

Health (Trans)gressions: Identity and Stigma Management in Trans* Healthcare Support Seeking

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This study explored the role of gender identity and stigma among trans* individuals in their pursuit of healthcare support. Through in-depth, qualitative interviews with 17 trans* individuals, we observed intersections of individual, interpersonal, and institutional modes of stigma across a variety of contexts of trans* healthcare. In our findings, we examine three specific themes related to trans* individuals' anxiety about seeking healthcare support—tough decisions, fear, and benevolent oppression—as well as potential directions for future improvement in trans* healthcare. Our findings reveal that trans* individuals' apprehension about seeking healthcare support stems from a “big picture” account of trans* healthcare, wherein their own individual experiences are situated against the larger backdrop of anti-trans* discrimination, both inside and outside the context of healthcare. These findings illuminate the intersectional workings of stigma and their inhibiting role on trans* healthcare support seeking. Findings are interpreted in light of participant suggestions for more inclusive trans* healthcare practices and potential steps to address noted inequities in trans* healthcare support provision.

Keywords: transgender, trans*, stigma, social support, health

Deep political and ideological obstacles have marred the global landscape for LGBTQ equality. Specifically, a chasm between affirmation and action regarding equality is especially obvious within the context of healthcare support and access for the LGBTQ community (Krieger, 1999, 2012). Much literature supports the need for increased attention to LGBTQ healthcare (Mayer et al., 2008), yet the trend in research to inadvertently lump all factions of the LGBTQ community together further stigmatizes trans* individuals and promotes a faulty ideology that “one size fits all” in LGBTQ healthcare (Worthen, 2013). Just as non-heterosexual

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individuals face unique health needs, so do those whose gender does not fit within the cis-normative gender binary.

While transgender individuals are part of the greater LGBTQ community, transgender health needs vary significantly from lesbian, gay, bisexual, or other sexuality-related health concerns (Worthen, 2013). For instance, in trans* populations, depression, low self-esteem, and suicidal thoughts related to gender identity may emerge (IOM, 2011). Further, trans* populations are at an increased risk for HIV/AIDS (Reisner, Perkovich, & Mimiaga, 2010), chronic disease (COE, 2011), and hormonal complications (COE, 2011), compared to LGB counterparts. Lack of trans*-specific health knowledge and inconsistent health insurance regulations also complicate trans* health in unique ways (JSI Research & Training Institute, 2000).

Trans* healthcare support is also unique because of the potential reluctance of trans* individuals to reveal their identities for fear of discrimination and reprisal. For trans* individuals, even routine health procedures often cue identity-related concerns, thus situating trans* healthcare interactions (i.e., patient-provider) as communicative contexts fraught with anxieties for individuals who may be at varying stages of public identity enactment (Brown & Rounsley, 1996). Though we subscribe to intersectional understandings of identity and acknowledge that sexuality and gender identities are intricately related, we propose that research focus on trans* health through a narrower lens, acknowledging both its fit within, and divergence from, the greater LGBTQ community.

Within healthcare contexts, stigma may drive health-related disparities (Krieger, 1999, 2012). Despite evidence that the public has increasingly positive views of the LGBTQ community in general (Krehely, 2009), widespread stigma against trans* individuals still exists (Grant et al., 2011; Hendricks & Testa, 2012; Lombardi, 2009). Although (perceived and factual) sexual orientation and gender conformity play significant roles in the appraisal of others, gender (non)conformity is a significant risk factor for anti-LGBTQ violence, discrimination, and stigma (Gordon & Meyer, 2007; Horn, 2007; Russell, 2003).

Trans* health disparities are further complicated by a lack of research on the healthcare experience (e.g., Roller, Sedlak, & Draucker, 2015; Sanchez, Rabatin, Sanchez, Hubbard, & Kalet, 2006). Driven to address this noted gap in the literature, we set out to examine how trans* healthcare is understood by those who have experienced it. Through in-depth interviews, we observe tensions between the themes outlined above—anti-trans* discrimination and stigma, trans*-specific healthcare concerns, and the precarious process that trans* individuals undergo in seeking healthcare support. Below, we further establish our framework.

A Framework for Trans* Health Stigma

Trans* definition.

While defining identities runs the risk of “essentializing” certain characteristics of social groups (Wood & Fixmer-Oraiz, 2017), it is important to conceptualize our use of “trans*” throughout this manuscript. Traditionally, “transgender” is conceptualized as an identity label for those whose gender identity

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is “opposite” of sex assigned at birth (Cruz, 2014). We regard transgender as an umbrella term, descriptive of those whose gender identity “transcends, breaks, transgresses, cuts through, or otherwise deviates from traditionally established gender categories” (Wagner, Kunkel, & Compton, 2016, p. 269; see also Green, 2004; Sears, 2005). We use “trans*” to be inclusive of all identities under this umbrella, including transgender, trans(s)exual, gender fluid, and otherwise gender “nonconforming.” We situate these groups together based on responses from trans* populations previously surveyed, as well as with respect to the wide range of subcategories associated with the term in other research (Bockting, 1999; Bockting, Robinson, Benner, & Scheltema, 2004; Kenagy, 2005). In our calls for “transgender participants,” members from the aforementioned groups responded and clarified their specific preferred identities (e.g., gender fluid).

We use “trans*” as a deliberate truncation of the term “transgender” and to respect and validate our participants. We recognize that linguistic nuances evolve and that debate about the terminology we use continues (Trans Student Educational Resources, 2016). Our goal is to be representative of our population, which approved our use of terminology. Our broad framework affirms those who choose to self-identify with the term “transgender,” while not unnecessarily limiting agency for those who prefer to use more specific and/or different labels.

Trans* healthcare.

In defining trans* healthcare, we employ Rachlin, Green, and Lombardi’s (2008) distinction of three unique sub-systems: (1) preventative healthcare, (2) critical care, and (3) transcare. *Preventative healthcare* visits (e.g., annual checkups, blood panels) are perhaps least face threatening to trans* individuals, as they allow for careful selection of medical providers who will best respect their identity. Even in these settings, trans* individuals may experience anxiety associated with instructing medical staff about their preferred pronouns and negotiating how their chosen name is used on forms and paperwork (Rachlin et al., 2008). Additionally, preventive care that aligns with born sex but not gender identity (e.g., gynecological exams for males assigned female at birth) presents a unique paradox; such procedures may trigger identity-related anxiety for trans* individuals, but may also be critical to maintaining health. Thus, participants are forced to choose between mental health (i.e., forgo a gynecological exam to avoid identity-related triggering) and physical health (i.e., undergo a gynecological exam but risk stigma or discrimination).

Critical care involves necessary and often urgent responses to acute health issues or serious medical events (e.g., a heart attack). The paradox outlined above may also manifest in critical care instances, whereby trans* individuals—unlike their cisgender counterparts—may be forced to make decisions regarding treatment based upon their identity. That is, trans* individuals seeking critical care may not have time and/or resources to locate inclusive environments and may hesitate to seek help out of fear of discrimination, refusal of services, or other negative outcomes (Lombardi, 2001).

Transcare is focused specifically on the biophysical transition that trans* individuals undergo to “achieve comfort with the gendered self” (Rachlin et al.,

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2008, p. 247) and may involve a variety of medical interventions. It is important to note that transcare may or may not involve sex reassignment surgery (SRS; Bockting, 2009; Jarolim, 2000). Instead, it is focused on medical interventions necessary for individuals to feel more comfortable as they transition from gendered physical expectations of their prescribed sex. Transcare may involve hormone treatment, mental health support and services, and/or surgery.

These subsystems of healthcare have only recently been clearly defined, likely because the history of transgender health scholarship is relatively limited. Only since the 1960s has research tuned into trans* healthcare support (see Vidal-Ortiz, 2008). The accepted framework of trans* health intervention has been oriented around treatment, with physicians most concerned about identifying and assisting “true transsexuals” (Bockting, 2009, p. 104) in surgical sex reassignment.

In recent years, the medical community has shifted from a disease-based model of trans* embodiment, (i.e., “something went wrong during development that needs to be corrected”) to an identity-based model, (i.e., “not the individual, but social stigma of gender variance and the associated health disparities are the problem;” Bockting, 2009, p. 104). Correspondingly, health practitioner attitudes towards trans* individuals vary greatly and follow no stated universally consistent ethic for trans* patient care (Sanchez et al., 2006). Thus, despite several advances in ideological framing and a deliberate shift towards inclusivity in the Western medical model (Safer, Coleman, & Hembree, 2016; Wylie et al., 2016), trans* individuals are still disproportionately subjected to inequitable healthcare support (Nadal, Skolnik, & Wong, 2012; Safer et al., 2016).

These medical disparities are also situated within contexts of widespread social panic about “wasted” insurance funding on SRS, hormone support, and the need for trans*-specific services (e.g., Fix This Nation, 2014; Ruse, 2014). However, the National Center for Transgender Equality (NCTE, 2010) notes that up to 78% of trans* people reported improved psychological functioning after receiving access to gender-confirming treatments and suicide dropped to a range of 0.8-6% for those who had access to gender confirming treatment, as opposed to a range of 19-29% among those who did not (NCTE, 2010). Furthermore, trans* individuals who receive gender confirming treatment report fewer mental health concerns, are less likely to abuse substances, and are more likely to be employed, ultimately *saving* state and federal funding (NCTE, 2010). These benefits, in tandem with trans* identity validation, justify the need for more trans*-inclusive health practices. Thus, an understanding of the above subsystems (i.e., preventative, critical, and transcare) provides a clear rationale for future analysis. Our study does not focus exclusively on one mode of trans* healthcare and seeks to better understand the current state of trans* health disparity by examining the role of stigma in each of these subsystems.

Trans* stigma in healthcare.

While the American Psychological Association no longer classifies transgender identity as a “disorder” (APA, 2013), the current social landscape is categorized by excessive cisgender privilege (Carroll, Gilroy, & Ryan, 2002; Lev, 2004; Pepper & Lorah, 2008) and trans* individuals are still highly stigmatized, both inside (Kosenko, Rintamaki, Raney, & Maness, 2013) and outside (Mizock &

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Mueser, 2014) healthcare spaces. Link and Phelan (2006) situate stigma within a nexus of five interrelated components: (1) identifying and labeling human difference, (2) linking stereotyped members of a community to undesirable behavior, (3) an “us” versus “them” dichotomy, (4) a loss of status or feeling of discrimination, and (5) the exercise of power. We understand stigma as the inner-workings of these five attributes and view stigma and discrimination as interrelated and inseparable acts, ranging in terms of their expression, while operating within a system of oppression (see Cruz, 2014).

We adopt Deutsch’s (2006) orientation that oppression “need not be extreme and involve the legal system (as in slavery, apartheid, or the lack of a right to vote) nor violent (as in tyrannical societies)” (p. 10) and Harvey’s (1999) notion of “civilized oppression.” Here, we make a distinction that civilized oppression is:

Embedded in unquestioned norms, habits, and symbols, in the assumptions underlying institutions and rules, and the collective consequences of following those rules. [It] refers to the vast and deep injustices some groups suffer as a consequence of often unconscious assumptions and reactions of well-meaning people in ordinary interactions that are supported by...the structural features of bureaucratic hierarchies and market mechanisms. (Young & Allen, 1990, p. 41)

Civilized oppression is especially important to consider in investigations of trans* healthcare, as most trans* stigma in healthcare environments is not enacted through violent means. Outside of healthcare, hate crimes and anti-trans* violence have escalated in recent years, with some researchers terming this epidemic as “not only [an] extremely serious and immediate public health problem, but also [a] genocide against a consistently invisibilized minority population” (Kidd & Witten, 2007, p. 31). This violence is intriguing, given the increased public acceptance toward the LGBTQ community noted earlier. While trans* discrimination in the context of healthcare likely constitutes civilized oppression (Bauer, Hammond, Travers, Kaay, Hohenadel, & Boyce, 2009; Lurie, 2005), we speculate that it is rooted in the same systemic, anti-trans* attitudes that undergird anti-trans* violence, further situating trans* healthcare as a context ripe for investigation.

Within trans* health spaces, stigma can be operationalized in individual, interpersonal, and institutional/systemic modes. *Individual* stigma “refers to the possession of a single discrediting attribute” (Feree & Smith, 1979, p. 87) and may include “anxious expectations of rejection and stigma avoidance, stigma concealment, and reduced self-efficacy” (White Hughto, Reisner, & Pachankis, 2015, p. 226). Here, stigma may directly influence the socioemotional orientations of the stigmatized who may adopt a self-orientation that is characterized by its relationship to the understood stigma. In the case of trans* health, individual stigma may inhibit help seeking and dialogue with providers in order to avoid discomfort or negative consequences (Reisner, White Hughto, Dunham, Heflin, Begenyi, Coffey-Esquivel, & Cahill, 2015).

Interpersonal stigma manifests in routine communicative encounters (i.e., physician-patient) and may involve enacted forms of stigma such as verbal abuse, pandering, excessive inquisitiveness, and hostility (White Hughto et al., 2015). In

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trans* healthcare interactions, avoidance may be a direct response to threats of perceived interpersonal stigma, whether based on factual past experiences or anticipated negative interactions (Socias, Marshall, Aristegui, Romero, Cahn, Kerr, & Sued, 2014). While interpersonal stigma may manifest in response to explicit stigma-enactment (i.e., deliberate and cognizant orientation of bias and/or direct discriminatory discourse), it may also emerge in response to implicit characteristics of the communication encounter (i.e., subconscious bias absent willful activation and/or benevolent inquisitiveness or “accidental” offense; Major, Mendes, & Dovidio, 2013).

Institutional stigma refers to systemic oppressive mechanisms (i.e., legislation, corporate policies, organizational ethos), wherein negative stigma about cultural groups influences structural and procedural practices of given systems (Holley, Stromwall, & Bashor, 2012). For trans* individuals, this manifests in multiple ways, including erasure from medical information and healthcare policies (Bauer et al., 2009), systemic microaggressions (i.e., assumptions of sexual pathology; Nadal et al., 2012), and health insurance disparities (Khan, 2011).

This multidimensional framework for stigma complements recent scholarship which documents widespread trans* discrimination and stigma at all levels of healthcare systems. For instance, Grant, Mottet, Tanis, Herman, Harrison, and Keisling (2011) found that 19% of their transgender population had been refused healthcare because of their gender expression (interpersonal stigma; communicative response toward trans* identity). Grant et al. (2011) also found that 28% of transgender individuals delayed or postponed needed or urgent medical care out of fear of harassment or discrimination (Grant et al., 2011; individual stigma; strategic behavior based on presumption of poor care due to identity). Perhaps this fear is justified. A meta-analysis by Dorsen (2012) reveals that a significant body of scholarship details discriminatory communication by nurses towards transgender individuals. Furthermore, data reveals that up to 50% of the surveyed trans* population report “teaching” their physicians about the necessary procedures for transgender care (Grant et al., 2011)—a practice to which virtually no other social group is routinely subjected (i.e., institutional stigma). These elements intersect in the context of trans* healthcare to create potentially problematic environments for health communication, health support seeking and provision, and overall well-being.

These modes of stigma do not occur in isolation; rather, they work in an intersectional manner to create and/or support systems of oppression (Crenshaw, 1989). Intersectionality refers to the “ways in which oppressive institutions... are interconnected and cannot be examined separately from one another” (McCall, 2005, p. 190). Thus, we endorse a holistic understanding of trans* stigma, recognizing that individual, interpersonal, and institutional/systemic mechanisms define the current state of trans* healthcare (Bith-Melander, Sheoran, Sheth, Bermudez, Drone, Wood, & Schroeder, 2010; Roberts & Fantz, 2014). This understanding fits within recent socioecological models of health theory (Baral et al., 2013; Link & Phelan, 2006) and moves toward a “big picture” understanding of the multiplicity of stigma-related concerns that may inhibit trans* health and wellness.

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We believe the intersectional workings of individual, interpersonal, and institutional stigma within health environments have potentially significant consequences for trans* individuals seeking healthcare support at a variety of levels (i.e., preventative care, critical care, and transcare). Exploring stigma through interviews with trans* individuals will help transcend the essentializing framing of trans* people as helpless, passive, and in need of rescuing (Fine & Asch, 1988; Reissman, 2000) by highlighting lived experience and exploring all three modes of stigma through an organized lens. This approach also echoes our cautious exploration of “stigma” as an overarching unit, as stigma is “often just the tip of the iceberg...and has frequently served as a means of giving short shrift to powerful social inequalities...that are much harder to identify and conceptualize” (Castro & Farmer, 2005, p. 53). Below, we further discuss the methodological procedures we used to enable this exploration.

Method

Participants and Procedures

Over 15 months, we interviewed trans* individuals solicited via direct contact and snowball sampling. While the four of us do not identify as trans*, we are connected at various levels to the trans* community. Each of us facilitated conversations with advocacy agencies, LGBTQ Resource Centers, and personal connections. After successfully completing nine interviews, our data collection stalled. While similar studies have yielded small participant samples (e.g., Nadal et al., 2012), we sought out leaders of LGBTQ caucuses at regional and national communication conferences and connected with a transgender studies listserv. Ultimately, we secured 17 interviews. Careful analysis of this data achieved theoretical saturation, wherein no new themes were uncovered and no additional data was needed. The number of interviews conducted also modeled other relevant studies (e.g., Sevelius, 2009). Our institutional review boards approved all procedures of this study, and pseudonyms were created to protect participants’ identities.

Our final participant pool included those who preferred a variety of terms, including *transgender*, *transsexual*, *genderqueer*, *gender fluid*, and *two-spirited*, affirming our commitment to a broad and inclusive understanding of trans* identity. After identifying participants, we established face-to-face, phone, or Skype interview arrangements. At the beginning of each interview, we gained informed oral consent. We then asked a series of demographic questions, regarding preferred pronouns, age, occupation, education level, and location.

Participants ranged in age from 18-58. Nearly all identified as White, with the exception of one African-American participant. Participants came from a wide variety of educational backgrounds, ranging from high school graduates through masters and professional program graduates. Additionally, participants’ daily lives varied greatly and their occupational careers ranged significantly from unemployed, healthcare, retail, administrative and support staff to full-time advocacy. Interviews with each participant followed a semi-structured format and ranged in length from 25 to 73 minutes ($M = 47$ minutes).

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We asked participants a variety of questions grouped into 7 categories: *demographics*, *identity schema* (e.g., “how do you conceptualize your gender identity?”), *healthcare access and support* (e.g., “how do you seek out a medical professional?”), *identity enactment* (e.g., “how do you reveal your gender identity in a new healthcare setting?”), *equity and treatment* (e.g., “how would you generally characterize your treatment in healthcare settings?”), *barriers* (e.g., “how has access to insurance shaped your healthcare experience?”), and *empowerment* (e.g., “what suggestions do you have for improving healthcare services for trans* individuals?”). While we used a scripted list of questions, we encouraged participants to guide the conversation in directions meaningful to them, using probes to facilitate further discussion or clarification when appropriate (Hesse-Biber, 2014).

Knowing that trans* populations face well-documented and significant obstacles to accessing *all* types of relevant healthcare (see Dewey, 2008; Sperber, Landers, & Lawrence, 2005; Xavier, Honnold, & Bradford, 2007), we allowed participants to share experiences across all healthcare contexts (i.e., preventative care, critical care, and transcare). Participants in our study understood healthcare in a multitude of ways and discussed seeking support from a variety of different health outlets, including free clinics, Veterans Health Administration clinics, private practices, emergency rooms, and dental offices.

All interviews were recorded and transcribed verbatim. Audio recordings spanned nearly 13.5 hours and transcription produced over 200 single-spaced typed pages. To help provide a clear analytical framework, all authors reviewed each transcript. Then, the lead author coded the data, revising based on continuous feedback from the other authors. Using Charmaz’s (2006) open coding process, complete units of thought were coded and then sorted into larger thematic units (Smith, Jarman, & Osborn, 1999), featuring hierarchical axial groupings under more focused themes (Strauss & Corbin, 1998). True to the interpretivist-oriented nature of this study (Manning & Kunkel, 2014), each unit of discourse also invoked a rigorous memo process, wherein notes were made regarding points of divergence and competing thematic elements. Within this paradigm, our goal as feminist researchers was to highlight the voices and experiences of trans* individuals and provide greater insight into how gender identity affects health experiences (see Sprague, 2005).

Results

Throughout our interviews with 17 trans* individuals, we observed tensions between individual, interpersonal, and institutional/systemic stigma, all of which intersect problematically for trans* people seeking healthcare support. Below, we summarize three key themes—tough decisions, fear, and benevolent oppression—that reveal the complex nature of trans* lived (health) experience.

Tough Decisions

The difficult decisions trans* individuals make in regard to their healthcare have been well documented (Sperber et al., 2005). Financial barriers, insurance issues, and access to services are all cited obstacles to equitable healthcare for trans* individuals and manifested in our findings. Below, we highlight two key obstacles

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that saliently emerged: financial constraints and unwilling identity outing.

Financial constraints. Many participants cited financial burdens as significant obstacles to health and wellness. For instance, Raina said, “the way I understood insurance growing up was that insurance covered your medical costs... I have to pay for my own hormones out of pocket, which is really expensive when you consider the estrogen is \$150 a vial.” Other participants also echoed this concern, often engaging in any activities needed to pay for treatment. Chase commented:

They charge...like \$500 a visit just for bloodwork and to get everything. They scalp the trans* community and give no help back...I was doing street testosterone illegally bought from someone else, that’s how bad I wanted to transition. The asshole first therapist—even though he knew I was street dosing—still would not agree to sign my gender conforming letter.

While Chase acknowledged “therapy is an important part of the process,” he felt caught between three competing forces: his mental health therapist, primary care physician, and insurance company. Each visit was costly, so he had to make a series of difficult decisions to receive healthcare support:

I did sex work to get my first injection of testosterone...which I’m not ashamed of because I did what I needed to do and I bought a vial on the streets from a friend and I knew it would be good because he got a real prescription for it...so it wasn’t like I did it stupid...but insurance don’t care as long as they’re getting paid.

Hadley noted a similar experience: “There were times where I had to choose between—you know—hormones or food...I generally wait for food and electricity.” These examples are representative of a widely cited struggle among our participants—a choice between trans*-specific healthcare support and day-to-day needs. While financial decisions are important considerations, they are only a subset of those that trans* individuals make when seeking healthcare support. Another difficult decision our participants reported regarded being publicly outed.

Unwilling identity outing. For many participants, being misgendered and/or unwillingly “outed” was a significant obstacle to equitable healthcare. They felt conflicted about *whether* they should out themselves to medical professionals. Carmen noted, “I always have to have this cost-benefit ratio; I have to weigh it out in every situation...is it going to be worth it to bring it up?” In some instances, the decision is easy. Felix provided an example:

You know, I have a relatively new dentist who I’ve not told that I am trans*...I pass as male going to the dentist...Obviously there is no need to remove my clothing...I don’t think it’s relevant to my dental care so I don’t talk about it...Obviously, with my gynecologist, it’s a little more [relevant].

Felix’s experience echoes findings that routine preventative healthcare is often the least face-threatening health context for trans* individuals (Rachlin et al.,

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2008). While routine care still presents risks for those who don't (or attempt to) "pass," individuals may still seek out trans*-friendly providers, do research, and select practices that best suit their individual concerns. Still, as Savannah noted, sometimes the process is not so clear cut:

I had a very mild heart attack in November, actually...I was experiencing some pain and I went to the hospital immediately...but I was talking to the cardiologist and I'm like, "Should I tell him I'm trans*?" Because I don't know if they treat women differently than they treat men. And biologically, I'm not exactly...you know...so here I am...experiencing heart pains and wondering whether to come out as trans*.

There, lying on a hospital bed in the midst of a heart attack, one of Savannah's chief concerns was whether or not to reveal her identity. Her reason? "I know of a transgender individual that when they came out as trans*, their doctor 'fired' them and said, 'I can't treat you now'...that's something that has [actually] happened."

Savannah's powerful narrative presents a unique conundrum: reveal trans* identity and face potential discrimination, or conceal identity while threatening attainment of appropriate care; biophysical composition may drastically influence medical response (as in the case of a heart attack), and choosing to forgo "outing" may have drastic medical consequences. This example mirrored those of many other participants who felt conflicted about identity enactment/revelation in medical settings; yet, deeper analysis revealed that this aversion did not always stem from previous experience (a point of divergence from our original assumptions). At their root, many of the tough decisions outlined above stem from *fear* not *direct experience*. Below, we further explore trans* individuals' connection between personal healthcare experiences and their understanding of a pervasive, anti-trans* narrative.

Fear

While we characterized trans* health experiences within a system of *civilized* oppression (Harvey, 1999), participants confirmed a well-documented culture of hostility and anti-trans* violence. Violence seemed to run thematically adjacent to trans* healthcare. Gail reflected upon the first time she sought out a primary care physician as an out trans* person. Connected to the local LGBTQ community of her small Midwestern town, she was given a list of trans*-friendly healthcare providers: "We call it the underground railroad for trans* people because most of the doctors on this list don't want their names publically associated because of concern over privacy and safety." In Gail's understanding, trans*-friendly physicians were also in the crosshairs as targets of anti-trans* violence. Similarly, Chase speculated that this "underground railroad" existed specifically because of the greater sociopolitical climate of transphobia. He recounted the struggle the physician he frequents had in becoming established:

They tried to rent medical facility rooms all over...and the business plan said "Lesbian, Gay, Bisexual, and Transgender." As soon as they took transgender off and just had "Lesbian, Gay, and Bisexual" as the main component[s]...they didn't have anybody allow them to do it when

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“Trans*” was at the end. They had to take the word transgender out of it entirely and that’s the only way that they could reserve a space medically. Everybody else absolutely refused...[if] the word transgender [was] in the business plan.

As we talked with Chase about his healthcare interactions, he drew a connection between his identity, hostile public reception, and apprehension about seeking healthcare support. He recalled numerous discriminatory comments such as, “you’re just a woman with her breasts cut off.” These hostile comments often spurred further acts—some violent. He recounted a recent incident at a bar:

I remember we were [dancing] in the bar and he just came up to...to me and said, “Are you a man or a woman?” and I said, “Man.” He said, “no you’re not” and...this was right after top surgery. He grabbed my shirt and pulled it down.

For Chase, this culture of violence was directly related to his trans* identity. His aesthetic performance of masculinity differed from social expectations of masculine embodiment, thus prompting an observer to police gender performance because of perceived incongruity. Violence as a response to trans* embodiment emerged frequently in participants’ narratives of healthcare support seeking (or avoidance thereof), though few noted they had actually been *recipients* of violence. Instead, many cited personal identification with the perceived and pervasive culture of anti-trans* violence.

For instance, though Madison had received relatively “routine” healthcare support, she called upon an assortment of interwoven anecdotal observations and personal experiences to synthesize her aversion to healthcare. This aversion was featured predominantly in response to her perception that, as a trans* individual, violence was to be expected. She noted: “A couple of years ago, there was a woman in...somewhere in the Great Lakes area that...an EMT refused to provide care for her because she was trans*...that woman died.” When asked how this impacted her specifically, she asserted that she was constantly worried if she was “seconds away from getting thrown out because the nurse thinks I’m a freak or pervert or something...that I’m going to get in a car accident and I’m going to die because the EMT won’t assist me.” Madison’s apprehensions about healthcare wove together themes of violence outside the healthcare system, observations of others’ experiences, and personal experiences. The protective mechanism Madison crafted to avoid violence meant even being accidentally mis-gendered in a healthcare setting was a significant offense. She regarded misgendering as a “form of violence”:

Once people start questioning my gender, that’s when discrimination can set in...It opens up the possibilities of someone overhearing that and being like, “Wait, no! I think that’s a DUDE, man!”...And then freaking out...Lonnie Nettles—they figured out she was trans* and they beat her so badly that, after five days on life support, she...she died.

Bree also recalled several “horror stories” of friends who were denied service or actively discriminated against in healthcare settings; when asked about her own experiences, however, she remarked that they were “pleasant...they treat

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me with respect and dignity and the whole nine yards.” In these experiences, trans* embodiment served as its own unique obstacle to healthcare support seeking; as the thing *to be feared*. While each interview focused extensively on healthcare, many participants cited examples of anti-trans* discrimination and violence outside of healthcare. And although no participants had experienced excessive violence or discrimination in any of their own personal healthcare experiences, the narratives of other trans* individuals imprinted as powerful influences on participants’ fears and apprehensions about seeking healthcare support. Below, we discuss participant’s experiences of benevolent oppression and the ways in which they contributed to apprehensions about seeking healthcare support.

Benevolent Oppression

As participants reflected upon their healthcare experiences, nearly all noted that trans* stigma and oppression were not necessarily overt, malevolent behaviors. Instead, many recalled how practitioners attempted to “validate” trans* identity in ways that were not deemed supportive. Below we summarize these instances of excessive questioning and well-intentioned objectification.

Excessive questioning. For some participants, their enactment and declaration of trans* identity was met not with violence, but with excessive questioning. For instance, Madison noted the following about her doctor:

He was actually really good for the most part. I don’t feel like he had much experience and he did devote what seemed to me an excessive amount of time trying to convince me...convince himself to believe me. And it seemed like he was almost trying to, like, get me to talk myself out of it or something. And I don’t think it was any intentional thing on his part. It may have just been him trying to figure out...He was just, like, “Uh, yeah, I believe you...but are you sure?”

Madison later recounted that she was “a bit nervous about seeking healthcare...but also really pragmatic about it” and that in these situations, she simply saw a “teaching moment.” But other participants provided similar encounters where physicians attempted to reason with them regarding their gender identity. For instance, Allison came out to her doctor during a routine procedure as a teenager; she still remembered his immediate response: “Are you sure this is really what’s wrong?” Peyton had a similar experience:

He didn’t really say anything. He kind of was shutting down on me and actually told me, “I think we need to make a...” you know, “we are gonna’ make a psychiatric consult for you.” Why? Because I just came out as trans*?!...I could tell he was very uncomfortable and I felt very uncomfortable.

While the World Professional Association for Transgender Health (WPATH, 2012) recommends that trans* individuals new to sex-hormone therapy complete a mental health evaluation, participants felt that gender policing occurred well beyond the scope of physicians’ due diligence. Participants also expressed discomfort at excessive questioning when it did not seem immediately relevant. For

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instance, when Carly met with her doctor to discuss a continuous bout of the flu, she was subjected to a host of other “unrelated” questions:

The flu is the flu is the flu... There [shouldn't be] the question of, “Oh, you think you have the flu? Well, when did you have your breast augmentation? When did you have a vasectomy? Have you had a hysterectomy? Have you undergone an SRS for male-to-...?” None of that would have any bearing whatsoever.

As we are not medical doctors, we cannot determine whether such questions are related; therefore, we choose to regard these instances as a type of benevolent oppression—well-intentioned, but perceived as misguided. Here, we make no evaluative judgments of the actual oppressive act, but regard it as oppressive in line with participants' evaluations of the behavior. Indeed, participants noted a general level of discomfort in being subjected to excessive questions about issues that were not deemed relevant to their immediate health concerns. This discomfort also manifested when practitioners went beyond the reasonable scope of due diligence in healthcare interactions.

Well-intentioned objectification. For some, communication with healthcare providers was uncomfortable because of perceived or received hostility. For others, their physicians were *more* than comfortable with their identity and offered guidance beyond the immediately salient healthcare concern. These physicians engaged in overcompensating acts of support, whereby they attempted to “validate” trans* individuals. For instance, Shane noted that after being accidentally outed to a physician, the doctor wanted to take the conversation in a different direction:

I identified as genderqueer but I wasn't out to anyone. And, like, this doctor...for some reason...thought that he wanted to do Safe Sex 101 with me...He started, like, talking about...playing with things [sex toys], and how I should be careful...It wasn't really what I was there for...I mean, I was in the E.R. for something else.

Overcompensation also manifested as excessive curiosity in medical contexts other than emergency rooms. Unlike the questions of certainty, noted above, participants indicated benevolent oppression through excessive curiosity, changing the valence from hostile policing to seemingly well-intended (yet misguided) validation. Carmen recounted:

I went into a [pharmacy]...this lady who was a nurse practitioner...she looks at me and she says, “You were born female?” “Yeah,” “and you changed your sex to male?” “Yeah.” “So you have female genitalia?” So clinical, right? “Well, I wouldn't really characterize it that way, but I guess by conventional standards, yes.” And so she [the nurse practitioner] says, “and you're taking testosterone?” “Yeah, I've been taking that for about five years now.” She says, “Oh! So that makes the clitoris grow?”...and I was just like, “I'm sorry...what does that have to do with my respiratory tract?”

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Discourses like these, though seemingly validating, still operated as oppressive mechanisms by positioning trans* bodies as objectified and exoticized artifacts. Carly clarified: “You’re a sort of show monkey for people. It’s like, ‘Oh, this is so cool. He looks so real’...I’m not a Smithsonian exhibit! I’m not here for your curious indulgence!” Jackie corroborated—“I’m not a science experiment”—as did Karen, who felt that her supportive doctor’s liberal exploration of trans* medicine rendered her body “like some chemistry experiment.” These seemingly validating responses were also deemed to be stigma-inducing, as they situated trans* bodies as spectacles.

Participant Response

In an effort to advance the empowerment of trans* individuals in *all contexts*—healthcare included—we engaged our participants in conversation about trans* healthcare reform. Nearly all suggestions pertained to increased education for healthcare providers. Summing her frustrations, Hadley commented:

You don’t know if where you’re going is a safe space so you don’t know if you can actually tell the doctor, you know—you’re trans*. The fact that people are doing healthcare on themselves shows how bad the issue is... how there’s such a lack of compassion from a number of healthcare professionals in both psych and medicine... The fact I’m pleased by appropriate treatment is a bad sign. Appropriate treatment needs to be the norm, not the exception.

Other participants, such as Chase, cited a need for increased training: “If I could wave a magic wand, every single healthcare professional would have to take a sensitivity training or a class about trans* lives and it would be taught by trans* people.” Conversely, Felix acknowledged that trans* individuals can play an important role in creating change but cautiously noted that physicians taking greater responsibility for trans* care is essential: “It shouldn’t have to be trans* people’s responsibility [to educate providers]. I think when you are in a situation or assessing healthcare and feeling vulnerable, it can be exceptionally hard to advocate for yourself.”

Like Felix, many of our participants felt pressure to be “self-experts”—masters of their own health concerns, history, diagnosis, and treatment options. In order to safely navigate healthcare spaces, participants took it upon themselves to ensure that their needs were addressed appropriately. For instance, Hadley indicated that she was the primary source of information for her doctor during the early days of her transition: “In the beginning, it was just me. I’m going, ‘Ok, this is how you treat me...’” Frustrated, Chad recalled similar experiences and gave the following advice: “Don’t always expect the patient to be doing the education...as a provider, you’re within your obligation to address changes in development and research and what’s out there.”

A few individuals noted that, ideal or not, the act of educating their physicians was crucial. For instance, Addison saw it as a personal responsibility:

It’s not just your doctor’s job to research—it’s your job too. I’ve met a lot of trans* people who...don’t go into what they need. They just kind of

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[start] crossdressing and then expect a doctor to have the miracle.

Though it is not particularly oppressive to ask individuals to play an active role in their own medical treatment, trans* participants expressed concern that their involvement went far beyond the bounds of reason and was incomparable to that of their cisgender counterparts. Thus, participants positioned themselves as anomalies in medical communities enmeshed in cisgender modes of operation and treatment. Whether through (perceived) hostile aggressions, such as gender policing and misgendering, or seemingly benevolent microaggressions and excessive curiosity, our participants widely demonstrated fear and apprehension toward seeking healthcare support. Our interviews with 17 trans* individuals revealed that this aversion to healthcare could not simply be explained away through previous negative experiences, alone. Below, we explore the complex nature of trans* individual stigma as it pertains to a larger systemic understanding of trans* discrimination.

Discussion

Participants' experiences presented a host of unique obstacles. Many cited the need to make tough decisions, situating their identity as necessary to acknowledge in healthcare contexts, but with full recognition that acknowledgement could lead to discrimination. Thus, participants had considerable fear when it came to seeking healthcare support, whether due to their own experiences or perceptions of negative treatment based on understandings of the bigger picture of trans* healthcare. This bigger picture was complex; although developments in trans*-inclusive medicine were acknowledged, many participants also found themselves disenfranchised by benevolent oppression. Many trans* individuals were forced to be their own advocates, and to some extent, recommend their own treatment paths to ensure all aspects of their physical and emotional health were appropriately addressed.

Trans* identity, along with the discourses that surround it, is fraught with anxieties surrounding perceptions, responses to, and validation of, that identity. While we expected participants to reflect upon physicians' perceptions/responses/validation (i.e., interpersonal stigma), the trans* healthcare context was understood as complex—defined by both personal anxieties (i.e., lived experiences of discrimination) and regarded anxieties (i.e., those experienced by another member of the trans* community and therefore salient in participants' support-seeking schema). Thus, we observed intersectional manifestations of individual, interpersonal, and institutional stigma.

Extant literature led us to believe that intersectional workings of stigma coalesce to situate healthcare as an anxiety-inducing environment for trans* individuals. Indeed, though many of our participants cited their own personal struggles, these instances alone were not the sole determinants in healthcare support-seeking apprehension or aversion. Instead, participants also indicted larger, systemic anti-trans* discrimination and violence as suppressors of support seeking.

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The operationalization of this intersection is informative. Above, we noted a consistent link between individual stigma and healthcare support seeking. Yet, self-stigmatization occurred as individuals internalized what they presumed to be a pervasive anti-trans* sentiment—one identified by violence, outright discriminatory behaviors (i.e., turning patients away because of their trans* identities), and the experiences of others. In many ways, *individual* stigma emerged as a mechanism of uncertainty avoidance and participants were often their own obstacles in pursuit of equitable healthcare. For instance, Madison's expressed concern about being denied treatment stemmed from observations of others in the trans* community. Though not a firsthand experience and also not clearly *institutional*, this event influenced Madison's overall reluctance to seek healthcare support. Here, this functioned as *individual* stigma, whereby Madison saw herself as having "a single discrediting attribute" (Feree & Smith, 1979, p. 87) and had "anxious expectations of rejection and stigma avoidance, stigma concealment, and reduced self-efficacy" (White Hughto et al., 2015, p. 226).

As noted throughout the results, many participants were direct targets of stigma, though often through a benevolent lens. From excessive questioning to misguided curiosity, trans* individuals demonstrated anxiety about seeking healthcare support both because of their perception of overarching anti-trans* sentiment, but also because of their own (albeit less hostile) experiences with anti-trans* stigma. These personal experiences were closely associated with other instances of trans* discrimination and others trans* individuals' experiences.

Our participants had either largely positive experiences or only benevolently oppressive experiences. Most had not experienced "extreme" discrimination or oppression. Yet, the uncertainty that defines trans* healthcare led participants to take an inventory of several cost-benefit ratios (e.g., do/not seek care, do/not reveal trans* identity); a process which supports scholarship on stress and coping (Lazarus & Folkman, 1984; Meyer, 2003). As trans* individuals seek to reconcile pervasive anti-trans* violence and discrimination with their own experiences, they appraise the social situation in terms of both an understood but not-fully-validated *threat* (i.e., violence, others' experiences, uncertainty) and their available resources for combatting that threat. The level of uncertainty and anxiety demonstrated throughout our study suggests that many participants believe there is significant risk for outing themselves as trans* and for simply *being trans** while seeking healthcare support. Participants' avoidance of healthcare support emerged as a self-protective coping strategy.

Identity concealment is a common strategy among stigmatized populations. One of Goffman's (1963) original works on stigma characterized the discreditable/discredited dichotomy. The stigmatized may attempt to conceal identity to avoid its perceived consequences. This strategy shifts after the stigmatized identity is revealed, as individuals must then attempt to get others "to use that information in forming impressions about her or him" (Herek, Chopp, & Strohl, 2007, p. 186). Individuals in our study demonstrated a will to avoid discussing trans* identity unless it was "immediately salient." This act originated in an effort to guarantee the most equitable healthcare—which was, ironically, often characterized by a lack of disclosure of their gender identity. Upon revelation of this

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identity, individuals demonstrated a propensity to self-advocate. For many, this was begrudgingly undertaken out of medical and emotional necessity.

We consistently observed tensions between multiple modes of stigma. As noted above, these modes intersect throughout the healthcare support process and influence healthcare support seeking *before* a health-related event, the process of identity negotiation and healthcare support *during* that event, and the collective memory of how the situation fits within the larger picture of trans* discrimination *after* the event. Further, we note the intersections of stigma working at all levels of trans* healthcare. Carmen's experience of being questioned by her pharmacist about her body highlights how interpersonal stigma manifests in preventative healthcare environments. Chase's decision to engage in sex work to manage the excessive cost of hormone therapy reveals how individual stigma and institutional stigma intersect in the context of transcare. Likewise, Savannah's anxiety about revealing her gender identity to medical providers while in the middle of having a heart attack reveals the intersections of individual, interpersonal, and institutional stigma in the context of critical care. These modes of stigma manifest saliently and intersectionally throughout all levels of trans* healthcare.

These findings are significant in light of current shifts in the healthcare system. In 2016, the U.S. Department of Health and Human Services enacted a policy extension of the Affordable Care Act that forbids hospitals and other medical facilities from discriminating against patients on the basis of gender identity (HHS, 2016). Still, these new provisions do not mandate that insurance companies cover costs related to gender transition (i.e., SRS). Additionally, while leading medical authorities denounce inequitable care for trans* individuals (AMA, 2016), recent scholarship highlights the vast discrimination that trans* individuals still face in these contexts (Jaffee, Shires, & Stroumsa, 2016; Rubin, 2015; Safer et al., 2016). Thus, we contend that explorations of the micro-nuances of trans* discrimination are crucial to ensuring an inclusive model of trans* healthcare support and provision.

Conclusion and Steps Forward

Through interviews with 17 trans* individuals, we observed intersections of individual, interpersonal, and institutional modes of stigma across a variety of contexts of trans* healthcare. Above, we examined three specific themes related to trans* individuals' anxiety about seeking healthcare support—tough decisions, fear, and benevolent oppression. Gender identity obviously played a significant role in the health and wellness experience. Stigma also played a critical role in the healthcare support-seeking process, with (perceived *and* experienced) individual stigma, interpersonal stigma, and institutional stigma forming complex intersections in the context of trans* healthcare. While the obstacles that trans* individuals face in their pursuit of equitable healthcare have been widely documented, our findings further indict stigma as an inhibitor to trans* healthcare support seeking.

While our data adds new dimensions to trans* healthcare research, we acknowledge its limitations. First, because it can be difficult to gain access to trans* populations, our interviewees were spread across the nation. We completed Skype

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and/or phone interviews with most participants, but as reflexive researchers, we acknowledge how inhibiting those mediums can be. Furthermore, we did not fully address the call for greater intersectional perspectives in LGBTQ research (Erel, Haritaworn, Rodriguez, & Klesse, 2010; Manning et al., 2008; Singh & McKleroy, 2011). Though we attempted to recruit from a variety of LGBTQ-aligned advocacy centers and groups, most of our connections were university-affiliated organizations and our participants were largely privileged in terms of race, class, access, and education. These identity elements may explain why none of our participants experienced egregious offenses within their actual healthcare experiences and may impact the scope of our findings.

We have identified several key suggestions for improving trans* healthcare that stem from this study. First, though the medical community has taken great strides to improve access to trans* services (see AMA, 2016; HHS, 2016), individuals in our study point to a need for overarching institutional transformation. In addition to ongoing systemic battles—such as insurance coverage for SRS and the cost of hormone therapy—micro-level changes, such as increased trans* healthcare training and increased validation of trans* identity in healthcare spaces are important starting points for this broader improvement. Medical providers must ensure their spaces are free from trans* discrimination, even at the micro level. Viewing trans* embodiment as a curious spectacle, addressing healthcare concerns through skepticism, and taking unnecessary liberties in extending the medical conversations beyond the scope of immediate medical issues run the risk of exotifying and further stigmatizing trans* individuals. Though these instances are most likely not malevolent, increased provider training on trans* healthcare issues can help preserve trans* dignity, autonomy, and agency in healthcare interactions.

Curricula for healthcare practitioners must also be clear on *when* trans* identity is an important factor in any given medical situation. Participants in our study expressed concern when their gender identity was woven into medical conversations that they did not deem as necessary. While we validate these concerns, it is important to also point out that the domain of medicine involves many sex-specific modes of healthcare support provision. For instance, Carmen noted that her gender identity was not “relevant” to her dental care so she chose not to discuss it. While this makes sense to the general population (i.e., that genitals don’t necessarily factor into dental care), routine care may involve sex-specific treatment options—dentistry included. For example, Zakrzewska (1996) notes that even dental examinations may involve sex-specific treatment options based on menstrual cycles, menopause, and sex-specific patterns of dental disease. Thus, clarification for providers and patients about when born-sex is relevant to the provision of healthcare may help increase trans* patient satisfaction and contribute to overarching systemic improvement.

Because of the cited fear that trans* individuals express in regard to healthcare contexts, as well as the frustration that accompanied individuals’ self-advocacy, it is critical for trans* medical models of support provision to foster open and collaborative dialogue between physicians and patients. As institutional reform allows for more trans*-inclusive healthcare support, medical providers must be

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clear with trans* patients about the influence of trans* identity on various medical diagnoses, as well as the ways in which trans* identity influences the future trajectory of health-related needs and treatment.

Finally, as trans* individuals situate their apprehension toward seeking out healthcare support against the much greater backdrop of trans* discrimination and violence, it is imperative that the medical community acknowledge trans* health concerns and decry anti-trans* discrimination at all levels. Though some strides have been made, these acknowledgements must address the inequitable practices that plague the medical community and respond appropriately. Through open dialogue, medical providers can validate trans* individuals by collaborating to offer a viable path forward for the future of trans* medicine.

We conclude with Karen's suggestion—a *big picture suggestion*, yet an important one: "There's so much diversity in our community... There is no 'one-size-fits-all' with transgender healthcare. Because everyone sees themselves differently and everyone has a different outcome a lot of times... [they all have different] expectations of what they want in the end." Regardless of what trans* individuals want "in the end," we contend that there is much work to be done to ensure the route toward that end is equitable. Through this study, we hope to illuminate one piece of the puzzle and inspire more scholarship on trans* healthcare so that all trans* individuals—no matter their goals or outcomes—feel safe and validated in healthcare spaces.

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