory sensitivity and specificity; recently, the UGDS-F was extensively validated and had a Cronbach’s alpha of .98 (Steensma, 2013). Further research is needed to examine if our failure to find a difference in gender dysphoria in natal females between genderqueer and transsexual people is due to low power or whether they may be an actual difference between natal females and natal males.

Overall, it seems safe to conclude that there are differences in treatment requested: genderqueers were more likely to request partial treatment than transsexuals. With regard to wellbeing the results of our study are somewhat inconclusive; with some comparisons we found the expected association between gender identity (transsexual/genderqueer(ness)) and wellbeing, with other comparisons – especially when using the categorical approach – we did not find differences between the groups. We found some indication that being genderqueer (i.e., having a non-binary gender identity) resulted in lower wellbeing. It should be noted, however, that this relationship was not always found and when it was found, the association was not always strong (i.e., the explained variance was not very large).
Study II: In-depth Biographical Interviews with Genderqueer People

Since not much is known about the development of genderqueer identifying individuals, we conducted a qualitative study that focused on the development of these individuals. The interviews were semi-structured; we established some central themes we wanted to discuss, but allowed the participants to talk freely and address topics that they might find relevant (which we did not necessarily listed as central topics). Conducting semi-structured, biographical interviews seems to be the best method to achieve this (Bryman, 2012).

We contacted the psychologists at the VUmc, and asked them whether they have individuals who identify as genderqueer in their caseload. We selected 5 individuals who lived somewhat close to Amsterdam and asked them if they were willing to participate in an interview. The criteria to be selected to participate in the study are: 1) the participant identifies as genderqueer (or with any other label that indicates a gender identity that falls in between or outside the gender-binary) and 2) the participant is competent in the Dutch language. The interviews were held at the Gender Identity Clinic of the VUmc. The interviews lasted between one hour and an hour and a half and were digitally recorded.

We developed a topic list for a semi-structured biographical interview. The questions on this topic list focuses on the current gender identity (“How do you describe you gender identity?”, “What does this mean to you?”) past gender role behavior / gender related preferences (“Can you describe how you behaved and felt when you were a child?”), periods of increase/decrease or stability in gender identity (“Did your feelings ever change about being male or female?”, “Can you describe your feelings in this period?”), physical development (“What did you think about the prospect of bodily changes during puberty?”, “How do you feel about your body now?”), sexual orientation/ sexual development (“When and who did you fall in love with for the first time?”, “Do you want to have children?”), psychological wellbeing, social support and stigmatization (“How satisfied are you with your life at this moment?”, “Do you ever get any reactions from others on your gender presentation?”). For the complete topic list, see Appendix X.
Participants and Method

We were able to interview 5 people: 4 natal females and 1 natal male. The semi-structured interviews were digitally recorded and transcribed verbatim. The transcripts were reviewed and analyzed using the method of open coding (Strauss & Corbin, 1990) and using the qualitative analysis software package ATLAS.ti V5.2. Coding categories were generated based on the aims of the study and the themes that emerged in the first interviews.

Results

Taking the current gender identity as a starting point, the results of the qualitative study (the developmental trajectories) are described chronologically (starting from childhood to the present time). Along with these descriptions, illustrative quotes from the interviews are presented.

Current Gender Identity

At the start of the interview, participants was asked to describe their current gender identity. All participants reported having a non-binary gender identity. The labels they preferred differed (the term gender neutral was popular). Participants added longer descriptions about what such a label meant to them, since labels other than male or female (like gender neutral or genderqueer) are not commonly used and can mean different things to different people.

♀ #1, 21 years old

I would call myself neutral. I tell most people I do not feel like a girl, but also not like a boy.
♀ #3, 26 years old

Genderneutral. I think that is a better description. Because me, well: male and female, no, actually neither. [...] I actually do not feel neither of the two. But to simplify it – within the binary, so to speak – when the middle is here, I am approximately in this area. It is very flexible. I mean: it really depends on my mood. So on this side, the middle to male side, so to speak. But that doesn’t mean I don’t have very feminine moods. So a bit like.. That’s why I prefer genderneutral. Because for me it doesn’t - for me many things are not necessarily related to gender. And for other people they apparently are, so then I’ll just explain it to them like this.

When it came to preferred pronouns, the participants reported that it did not really matter to them which pronoun was used (he/she), since there was no good option available. In the Dutch language, there is no neutral pronoun like there is in English, where ‘they’ can be used as a singular personal pronoun.

♀ #3, 26 years old

I think it would cost too much energy to think of some neutral pronoun and then get everyone to really start using it. Yeah, you know, it doesn’t really matter to me. [...] I don’t really care and people should just do what feels right for them and the way they address me doesn’t change anything about my identity.

However, if they could choose one or the other, the pronoun opposite of the natal sex was preferred, because using the pronoun of the natal sex clearly did not feel right.
♀ #1, 21 years old

Well it doesn’t really hurt, but when someone addresses me specifically as a woman, I always feel uncomfortable. […] With ‘he’ that feeling is a lot less, but that is probably mostly because... at least it is not female. It’s not like ‘he’ fits perfectly. […] Actually, I prefer neither, but in Dutch, it is quite difficult to find an appropriate word for it.

Childhood

How did the participants come to identify outside of the gender binary? To explore the developmental trajectories, the participants looked back on their childhood. In general, the participants did not seem to question their natal gender(role) and gender dysphoric feelings were absent in childhood.

♀ #4, 19 years old

[I was] very girly. That’s what my parents have always said. My two other sisters have always been much more boyish. So yeah, I loved wearing dresses and all that stuff. And yes, I do not feel ashamed thinking back on that.

♂ #2, 19 years old

I did always play with boys. And my hobbies… Well.. I liked Lego’s, cookies and games. I wasn’t a real boy, but it wasn’t like I was very girly or something. […] When we divided into a group of boys and a group of girls, I didn’t think: I want to be part of the other team. So when it was “either, or”, it wasn’t a problem for me.
Adolescence

While childhood seemed to be a relatively peaceful time in gender-related issues, adolescence was described as a confusing, tumultuous time. Especially the start of the puberty seemed to be a highly influential point in one’s development and experience. All people reported disliking the bodily changes that occurred. The development of secondary sex characteristics (e.g., the breast development and start of menstruation in natal females; the growth of body and facial hair and Adam’s apple in natal males) was a very unwelcome and often highly unpleasant and stressful experience.

♀ #1, 21 years old

That was a bit at the end of elementary school; I didn’t like it. […] I started to avoid going to physical education classes. The showering afterwards, I didn’t do it, I couldn’t do it.

♂ #2, 19 years old

Mostly, it was my voice changing, that I started worrying about that; I thought that was really dreadful. And that all sorts of things were happening down below that made me feel horrible, that I felt horrible about. […] That it started growing and having erections: that was what I was having problems dealing with mostly.

Even though the expected bodily changes caused by puberty were considered negative, most people reported that they – at that time – found a way to resign, at least to a certain degree, to the “forces of nature”.
♀ #2, 19 years old

I was afraid of it; that it would happen. But as far as I knew, I couldn’t do anything about it. So I resigned to it. And then I hoped that everything would take a while before the time came.

Hearing about Being Transgender

Participants experienced the bodily changes that resulted from puberty as stressful. At the same time, they reported reluctantly accepting these changes because they did not know of any way to prevent them from happening. Another shared experience of our participants was when they heard about transgenders and the possibility to undergo hormone treatments and/or genital surgery to bring one’s body in line with the other/experienced gender. Our participants mentioned seeing something on TV about a trans person or hearing about trans people from friends. Learning that something like being transgender existed caught their attention.

♀ #1, 21 years old

For quite some time, I was aware that transgender existed. When I realized that it could also be applicable to me, that was… uhm… when a friend of mine came out as transgender. And… yes, that got stuck in my head.

♀ #3, 26 years old

I did have something of a fascination for transsexuals, but I didn’t know where that came from. I thought – I did think for a while that it was sexual attraction.

After learning that something like being transgender existed, people generally started to experiment with changing their gender expression/gender role and identified with the opposite gender.
♀ #4, 19 years old

At the end of the first year of high school, I started having the thought: I wish I were a boy.

♂ #2, 19 years old

Because, at first I came out: “I feel more like a girl”. […] Well, then it happened pretty quickly that I completely transitioned and told everybody. And at that point I started studying, so then I thought: “this is a good fresh start, because now no one knows me as a boy.” And then I immediately started presenting completely as a woman.

Realizing there was a possibility to change one’s gender was considered valuable information, because the participants shared a strong feeling that it was uncomfortable being seen or living as a person of their natal gender. The only other known available option was transitioning to someone of the opposite gender. The desire to transition (or in some cases: actually transitioning) was attributed to this strong desire to move away from the natal gender and going towards the only other know option: living as someone of the opposite gender.

♀ #1, 21 years old

I think that around age 14, age 15, that I primarily wished to be a boy, but of course I thought about that for a few years, and then I realized that being a boy isn’t it, that wasn’t something for me. […] I think that my wish to be a boy was mainly due to the feeling that I didn’t want to be a girl. And if you have known only two options for whole your life, that might make sense.
♂ #2, 19 years old

Yes, that idea prevailed with me too. That’s why I originally thought: oh, so I am not a boy, then I must be a girl. […] I was really like: I am not a boy, so I am a girl. So I will start presenting as a girl.

After a period of cross-gender identification and exploration of the other gender role, the realization came that this transsexual path (i.e., going from ‘male-to-female’ or going from ‘female-to-male’) was not the path they desired.

♀ #3, 26 years old

In high school, about halfway through I think, it was like: then I knew that you could go from female to male and from male to female, but I had a feeling like: ok, but that is not what I want. So that won’t be it. […] No, I’m not a man. Period. […] No, that became clear to me pretty quickly. […] So, yes, I found that very confusing. That you are searching in the right direction, but what is offered to you is still not what you want.

♂ #2, 19 years old

And I had not really thought much about what it meant to be a woman and to be treated as a woman beforehand. So only when I started presenting as female, I realized: oh, but this also isn’t it: this does not fit me.

Then people described finding out there were more than two options when it comes to gender identity. Information was found through the Internet, or through friends who also were transgender.
♂ #2, 19 years old

Being in contact with other transgenders, that resulted in getting it clear for myself: “yes, you don’t have to choose between one or the other.” At first I didn’t want it, without having the idea: yes, that’s a possibility in the real world. […] Later, I met other transgenders who were not one of the two and that really helped me to realize: it really is a possibility to be in-between.

Current Body Image and Treatment Request

When it came to body image, participants reported they were suffering from bodily dysphoria and wanted to change their body in one way or another. This was unsurprising, since we only spoke to people who applied to the VUmc because they wanted to have some kind of treatment.

♀ #5, 27 years old

The fact that I came to the hospital is that, since I’m getting older, I’m getting less androgynous. […] Increasingly, I’m being called “madam”. And I cannot continue to cope with it, because constantly I feel unseen and that is very painful.

♀ #3, 26 years old

The physical aspect, yes, I am really suffering from that. […] Well, I don’t think it is a good thing to be really disgusted by your body. That is not, that just not right. And you can hold out for a while, and you can change clothes three times a day when one day it really sucks – it often really sucks for a really long time. But it’s not… No, no, no it’s not doable. It is.. You know, that’s why I’m here. I can’t go on like this for another five years.
At the time of the interview, the natal male was not sure about which treatment was desired. All natal females reported suffering from having feminine body parts. They wanted a mastectomy, but none wanted to have surgery to create a penis.

♀ #5, 27 years old

When I start using hormones, I want a breastoperation. And for me that is now, and I think forever, the only thing I want.

So, in general, individuals were suffering from their secondary sex characteristics and expressed the desire for medical treatment to be rid or change those.

**Conclusion**

With the interviews we attempted to explore the developmental trajectories of people who did not identify as 100% male or 100% female. It turned out they had some things in common: during childhood, gender dysphoric feelings were absent. This is in contrast to reports of people with early onset gender dysphoria – where children from a very young age onwards describe a strong incongruence between the experienced/expressed gender and the assigned gender (DSM-5, American Psychiatric Association, 2013). Gender dysphoric children often display gender variant behavior: for example, a natal girl might dislike activities that are typically considered appropriate or “normal” for girls (e.g., dressing up, playing ‘house’ or playing with dolls) and has a preference for stereotypical boy’s activities or play (e.g., soccer, cars, rough and tumble play) (Steensma, 2013). In contrast, the people we talked to (with non-binary or genderqueer identities) did not report aversion to things and activities that typically “belonged” to their natal sex.

However, the anticipated and actual changes that occurred during puberty were very unpleasant and caused great amounts of stress and confusion. When our participants learned that something like being transgender or transsexual existed, all felt a fascination for or identification with them.
While some soon realized that they did not desire to transition from their natal gender to the ‘opposite’ gender, others started to experiment with presenting as the other gender or even started living as the other gender. A common theme that emerged was that, for a long time, people had felt that there were only two possible options: either you are male or you are female. Identifying with or presenting as the other gender was explained mainly as the result of a desire to move away from their natal gender rather than a desire to go move towards the opposite gender. At a later point in their lives, everyone we interviewed found out that there were other options and/or they met people who did not identify or live as male or female. When we interviewed them, most people identified as gender neutral. The participants expressed a desire for medical (surgical) treatment since they felt distressed about and were suffering from certain body parts; for the natal females, especially having breasts was strongly disliked.

The interviews served as a way to explore themes that genderqueer people\textsuperscript{11} considered relevant to their developmental trajectories. Also, we were able to got into depth about what kind of treatment was desired and requested. However, because of the small sample size (we interviewed 5 people), these findings cannot be replicated to a larger group of people. Unfortunately, we were only able to interview one natal male (this was due to practical reasons; one natal male we invited to participate cancelled the interview last-minute). Therefore, we cannot really compare the experiences of natal females and natal males. Also, as mentioned several time before, our sample was biased in that all participants had applied to the VU and thus desired treatment because they suffered from body dysphoria. Most likely, there are other people with non-binary gender identities who do not experience distress nor desire any medical treatment. Our findings cannot be generalized to this group, so future research should explore whether and if so, how their developmental trajectories differ from the people in our sample.

\textsuperscript{11} I.e., people who do not identify as 100% male or 100% female. So gender-neutral people also fall within our definition of genderqueer.
Overall Conclusion

Conclusions and Discussion

The goal of this study was to answer the following three main questions: 1) What is the percentage of individuals who identify as genderqueer within the Center of Expertise on Gender Dysphoria at the VU University Medical Center and how can we reliably determine whether one is genderqueer or not? 2) What is the wellbeing of genderqueer people (compared to transsexual people)? 3) How does a genderqueer identity develop; which factors contribute to the current gender identity? Here, I will discuss the main findings, the relevance for gender identity clinics, point out some limitations of the studies, and discuss opportunities for future research.

As discussed previously, the answer to the first main question depends on the definition and operationalization of being genderqueer. The most conservative estimate is 1.3% while this percentage increases to 18.1% if more lenient criteria are used. So it seems like there are at least some people who do not have a gender identity that fits within the gender binary. This finding is in line with previous findings and recent insights that binary gendered models are not applicable to all transgenders and the idea that “the transsexual trajectory is not the only form of transgender experience,” (Diamond et al., 2011; Kuyper, 2012). Thus it seems important for counsellors and other people working with transgender individuals, to be sensitive and open to the variation in gender identity and experience and to not assume that the transsexual model is applicable to everyone who applies to a gender identity clinic.

Overall, we concluded that there are differences in treatment requested: genderqueers were more likely to request partial treatment than transsexuals. With regard to wellbeing, the results of our study are not uniform; with some comparisons we found the expected association between gender identity and wellbeing, with other comparisons we did not find differences between the groups. We found some indication that being genderqueer resulted in lower wellbeing. It should be noted, however, that this relationship was not always found and when it was found, the association was not always strong. With interviews we tried to gain an understanding of the
developmental trajectories or genderqueer people. A few important moments and factors contributing to the current gender identity emerged from the interviews: the absence of gender dysphoric feelings during childhood, the aversion to bodily changes during puberty, learning that there was something like ‘being transgender’, experimenting with or presenting as the other gender or realized that they did not identify as the other gender. Furthermore, they described having the feeling there were only two possible gender identities (male/female) and identifying with or presenting as the other gender was explained mainly as the result of a desire to move away from their natal gender rather than a desire to go move towards the opposite gender. At the time of the interview, all participants had a non-binary gender identification. The participants expressed a desire for medical (surgical) treatment since they were suffering from certain body parts; for the natal females, especially having breasts was strongly disliked.

The present data do not allow drawing any strong conclusions and indicate that more research is needed. In the first place, it would be interesting to interview genderqueer people outside of a gender identity clinic. They most likely do not desire any type of medical treatment and may be satisfied with their body (Raj, 2002). Their wellbeing, experiences and developmental trajectories might thus differ from the individuals in our sample. Another limitation of the present study was that the samples sizes were relatively small for the genderqueer groups. As a result, the quantitative analyses may have been underpowered and may not have enabled us to find group differences where they might have been. Also, the qualitative study was conducted with a small number of individuals. However, from the interviews valuable information emerged about common developmental trajectories. The small sample sizes were not surprising since non-binary gender identities are still uncommon and have only recently started to receive more (scientific) interest. The studies conducted in this thesis should be seen as an exploration of the variation of experiences, identity and developmental trajectories of transgender people. As our studies took place within the limits of a specialized gender identity clinic, the results cannot be generalized to a larger group of people. However, the information gained with this study can inform policy
makers and counsellors who work with transgender people. Our study was a first step in looking at variation in transgender identities within a gender identity clinic. We found that there are at least some people with non-binary (or genderqueer) identities who apply to the Center of Expertise on Gender Dysphoria at the VU University Medical Center, though their number may not be extremely large. Also, genderqueerness showed to be indicative of the type of treatment requested: partial treatment and partial social role change was more often preferred as people were more genderqueer. Furthermore, we found some indication that if people are more genderqueer, they have lower wellbeing. For gender identity clinics, it might be useful to collect information on the gender identity of their applicants, as this could lead to an adjustment in clinical approach. For example, the care could be individualized by providing, to someone who indicates not having a binary gender identity, information about the medical possibilities and impossibilities (for example, not taking any sex-hormones for a long period of time, might be harmful). From an early stage on then, people receive the information that is relevant for them. Also, if our results about the association between (more) genderqueerness and (less) wellbeing will be replicated, it might be wise to provide additional counselling to this group who is more vulnerable for lower wellbeing and more health-related problems.
References


IBM SPSS Statistics for Macintosh, Version 21.0.


Appendices

Appendix I: Treatment Request Form

Wat is uw behandelwens? (Interviewer categoriseert)

___ Volledige sociale transitie naar het “andere” geslacht, met juridische geslachtsaanpassing en met volledige lichamelijke geslachtsaanpassing (inclusief genitale chirurgie)

___ Volledige sociale transitie naar het “andere” geslacht, met juridische geslachtsaanpassing, maar gedeeltelijke fysieke/medische behandeling (bv geen vaginaplastiek of falloplastiek of andere operaties)

___ Gedeeltelijke sociale transitie naar het “andere” geslacht, zonder juridische geslachtsaanpassing en zonder volledige medische behandeling.

Als de persoon aangeeft een behandelwens te hebben overeenkomstig met optie twee of drie.

Vraag: Waarom wilt u dit?: (doorvragen naar medische redenen, redenen vanuit identiteit, angst of andere redenen:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Welke behandelingen wenst u? (omcirkelen/aankruisen) (omschrijven)

<table>
<thead>
<tr>
<th></th>
<th>Hormonen</th>
<th>Borstoperatie</th>
<th>Genitale operatie</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MV</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Anti-androgenen (androcur) en Oestrogenen</td>
<td>Borstvergroting dmv implantaten (als nodig)</td>
<td>Verwijdering van de testikels</td>
</tr>
<tr>
<td></td>
<td>Alleen oestrogenen</td>
<td>Vervrouwelijken aangezichtschirurgie (FFS; als nodig)</td>
<td>Verwijdering van de penis</td>
</tr>
<tr>
<td></td>
<td>Alleen anti-androgenen (androcur)</td>
<td></td>
<td>Vaginaplastiek (neo-vagina)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Anders:</td>
</tr>
<tr>
<td><strong>VM</strong></td>
<td>Testosteron (androgenen)</td>
<td>Bortsverwijdering / Borstreconstructie</td>
<td>Baarmoeder- en Eierstokverwijdering</td>
</tr>
<tr>
<td></td>
<td>Alleen progesterone (orgametril)</td>
<td></td>
<td>Falloplastiek (neo-penis)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Metadoioplastiek (neo-penis)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Anders:</td>
</tr>
</tbody>
</table>
Appendix II: Quality of Life Scale

Kwaliteit van leven

Wij willen graag vernemen hoe u zich heeft gevoeld de afgelopen dagen. Kruist u alstublieft aan welk antwoord het beste bij u past.

1. Hoe voelt u zich wanneer u uw leven als geheel in ogenschouw neemt?
   - [ ] Goed
   - [ ] Redelijk
   - [ ] Niet goed

2. Alles wel beschouwd, hoe gelukkig voelt u zich deze dagen?
   - [ ] Zeer gelukkig
   - [ ] Redelijk gelukkig
   - [ ] Niet zo gelukkig

3. Als het erom gaat "er wat van te maken in het leven", vindt u dan dat u
   - [ ] Het heel goed doet
   - [ ] Het redelijk goed doet
   - [ ] Het niet zo goed doet

4. Als u eens kijkt naar hoe uw leven zich nu afspelt, zou u dan
   - [ ] graag op dezelfde manier willen verdergaan
   - [ ] graag enkele dingen willen veranderen
   - [ ] graag vele dingen veranderen

Appendix III: Social Functioning Scale

Sociaal functioneren

In de afgelopen 2 weken:

a. Bent u erin geslaagd uzelf te vermaken en bezig te houden?  [ ] ja  [ ] min of meer  [ ] nee

b. Had u het gevoel dat u, over het algemeen genomen, de dingen goed deed?  [ ] ja  [ ] min of meer  [ ] nee

c. Maakte u nieuwe vrienden of kennissen?  [ ] ja  [ ] min of meer  [ ] nee

d. Had u het gevoel hetzelfde energieniveau te hebben als 10 jaar geleden?  [ ] ja  [ ] min of meer  [ ] nee

e. Had u het gevoel de juiste beslissingen te kunnen nemen over dingen?  [ ] ja  [ ] min of meer  [ ] nee

f. Was u in staat om van de dagelijkse activiteiten te genieten?  [ ] ja  [ ] min of meer  [ ] nee

g. Had u het gevoel dat u bijzonder opgewonden of geïnteresseerd was in iets?  [ ] ja  [ ] min of meer  [ ] nee

h. Zou u zichzelf beschouwen als een zorgeloos persoon tijdens het grootste deel van uw leven?  [ ] ja  [ ] min of meer  [ ] nee

i. Heeft u zich de laatste tijd onder stress voelen staan?  [ ] ja  [ ] min of meer  [ ] nee

j. Heeft u meestal vrede met de wereld?  [ ] ja  [ ] min of meer  [ ] nee

k. Heeft u diverse hobby’s of andere tijdvredende bezigheden die u leuk vindt?  [ ] ja  [ ] min of meer  [ ] nee

l. Heeft u de meeste dagen momenten van plezier en blijheid?  [ ] ja  [ ] min of meer  [ ] nee

m. Zonder ijdel te willen zijn, bent u redelijk tevreden over uzelf?  [ ] ja  [ ] min of meer  [ ] nee

n. Lijkt u altijd wel iets prettigs te hebben om naar uit te kijken?  [ ] ja  [ ] min of meer  [ ] nee
Appendix IV: SCL-90-R

In deze vragenlijst wordt u gevraagd in welke mate U last heeft van lichamelijke en psychische klachten. Wilt U voor elk van de onderstaande klachten aangeven, in hoeverre U last heeft, door een kruisje te plaatsen bij het antwoord, dat het meest van toepassing is?

Het gaat er hierbij steeds om, hoe U zich gedurende de afgelopen week, met vandaag erbij, voelde.

In welke mate werd U gehinderd door de volgende klachten:

1. Hoofdpijn
2. Zenuwachtigheid of van binnen trillen
3. Nare gedachten of ideeën niet kwijt kunnen raken
4. Duizeligheid
5. Geen sexuele interesse meer hebben of er geen plezier aan beleven
6. Kritisch staan tegenover anderen
7. Het idee dat iemand anders je gedachten kan beheersen
8. Het gevoel dat anderen schuld hebben aan de meeste van je problemen
9. Moeilijk iets kunnen onthouden
10. Piekeren over een slordigheid of iets wat je vergeten bent
11. Je gemakkelijk verveeld of geïrriteerd voelen
12. Pijn in borst of hartstreek
13. Je angstig voelen in open ruimten of op straat

Datum: 

Behandelaar: 

SCHEMA 8
In welke mate werd U gehinderd door de volgende klachten:

<table>
<thead>
<tr>
<th></th>
<th>Helemaal niet</th>
<th>Een beetje</th>
<th>Nogal</th>
<th>Tamelijk veel</th>
<th>Heel erg</th>
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</thead>
<tbody>
<tr>
<td>14. Weinig puf (energie) hebben</td>
<td></td>
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<tr>
<td>15. Denken om er maar een eind aan te maken</td>
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<tr>
<td>16. Stemmen horen die andere mensen niet horen</td>
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<td>17. Trillen</td>
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<td>18. Het gevoel dat de meeste mensen niet te vertrouwen zijn</td>
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<td>19. Weinig eetlust hebben</td>
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<td>20. Gauw huilen</td>
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<tr>
<td>21. Je verlegen en niet op je gemak voelen bij de andere sexe</td>
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<td>22. Verstrikt zijn of gevangen voelen</td>
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<td>23. Zomaar plotseling schrikken of bang worden</td>
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<td>24. Woedeuitbarstingen die je niet in de hand hebt</td>
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<td>25. Bang zijn om alleen uit huis te gaan</td>
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<td>26. Jezelf van allerlei dingen de schuld geven</td>
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<td>27. Pijn onder in de rug</td>
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<td>28. Je belemmerd voelen in het uitvoeren van allerlei dingen</td>
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<td>29. Je eenzaam voelen</td>
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<td>30. Het gevoel in de put te zitten</td>
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<td>31. Te veel over de dingen piekeren</td>
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<tr>
<td>32. Nergens meer belangstelling in hebben</td>
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</table>
In welke mate werd U gehinderd door de volgende klachten:

<table>
<thead>
<tr>
<th>Klacht</th>
<th>Helemaal niet</th>
<th>Een beetje</th>
<th>Nogal</th>
<th>Tamelijk veel</th>
<th>Heel erg</th>
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<tbody>
<tr>
<td>33. Je bang voelen</td>
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<tr>
<td>34. Je gauw gekwetst voelen</td>
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<tr>
<td>35. Het idee dat andere mensen je geheime gedachten kennen</td>
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<td>36. Het gevoel dat andere je niet begrijpen of onaardig zijn</td>
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<tr>
<td>37. Het gevoel dat anderen onvriendelijk zijn of je niet mogen</td>
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<tr>
<td>38. Iets langzaam moeten doen om er zeker van te zijn dat je het goed doet</td>
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<td>39. Hartkloppingen</td>
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<td>40. Misselijkheid of een maag die van streek is</td>
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<td>41. Je tegenover anderen de mindere voelen</td>
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<td>42. Pijnlijke spieren</td>
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<td>43. Het gevoel dat anderen je in de gaten houden of over je praten</td>
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<tr>
<td>44. Moeilijk in slaap kunnen komen</td>
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<td>45. Steeds maar moeten controleren wat je doet.</td>
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<tr>
<td>46. Moeilijk beslissingen kunnen nemen</td>
<td></td>
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<tr>
<td>47. Bang zijn om te reizen in bussen, treinen of trams</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>48. Moeilijk adem kunnen krijgen</td>
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<tr>
<td>49. Je soms erg warm, dan weer erg koud voelen</td>
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<tr>
<td>50. Bepaalde plaatsen of dingen moeten vermijden, omdat je er angstig van wordt</td>
<td></td>
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<tr>
<td>51. Een gevoel van leegte</td>
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<tr>
<td>52. Een verdoofd of tintelend gevoel ergens in je lichaam</td>
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<tr>
<td>53. Een brok in je keel</td>
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</tbody>
</table>
In welke mate werd U gehinderd door de volgende klachten:

<table>
<thead>
<tr>
<th>Nummer</th>
<th>Klacht</th>
<th>Niberlijke Klassificatie</th>
</tr>
</thead>
<tbody>
<tr>
<td>54.</td>
<td>Je wanhopig over de toekomst voelen</td>
<td>Helemaal niet</td>
</tr>
<tr>
<td>55.</td>
<td>Je moeilijk kunnen concentreren</td>
<td>Een beetje</td>
</tr>
<tr>
<td>56.</td>
<td>Je lichamelijk ergens slap voelen</td>
<td>Nogal</td>
</tr>
<tr>
<td>57.</td>
<td>Je gespannen voelen</td>
<td>Tamelijk veel</td>
</tr>
<tr>
<td>58.</td>
<td>Zwaar voelen in armen of benen</td>
<td>Heel erg</td>
</tr>
<tr>
<td>59.</td>
<td>Denken aan dood of sterven</td>
<td></td>
</tr>
<tr>
<td>60.</td>
<td>Te veel eten</td>
<td></td>
</tr>
<tr>
<td>61.</td>
<td>Je niet op je gemak voelen, als mensen naar je kijken of over je praten</td>
<td></td>
</tr>
<tr>
<td>62.</td>
<td>Gedachten hebben die niet van jezelf zijn</td>
<td></td>
</tr>
<tr>
<td>63.</td>
<td>Aandrang voelen anderen te slaan, te verwonden of pijn te doen</td>
<td></td>
</tr>
<tr>
<td>64.</td>
<td>Te vroeg wakker worden</td>
<td></td>
</tr>
<tr>
<td>65.</td>
<td>Alsmaar hetzelfde moeten doen, zoals dingen even aanraken, tellen of wassen</td>
<td></td>
</tr>
<tr>
<td>66.</td>
<td>Een onrustige of gestoorde slaap</td>
<td></td>
</tr>
<tr>
<td>67.</td>
<td>Aandrang voelen dingen te vernielen of stuk te gooien</td>
<td></td>
</tr>
<tr>
<td>68.</td>
<td>Gedachten of opvattingen hebben die anderen niet met je delen</td>
<td></td>
</tr>
<tr>
<td>69.</td>
<td>Je pijnlijk bewust zijn van je aanwezigheid bij anderen</td>
<td></td>
</tr>
<tr>
<td>70.</td>
<td>Je niet op je gemak voelen in menigten, zoals bij het winkelen of in de bioscoop</td>
<td></td>
</tr>
<tr>
<td>71.</td>
<td>Het gevoel dat alles moeite kost</td>
<td></td>
</tr>
<tr>
<td>72.</td>
<td>Aanvallen van angst of paniek</td>
<td></td>
</tr>
</tbody>
</table>
**In welke mate werd U gehinderd door de volgende klachten:**

<table>
<thead>
<tr>
<th>Klacht</th>
<th>Helemaal niet</th>
<th>Een beetje</th>
<th>Nogal</th>
<th>Tamelijk veel</th>
<th>Heel erg</th>
</tr>
</thead>
<tbody>
<tr>
<td>73. Je niet op je gemak voelen, wanneer je iets eet of drinkt in het openbaar</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>74. Vaak in ruzies verzeild raken</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>75. Je zenuwachtig voelen als je alleen gelaten wordt</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>76. Het gevoel dat anderen je niet op juiste waarde schatten</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>77. Je alleen voelen, zelfs bij andere mensen</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>78. Je zo rusteloos voelen dat je niet stil kunt blijven zitten</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>79. Gevoelens dat je niets waard bent</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>80. Het gevoel dat iets naars je gaat overkomen</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>81. Schreeuwen of met dingen smijten</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>82. Bang zijn om in het openbaar flauw te vallen</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>83. Het gevoel dat mensen misbruik van je zullen maken, als je ze hun gang laat gaan</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>84. Gedachten over seks die je erg hinderen</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>85. De gedachte, dat je voor je zonden gestraft zou moeten worden</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>86. Gedachten en bepaalde voorstellingen van angstige aard</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>87. De gedachte dat er iets erg verkeerd is met je lichaam</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>88. Je nooit met iemand anders nauw verbonden voelen</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>89. Schuldgevoelens</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>90. De gedachte dat je psychisch niet helemaal in orde bent.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix V: UGDS-F

VU Medisch Centrum - Zorgcentrum Gender

VROUW naar MAN VERSIE

1. Ik gedraag mij het liefst als man.
   - Helemaal eens
   - Enigszins eens
   - Neutraal
   - Enigszins oneens
   - Helemaal oneens

2. Steeds als ik als vrouw word behandeld, voel ik me gekwetst.
   - Helemaal eens
   - Enigszins eens
   - Neutraal
   - Enigszins oneens
   - Helemaal oneens

3. Ik vind het plezierig om als vrouw door het leven te gaan.
   - Helemaal eens
   - Enigszins eens
   - Neutraal
   - Enigszins oneens
   - Helemaal oneens

4. Ik verlang er doorlopend naar om als man behandeld te worden.
   - Helemaal eens
   - Enigszins eens
   - Neutraal
   - Enigszins oneens
   - Helemaal oneens

5. Een leven als man is voor mij aantrekkelijker dan een leven als vrouw.
   - Helemaal eens
   - Enigszins eens
   - Neutraal
   - Enigszins oneens
   - Helemaal oneens

6. Ik voel me ongelukkig omdat ik als vrouw moet gedragen.
   - Helemaal eens
   - Enigszins eens
   - Neutraal
   - Enigszins oneens
   - Helemaal oneens

7. Het leven als vrouw ervaar ik als positief.
   - Helemaal eens
   - Enigszins eens
   - Neutraal
   - Enigszins oneens
   - Helemaal oneens

8. Ik vind het prettig mezelf naakt in de spiegel te zien.
   - Helemaal eens
   - Enigszins eens
   - Neutraal
   - Enigszins oneens
   - Helemaal oneens

9. Ik vind het prettig om mezelf seksueel als vrouw te gedragen.
   - Helemaal eens
   - Enigszins eens
   - Neutraal
   - Enigszins oneens
   - Helemaal oneens

10. Ik vind het afschuwelijk om te menstrueren omdat mijn vrouw-zijn benadrukt.
    - Helemaal eens
    - Enigszins eens
    - Neutraal
    - Enigszins oneens
    - Helemaal oneens

11. Ik vind het onaangenaam om borsten te hebben.
    - Helemaal eens
    - Enigszins eens
    - Neutraal
    - Enigszins oneens
    - Helemaal oneens

12. Ik was het liefst als jongen geboren.
    - Helemaal eens
    - Enigszins eens
    - Neutraal
    - Enigszins oneens
    - Helemaal oneens
Appendix VI: UGDS-M

VU Medisch Centrum - Zorgcentrum Gender

6014532898

SCHEMA 2D
Volwassenen

UGDS-M

Datum: 

Behandelaar:

MAN naar VROUW VERSIE

1. Het leven is voor mij volstrekt zinloos wanneer ik als man moet leven.
   □ Helemaal eens  □ Enigszins eens  □ Neutraal  □ Enigszins oneens  □ Helemaal oneens

2. Steeds als ik als man word behandeld, voel ik me gekwetst.
   □ Helemaal eens  □ Enigszins eens  □ Neutraal  □ Enigszins oneens  □ Helemaal oneens

3. Ik voel me ongelukkig wanneer iemand mij met 'mijnheer' aanspreekt.
   □ Helemaal eens  □ Enigszins eens  □ Neutraal  □ Enigszins oneens  □ Helemaal oneens

4. Ik voel mij ongelukkig omdat ik een mannetjechaam heb.
   □ Helemaal eens  □ Enigszins eens  □ Neutraal  □ Enigszins oneens  □ Helemaal oneens

5. Het idee dat ik altijd een man zal zijn geeft mij een beklemmend gevoel.
   □ Helemaal eens  □ Enigszins eens  □ Neutraal  □ Enigszins oneens  □ Helemaal oneens

6. Ik heb een hekel aan mezelf omdat ik een man ben.
   □ Helemaal eens  □ Enigszins eens  □ Neutraal  □ Enigszins oneens  □ Helemaal oneens

7. Ik voel me altijd en overal onbehagenlijk in mijn doen en laten als man.
   □ Helemaal eens  □ Enigszins eens  □ Neutraal  □ Enigszins oneens  □ Helemaal oneens

8. Het leven zou voor mij alleen zin hebben wanneer ik als vrouw zou leven.
   □ Helemaal eens  □ Enigszins eens  □ Neutraal  □ Enigszins oneens  □ Helemaal oneens

9. Het staat mij tegen om staande te plassen.
   □ Helemaal eens  □ Enigszins eens  □ Neutraal  □ Enigszins oneens  □ Helemaal oneens

10. Ik ben ontevreden over mijn gezichtsbeharing omdat het mij een mannelijk uiterlijk geeft.
    □ Helemaal eens  □ Enigszins eens  □ Neutraal  □ Enigszins oneens  □ Helemaal oneens

11. Ik vind het onaangenaam om een erectie te krijgen.
    □ Helemaal eens  □ Enigszins eens  □ Neutraal  □ Enigszins oneens  □ Helemaal oneens

12. Het zou beter zijn om niet meer te leven dan om als man te leven.
    □ Helemaal eens  □ Enigszins eens  □ Neutraal  □ Enigszins oneens  □ Helemaal oneens
Appendix VII: Demographics

1. Leeftijd _______________ jaar

Hoogste voltooide opleiding:
- Lager onderwijs (basisonderwijs)
- Lager beroeps onderwijs (bv. LBO)
- Middelbaar onderwijs (bv. VMBO, MAVO)
- Middelbaar beroeps onderwijs (bv. MBO)
- Voortgezet onderwijs (bv. HAVO, VWO)
- Hoger beroeps onderwijs (bv. HBO)
- Hoger onderwijs (bv. propedeuse, bachelor)
- Wetenschappelijk onderwijs (universiteit)

Tot wie voelt u zich nu seksueel aangetrokken?
- Helemaal tot vrouwen, zonder verlangen naar mannen
- Voornamelijk tot vrouwen, een enkele keer tot mannen
- Voornamelijk tot vrouwen maar regelmatig tot mannen
- Evenveel tot vrouwen als tot mannen
- Voornamelijk tot mannen, maar regelmatig tot vrouwen
- Voornamelijk tot mannen, een enkele keer tot vrouwen
- Helemaal tot mannen, zonder verlangen naar vrouwen
- Transseksueelen
- Nvt
## Appendix VIII: Genderqueer Identity Scale

### GQI-Scale

<table>
<thead>
<tr>
<th></th>
<th>Helemaal niet mee eens</th>
<th>Enigszins oneens</th>
<th>Neutraal</th>
<th>Enigszins mee eens</th>
<th>Helemaal mee eens</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ik beschouw mijzelf als &quot;gender queer&quot; (d.w.z. anders dan man of vrouw / derde gender)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Sociale interacties</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ik wil door anderen niet gezien worden als man of vrouw</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Ik probeer anderen opzettelijk in verwarring te brengen of ik man of vrouw ben</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Ik probeer mij over het algemeen zowel mannelijk als vrouwelijk te gedragen</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Ik vind het prettig als mensen er niet zeker van zijn of ik man of vrouw ben</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Ik vind het vervelend als anderen twijfelen of ik een man of een vrouw ben</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Straks als ik mijn transitie door ben (klaar ben met mijn behandeling)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Verwacht ik dat mijn gedrag overeenkomstig is met wat er traditioneel van mijn nieuwe geslacht wordt verwacht (typisch mannelijk of typisch vrouwelijk)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Zal mijn gedrag (de manier waarop ik mij vrouwelijk of mannelijk gedraag) elke dag ongeveer gelijk zijn</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Verwacht ik dat anderen nog maar zelden zullen twijfelen aan mijn geslacht (gender)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Verwacht ik dat mijn gedrag (de manier waarop ik mij vrouwelijk of mannelijk gedraag) geregeld zal veranderen, in verschillende situaties</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Verwacht ik dat mijn gedrag niet traditioneel zal zijn (dwz niet ‘passend’ bij mijn nieuwe geslacht)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

De manier waarop ik over mijn gender / geslacht denk:

<table>
<thead>
<tr>
<th>Is altijd hetzelfde geweest</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Komt op een natuurlijke manier vanuit mijzelf</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Is iets waar ik lang over heb gedaan om achter te komen</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Verschilt en hangt af van de persoon met wie ik ben</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Is beïnvloed door de ervaringen in mijn leven</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Is iets waar ik met anderen vaak over praat</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Zal waarschijnlijk nog verder veranderen als ik ouder word</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

Verwachtingen vanuit de maatschappij

<table>
<thead>
<tr>
<th>Ik heb veel gelezen over gendergedrag, genderrollen en genderidentiteit</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ik probeer anderen te overtuigen dat de maatschappij niet gericht moet zijn op twee geslachten (man of vrouw)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
Helemaal niet mee eens | Enigszins oneens | Neutraal | Enigszins mee eens | Helemaal mee eens
--- | --- | --- | --- | ---
Ik probeer anderen te overtuigen dat de maatschappij te veel van mensen verwacht dat ze zich gedragen naar hun biologische geslacht | 0 | 1 | 2 | 3 | 4
In mijn omgeving zorg ik er bewust voor dat anderen zich vrij voelen om zich zo mannelijk of vrouwelijk gedragen als ze willen | 0 | 1 | 2 | 3 | 4
De manier waarop ik mij gedraag is belangrijk omdat ik er zo voor zorg dat anderen gaan twijfelen over traditionele gender gedragingen | 0 | 1 | 2 | 3 | 4
Ik moedig anderen aan om meer open te zijn wat betreft gender rollen | 0 | 1 | 2 | 3 | 4
Appendix IX: The Corrected Item-Total Correlation and Cronbach’s Alpha if Item Deleted for Each of the Final 20 Items of the Genderqueer Identity Scale.

<table>
<thead>
<tr>
<th>Corrected Item-Total Correlation</th>
<th>Cronbach's Alpha if Item Deleted</th>
</tr>
</thead>
<tbody>
<tr>
<td>GQI 1</td>
<td>.522</td>
</tr>
<tr>
<td>GQI 2</td>
<td>.325</td>
</tr>
<tr>
<td>GQI 3</td>
<td>.384</td>
</tr>
<tr>
<td>GQI 4</td>
<td>.459</td>
</tr>
<tr>
<td>GQI 5</td>
<td>.362</td>
</tr>
<tr>
<td>GQI 7</td>
<td>.268</td>
</tr>
<tr>
<td>GQI 8</td>
<td>.343</td>
</tr>
<tr>
<td>GQI 9</td>
<td>.335</td>
</tr>
<tr>
<td>GQI 10</td>
<td>.437</td>
</tr>
<tr>
<td>GQI 11</td>
<td>.487</td>
</tr>
<tr>
<td>GQI 12</td>
<td>.300</td>
</tr>
<tr>
<td>GQI 13</td>
<td>.326</td>
</tr>
<tr>
<td>GQI 15</td>
<td>.392</td>
</tr>
<tr>
<td>GQI 16</td>
<td>.329</td>
</tr>
<tr>
<td>GQI 18</td>
<td>.305</td>
</tr>
<tr>
<td>GQI 20</td>
<td>.422</td>
</tr>
<tr>
<td>GQI 21</td>
<td>.435</td>
</tr>
<tr>
<td>GQI 22</td>
<td>.246</td>
</tr>
<tr>
<td>GQI 23</td>
<td>.441</td>
</tr>
<tr>
<td>GQI 24</td>
<td>.337</td>
</tr>
</tbody>
</table>
Appendix X: Topic List Interviews

**Topiclijst Interviews**
Volgorde van de topics is bepaald met het oog op een optimaal verloop van het gesprek. Gesprek vangt aan met een uitleg van het doel van het onderzoek en vervolgens met het in kaart brengen van de huidige identificatie, situatie en behandelwens. Vervolgens zullen de topics chronologisch langs de leeftijdsfasen; Prepuberteit => Puberteit => Huidige situatie aan de orde komen. Naargelang de dynamiek van het gesprek kan van de volgorde van de topics, als van de chronologische opbouw naar leeftijdsfasen, worden afgeweken. Elk thema kan ongeveer 10 minuten besproken worden.

**Introductievragen:**
- Welk label gebruik je om jezelf te omschrijven? Hoe omschrijf jij je genderidentiteit?
- Wat betekent dit label voor jou? (omschrijving/definitie)
- Wat voor persoonlijk voornaamwoord (hij/zij/zhij/het/etc) wil je het liefst dat mensen voor jou gebruiken?

1. **Genderidentiteit en genderrolgedrag**
   - Hoe oud was je toen je je voor het eerst ‘anders’ voelde: een gevoel dat je van het andere geslacht was / het gevoel niet (of beide) man of vrouw te zijn?
   - Kun je vertellen wat dit gevoel/deze wens inhield?
   - Hoe beleefde je dit gevoel? (positief/negatief) (pretzig/onpretzig) (gewenst/ongewenst)
   - Kun je omschrijven hoe jij je gedroeg? Was dat anders dan andere kinderen?
   - Wie waren je vrienden / speelkameraden? Hoe functioneerde je sociaal: (had je veel vrienden; was je populair/op jezelf?)
   - Heb je vroeger (voordat je naar de VU kwam) hulp gezocht voor vragen/problemen betreft jouw genderidentiteit? (en bij wie?)
   - Kan je vertellen over hoe je je nu voelt over man en/of vrouw zijn? (Hoe zit het in elkaar/hoe ervaar je het? (positief/negatief))
   - Zijn je gevoelens over man en/of vrouw zijn ooit veranderd? (fluctuerend vs. stabiel)
   - Denk je dat het gevoel man of vrouw te zijn (je genderidentiteit) iets is dat vaststaat (waar je mee geboren wordt) of als iets dat veranderlijk is? => Toekomst?
   - Stel je werd opnieuw geboren: hoe zou je dan willen dat je geboren was? (man/vrouw/genderqueer/……)
   - Wat zou je het liefst willen dat je in paspoort stond bij “geslacht”? M/V/X (als dat mogelijk zou zijn)?

2. **Labeling**
   - Hoe lang identificeer je je al als [zelfgekozen label]?
   - Kan je iets meer vertellen over hoe je ertoe bent gekomen om [dit label] te gebruiken?
   - Hoe leerde je over de term “transgender”/”genderqueer”/”neutrios”/”agender”/.. (lees je veel over [termen])?
   - Heb je veel contact met anderen die zich ook zo voelen / noemen? (En is dat face-to-face en/of via het internet en alleen in Nederland of ook in het buitenland?)
   - In hoeverre vindt je dat jouw genderidentiteit invloed heeft op wie je bent?
- Denk je veel na over jouw genderidentiteit en/of praat je er veel met anderen over?

### 3. **Periode van cross-gender gedrag/gevoel**
- Kun je vertellen hoe je uiting hebt gegeven je genderidentiteit?
- Is er een periode geweest dat je deels of helemaal in de rol van het andere geslacht hebt geleefd? Of Vanaf welk moment ben je in de rol van het andere geslacht gaan leven?

**Zo ja:**
- Kun je vertellen hoe deze periode is verlopen (inhoudelijk & tijdsduur)
- Door wie kwam dat, denk je? (ouders, zelf, vrienden)
- Hoe heb je deze periode ervaren/beleefd?
- Hoe was de reactie van de omgeving (gezin/klasgenoten/familie/buurthuwhers)?
- Voor zover relevant:
  - Waarom stopte je daarmee?
  - Of - als je maar deels leefde in rol van het andere geslacht en nu volledig:
    - Waarom ben je uiteindelijk helemaal zo gaan leven?

### 4. **Lichamelijke ontwikkeling**
- Kun je vertellen hoe je als kind je eigen lichaam beleefde/ervoer? (positief/negatief)
- Wat vond je als kind van het vooruitzicht van lichamelijke veranderingen die ontstaan door de puberteit?
- Wanneer begon bij jou de puberteit, wanneer en welke lichamelijke veranderingen merkte je het eerst?
- Hoe heb je deze lichamelijke veranderingen beleefd/ervaren?
- Kun je vertellen hoe je met deze lichamelijke veranderingen bent omgegaan?
- Wat vind je nu van je je lichaam?
  - Evt. Bij afkeer van het lichaam: Is er sprake geweest van misbruik?
- Hoe zou je het liefst willen dat je lichaam eruit ziet?
- Is dat steeds hetzelfde of verandert dat af en toe?

### 5. **Seksuele oriëntatie / Seksuele ontwikkeling**
- Wanneer was je voor het eerst verliefd, op welk geslacht? Kan je beschrijven wat er gebeurde?
- Kun je vertellen hoe je als kind met verliefdheid bent omgegaan? Verkering?
- Heb je ooit seksuele fantasieën gehad?

**Zo ja:**
- Kun je vertellen wat deze fantasieën inhielden? (m.b.t. genderidentiteit: eigen geslacht/partnerkeuze)
- Hoe ervoer je/beleefde je de seksuele fantasieën? (positief/negatief)
- Hoe was de houding van je omgeving (gezin/familie/vrienden) ten aanzien van seksualiteit en seksuele oriëntatie?
- Kun je vertellen hoe je als kind/puber met seksualiteit bent omgegaan? (actief/passief)
- Stond je lichaam daarbij in de weg?
- Wat is je huidige seksuele geaardheid? Partnerkeuze?
- Is deze geaardheid veranderd?
- Denk je dat je geaardheid in de toekomst zal veranderen?
- Heb je een kinderwens (of deze ooit gehad)? Hoe zie je dit voor je? ("eigen" kinderen of adopteren o.i.d. Bij biologische vrouwen: zou je een kind willen dragen en baren?)

6. Psychologisch welzijn/ Sociale steun/ Discriminatie

- Psychologisch welzijn/Sociale steun
  - Hoe tevreden ben je op dit moment met je leven?
  - Zijn er dingen die je zou willen veranderen aan je leven?
  - Kan je voor jouw gevoel altijd terecht bij iemand als je problemen hebt of de behoefte hebt om te praten?

- Reacties van anderen/discriminatie
  - Hoe denk je dat mensen die je niet kent over jou denken?
  - Hoe zou je het liefst willen dat mensen jou zien?
  - Krijg je wel eens reacties over je genderpresentatie van mensen die je niet kent?
    - En wat voor soort reacties zijn dat? (positief/negatief?)
    - Ben je wel eens gepest of gediscrimineerd verwege je genderidentiteit of genderexpressie?
  - Hoe zou de wereld moeten veranderen zodat het voor jou makkelijker zou zijn om door het leven te gaan?