Embodied disruption: “Sorting out” gender and nonconformity in the doctor's office

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Abstract

Among LGBTQ people, those who are gender nonconforming (GNC) may be at heightened risk of both discrimination and underutilization of healthcare—yet little is known about what happens during healthcare encounters to compel GNC individuals to continue or avoid seeking future care. This study qualitatively examines the healthcare experiences of a racially diverse sample of 34 adult LGBTQ cis women, transgender men, and nonbinary individuals in a metropolitan area of the United States who do not conform to dominant biomedical schemas of sex and gender. GNC individuals experience *embodied disruption* in medical settings when patients are *mis/recognized;* providers respond to disruption in ways that further distress patients. Broadly, participants report similar experiences across racial and gender identities, but patients manage disruption somewhat differently depending on their embodied positions to gender norms. This study contributes to literatures of stress, stigma, and sex, gender and sexuality within medicine by illuminating how stigmatizing healthcare interactions deter LGBTQ individuals from seeking healthcare. Findings point to the importance of considering both structural factors and embodied visibility in future research addressing how stigma and discrimination manifest within health settings to disadvantage LGBTQ groups.

Key words: USA; LGBT; Stigma; Discrimination; Transgender; Medicalization; Healthcare Settings; Qualitative Research.

Lesbian, gay, bisexual, transgender (trans), and queer (LGBTQ) individuals experience worse health by a wide variety of measures and at every stage of the life course, compared to their heterosexual and cisgender (non-transgender, hereafter cis) peers (Conron et al., 2010; Fredriksen-Goldensen et al., 2013; IOM, 2011). Minority stress models highlight within and between individual processes as well as biopsychosocial pathways through which stress resulting from stigma and discrimination produce LGBTQ health disparities (Hatzenbuehler, 2009; Hendricks and Testa, 2013; IOM, 2011; Lick et al., 2013; Meyer, 1995). Health and mortality outcomes among LGBTQ populations are also negatively impacted by exposure to stigma at the structural level in the forms of discriminatory policies and societal norms about gender, sex, and sexuality that define LGBTQ people as non-normative (Hatzenbuehler, Phelan, & Link, 2013; Hatzenbuehler et al., 2014; Hughto et al., 2015). Underutilization of healthcare is one pathway through which minority stress and stigma are theorized to diminish health among LGBTQ groups, when—for example—fear of discrimination within health settings discourages people from seeking care (Everett and Mollburn, 2014; Grant et al., 2011; Hughto et al., 2015; Hughto et al., 2017; Wagner et al., 2016). Recent studies show that transgender people who delay or are denied care are in worse health (Romanelli, Lu, & Lindsey, 2018; Seelman et al, 2017; Whitehead, Shaver, & Stephenson, 2016). Although denial of care, violence, discrimination, and fear of discrimination in health settings is demonstrated to deter LGBTQ people from seeking care, further insight into how LGBTQ patients *experience* medical encounters is needed (Shires & Jaffee, 2015). Current interventions designed to increase LGBTQ utilization of care, therefore, may be ill-informed. Additionally, a small but compelling literature suggests that conformity or nonconformity to binary gender norms may help to explain variations in LGBTQ experiences of discrimination.

Miller and Grollman (2015) introduce the concept "visibly stigmatized"—developed from Goffman's original typologies of stigma (1963)—to shift focus from one's stigmatized identity to whether or not one is likely to be categorized as part of a stigmatized group by an onlooker. They find that transgender individuals who affirmatively answer the question "People can tell I'm transgender/gender nonconforming even if I don't tell them" are indeed more likely to experience discrimination compared to those who do not. Additionally, individuals who identify as genderqueer are more likely than those who identify as transgender to report delaying care (Cruz, 2014). And one study found that among cis lesbians in the U.S. and Canada, those who are gender nonconforming—or "gender-atypical"—were more likely to face discrimination in medical settings and avoid healthcare than their conforming counterparts (Hiestand, Horne, & Levitt, 2007). Gordon and Meyer (2007) similarly found that visible nonconformity helped explain prejudice events among LGB cis people, concluding that "there is an implicit link between gender nonconformity and sexual orientation," and therefore "The importance of paying attention to gender nonconformity in close relation to, or overlapping with, sexual minority status cannot be overstated," (p. 67-68). Extant studies examining factors shaping LGBTQ experiences of healthcare, however, overwhelmingly focus on sexual and gender identity without regard for "visible stigmatization," or what I refer to as gender nonconformity.

This study draws attention to nonconformity to societal norms (Hughto et al., 2015), and the consequences of gender nonconformity in everyday medical interactions. Gender nonconformity, in this paper, is related but not tied to identity; instead, it refers to one's performed or embodied relationship to dominant biomedical definitions of binary sex/gender/sexuality, which assume gender identity, sex assigned at birth, sexual identity, and performance of gender to normatively align. Therefore identity is not the primary focus: whether

or not one appears to transgress or deviate from a gender norm is not, in and of itself, indicative of identity. This definition rests on the foundational notion that sexual and gender differences are constructed through social processes (see Almeling, 2007; Butler, 1993; Fausto-Sterling, 2000). Conformity is not static; it can change over short and long periods of time. For example, trans individuals who seek gender-affirming medical and surgical care to transform their embodiments may appear conforming and nonconforming in different periods of their lives. Even when trans individuals "pass" (are identified by an onlooker as cis), their embodiments diverge from gender schemas because their gender identity and sex assigned at birth do not normatively align (Hughto et al., 2015). As argued by Hughto and colleagues (2015), medicalization of gender nonconformity makes nonconforming individuals susceptible to institutional practices designed to reinforce gender norms within medical contexts.

Additional studies investigating stigma and discrimination in concert with power and authority in medicine can shed important theoretical and empirical insight into this query. Poteat and colleagues (2013) found that within medical interactions, providers stigmatized transgender patients in an effort to reinforce their own medical authority. Providers also report delaying transgender patients' access to gender-affirming care when they do not believe patients will "successfully" perform normative (heterosexual, binary) gender (Davis, Dewey, & Murphy, 2016). These findings illustrate the power of reigning medical schemas of sex/gender/sexuality and point to the larger structural forces at play within micro-medical interactions.

Medicine is a key social institution through which social categories are constructed, produced, reified—as well as (potentially) challenged and redefined. The institution of medicine is organized by and imbued with the authority to act upon bodies toward the goal of promoting and controlling individual and collective societal health (Conrad, 1992). When it comes to

defining bodies and the social categories into which they are sorted, medicine remains one of the most powerful and influential institutions shaping our cultural definitions of sex, gender, sexuality (see Epstein, 1996; Fausto-Sterling, 2000). Boundaries related to these primary social categories are drawn and redrawn among medical actors, and they are disciplined within medical settings (Foucault, 1973). Studies investigating medical responses to intersex infants' embodied variance from medical constructs of binary biological sex, such as medically unnecessary genitoplasty—which is routinely recommended for and performed on young children—documents one of the most extreme examples of how sex is regulated in the doctor's office (see Davis, 2015). More generally in the U.S., medical actors are the first to determine one's legal sex: we leave our first medical encounter (birth) with a legal document marked M or F (although a third option is currently offered in three states). In these initial ways—and many more—medicine is a fraught and consequential site through which gender as an institution is reproduced and binary constructs of gender and sex are reified (Martin, 2004). The medicalization of sex, or the medical definition of biological sex as under the purview and thus authority of medicine (Conrad, 1992; Zola, 1972), is inextricably entangled with the medicalization of gender and sexuality (see Geist et al., 2017; Gordon & Meyer, 2007; Springer et al., 2012), and actions taken by medical authorities to regulate each reflect this entanglement (Davis et al., 2016).

Still, few studies have examined how LGBTQ patients' nonconformity to dominant norms are shaping their medical experiences, and scholars call for further insight into which LGBTQ people are troubled by nonconformity in medical settings (Johnson, 2015). Transgender and GNC-identified patients report that in response to nonconformity, providers express discomfort and perform unnecessary examinations (Chisolm-Straker et al., 2017; Kosenko et al., 2013). One study of cis LGB people found that women were more likely than men to interpret

prejudice events to stem from gender nonconformity (Gordon & Meyer, 2007). And nonbinary people, who identify as neither male nor female, report being misunderstood even in clinics designed to serve transgender populations (Lykens et al., 2018). Moreover, although people of color experience more discrimination than whites in general, it is unclear whether or how GNC-related healthcare discrimination is racialized. Kattari and colleagues (2015) found that compared to whites, multiracial and Latinx trans and GNC-identified people reported more nonconformity-related discrimination in health settings, while black participants reported less. By analyzing in-depth interviews with GNC individuals with a variety of racial, sexual, and gender identities, this study aims to address these gaps and reveal how nonconformity becomes salient within healthcare encounters.

Methods

This study uses a subsample from a larger study of LGBTQ healthcare experiences, which received ethical approval from the Institutional Review Board at The University of Texas at Austin to conduct semi-structured narrative interviews with 50 LGBQ cis women and transmasculine individuals between 2014 and 2017. The sample was restricted to individuals assigned female at birth because recent studies suggest LGBQ cis women and trans men are less likely to seek healthcare than gay, bisexual, and queer men and trans women, respectively (Cruz, 2014; Everett and Mollburn, 2014; Grant et al., 2011). Participants were recruited through a variety of methods, including: online LGBTQ forums (e.g., LGBTQ facebook groups); provider outreach at an LGBT health center; outreach through LGBT community organizations; flyers distributed at Pride festivals; and snowball sampling. The majority of participants learned of the study through online forums and participant referral. Because the larger study is concerned with

experiences across different health contexts, all participants had—at some time—accessed healthcare at an organization purposed specifically for the LGBTQ community.

Participants from the larger sample are included in this study if they are one of the following: 1) LGBQ cis women who are GNC; 2) trans men; or 3) nonbinary. Nonbinary is used here as a category for individuals in this sample who were assigned female at birth and identified as neither male nor female, although some primarily identified with a different term than nonbinary (e.g., genderqueer or gender nonconforming). 34 out of the original study participants are included in this sample. Out of this 34, 13 identified as white and 21 identified as nonwhite—specifically: Black or African American (N=11), mixed race (N=5), Latino (N=4), Puerto Rican (N=1), and Filipino/Asian-Pacific Islander (N=1). All participants were between the ages 21-46 and lived in one major metropolitan area in the Mid-Atlantic region of the United States. Because funds for research were available in two years (2015 and 2017) of this study, only individuals interviewed in those years were paid for their participation. In total, eight participants were given no incentive, four were paid $30, and the remaining 22 were paid $50.

Interviews took place at coffee shops, restaurants, parks and participants' homes, and ranged from 31 to 152 minutes (average interview length = 74 minutes). All participants read and signed a consent form explaining study protocol. During interviews, I asked participants to describe their identities in their own words, relay medical concerns and encounters, and then "walk me through" their most positive, negative, memorable, and recent healthcare experiences. As participants responded to these questions, I probed for more information about their thoughts and feelings, as well as decisions they made to continue or cease care following their experiences (including whether and if so, how their health need was ultimately met).

Positionality and Reflexivity

I identify as LGBTQ and am commonly visibly identified by others as LGBTQ, and so interviewees were (likely) more detailed *and* more limited in how they described experiences to me (compared to a hypothetical non-LGBTQ interviewer). For example, participants signaled that they were withholding information because they assumed I already understood their experience. Over the course of gathering data, I developed an approach to address this dynamic. After interviews, I wrote detailed notes about any thoughts or feelings (of mine or that I perceived from participants) that arose during interviews related to shared or different sexual, gender, racial, and class identities. These notes were not analyzed as data but were instead used to establish a method wherein I leveraged my positionality to cultivate openness and trust based on shared group membership paired with recognition of difference. I encouraged participants to share as much detail as possible, "for the data," as though they were explaining their experiences to someone with no knowledge of LGBTQ issues. As I continued interviewing, I was also able to draw on other participants' experiences in order to affirm an interviewee's perception of their experience.

As a white person with an advanced degree, I also worked to demonstrate my interest in and belief of interviewees' perceptions of how our unshared identities, specifically in relation to race or education, came to play within their healthcare interactions. To do so, I began each interview by asking participants to tell me about themselves in terms of gender, gender expression, sexuality, race and ethnicity, class (background and current), education and religion. I asked these questions instead of using a survey with predetermined options to signal that I considered participants to be the experts of their identities, and that all identities were important to our discussion. Insight into how participants thought about their social positions allowed me to ask informed questions to probe for more information; when participants brought up their

identities in discussions of healthcare experiences, I mirrored their language and asked them to tell me more. In these ways, I worked to be reflective of my positionality during interviews, and leveraged my identities as well as the experiences of other participants throughout the interview process in order to generate rich and detailed data.

Analytic Approach

Interviews were transcribed in full and entered into the coding program MAXQDA12. All interviews were coded using abductive analysis (Timmermans and Tavory, 2012). Abductive analysis combines inductive and deductive approaches, and departs from grounded theory by emphasizing the importance of entering the field armed with a strong foundation of "cultivated theoretical expertise," in addition to the intention to generate "new concepts… to account for puzzling empirical materials," (p. 180). During initial analysis, I identified passages discussing experiences of stigma and discrimination as well as passages wherein gender nonconformity became salient in health settings, while also attending to related emergent themes. Relevant passages were then coded line-by-line and next grouped into themes and subthemes. As themes emerged throughout the coding process, I revisited coded passages to establish their relationship to new themes, writing memos to clarify connections as I coded. Finally, I examined categories of themes and subthemes in light of gender and racial identities.

Findings:

Embodied Disruption is the predominant theme that emerged from analysis. Participants experienced embodied disruption when they were *mis/recognized* by providers who either assumed them to embody a normative binary identity, or could not recognize how to categorize them. The "/" dividing "mis" from "recognition" in this term serves to illustrate the multifaceted processes at play during provider attempts to recognize patients, described below. Patients'

emotional experiences of these moments are marked by confusion, panic, fear, distress, and at times, momentary elation. Amid emotional reactions, patients balanced a desire to address health concerns with a desire to diminish fall out from disruption in their urgent decisions about how to respond. Disruptions triggered a variety of responses from medical providers. Compared to experiences in typical settings and with straight cis providers, disruptive experiences were less common and responses to disruption were less stigmatizing in LGBT health settings or with LGBT providers, respectively. Experiences and reactions to disruption did not otherwise vary by provider or care type. For patients, disruption was unambiguously (though to varying degrees) interpreted to be distressful. Patients typically prioritized avoiding future disruption over meeting health needs in their subsequent decisions about seeking care. Provider responses to disruption unfolded in multiple, overlapping ways, including: *disengagement, sorting out, denial* and *disciplining*. Below, I illustrate embodied disruption and reactions with examples from patients' narratives before discussing similarities and differences in participants' experiences by race and gender.

Mis/recognition was often confusing for patients, and invoked a range of emotions, given that mis/recognition often initially validated patients' identities—for example, when a provider assumed a trans man was a cis man, mis/recognition affirmed his gender identity. Yet joy at being mis/recognized quickly give way to distress, as patients had to decide how to manage provider perceptions. Patients' bodies and embodied gender performance became central actors in their decision-making processes about how to manage mis/recognition. Similarly, the ways in which health needs did or did not relate to medically gendered/sexed body parts figured into patient strategies.

For example, Pablo, 33, a Latino trans man, recalled visiting an LGBT Clinic out of concern he had contracted an STI. At this time, he had not yet received gender-affirming surgery, and was not commonly perceived by onlookers to be a man. He was aware the STI test would require an anal swab. First, Pablo watched the provider look at his chart before confirming the reason for his visit. Pablo relayed the provider's reply to his question about STI transmission: "He said, 'Well, so, the various ways you can transmit,'—it was like, through the throat, or, something—and then he's like, 'The back of your throat, if you are receiving oral sex, and the pink of your part touches the pink of their part in the back of their throat, then the transmission can happen that way.'" Here, the provider signaled his assumption that Pablo possessed genitalia able to reach the back of his partner's throat during oral sex—which he did not. Pablo then detailed his embodied emotional response to this mis/recognition:

> So, immediately, I was like, Oh shit... because I was being read as cis, which was so exciting for me at the time. That was before top surgery, so I was sometimes passing, sometimes not, depending on what people were picking up. So to pass was so exciting. I mean it's always exciting, but now it happens all the time, it doesn't *not* happen. Then it was rarely happening, so I was feeling a mix of emotions. One, I was so excited it was happening, two, now incredibly self-conscious about my chest, I was unbound, I had on a sweatshirt, I tucked my chest in and was like, I hope he doesn't [notice] now—and I had all kinds of social anxiety stuff coming up that shouldn't happen in healthcare, because you have to be honest to get honest treatment, but I was reverting into that mode of: Now I can't be found out.

Amid the confusion, Pablo described quickly weighing the benefits of being "found out" against his meeting his healthcare needs:

> But then, obviously, feeling like I'm not going to get the information I need because I can't share my actual experience with him to get the feedback I need… It must've happened another way, what could those ways be, so I was getting inaccurate information, but also feeling like I didn't want to say it, so then I didn't say anything, but I had to do a rectal swabbing…

Pablo attributes his decision not to correct the provider's mis/recognition of his gender embodiment before the anal swab to the confusion caused by mis/recognition. After the swab, during which his genitals were exposed, the provider abruptly *disengaged*: "The good thing was he didn't react in any overt type of way, but after that happened: no eye contact, no more conversation." This type of disengagement was common after moments of disruption, and was evaluated by patients to be the least distressful type of negative reaction. Nonetheless, although Pablo was tested for the STI, the provider did not offer and Pablo did not receive the correct information about modes of transmission specific to Pablo's embodied sexual practices.

The experience of Liza, 26, a white/Jewish/Italian "boy-looking girl," exemplifies another case of disruption in which Liza experienced significant distress as a result a *sorting* response to mis/recognition. After experiencing chronic gastrointestinal distress, Liza went to see a gastroenterologist, whom she described as "probably like 60…65? 60ish Italian American guy, and he actually was pretty nice." He first conducted a thorough intake, she recalled: "We sat for a long time, 20 or so minutes just talking about my life… He wasn't just asking about my body, he was asking about my lifestyle and substances that could be tying in. He was *really* talking to me, which is what, later in the story, really confuses me because of what ended up happening." The provider then told Liza that he would do a physical exam, and asked her to go into the exam room and take off everything but her boxers. At first, this instruction struck Liza as odd, but she

interpreted it as a sign that the doctor *did* "get" her gender: he understood that it would make sense for a boy-looking girl to wear boxers. This was not a common experience for Liza, and the perceived recognition of her nonconformity was exciting, as she explained in the following exchange:

> Liza: And I was like, interesting that he said that, but okay cool, he knows I wear boxers, that's awesome. And so I went in, I was wearing my boxer-briefs… But I have like—breasts, that is clear thing, right [gesturing to her chest]?
>
> Interviewer: [nodding] Yes…
>
> Liza: Yeah. So what happens is he comes in, and I'm standing there [in only boxer briefs], and he looks at me, and he's like, 'Do you take hormones?' And I was like, does he think that I'm taking T [testosterone] to transition [from female to male] or something? And I said, 'Like what hormones?' And he's like, 'Steroids?' And I'm like, [to interviewer] do I look like I'm on steroids? And later I put it together that he was trying to attribute my breasts to something. So he does the whole exam, he feels around [gesturing to her chest] cause I guess he was trying to figure out what was going on with them—in retrospect, I was thinking why is this… But he did a whole breast exam, he's looking at me, and he's kind of being weird, but then he's like 'Okay,' and he goes and sits in a chair, he says 'Okay now come stand in front of me, I'm going to examine your testicles.' [Liza pauses.] And I was like, 'Well, I'm a woman.'

After I asked Liza how the doctor responded, she continued: "He was like 'Oh, I thought you might be.' And I [thought] like, Oookay… Way to go. Way to use your investigative skills… you could also like, you could use your words. Or look at my chart even." Whether or not Liza's

provider had read the gender marker on her chart, Liza interpreted his reactions as purposed to protect his medical authority, at the expense of her well-being. She explained:

> And so then, he never got weird, he was kind of like, *I'm a man doctor*. But he said "Okay well, um, put on your clothes and we'll talk in my office." So then I'm feeling totally upset. And I get dressed and I walk into his office and sit down and he's like, "Well now that we have your gender *sorted out*," and I was thinking, Oh hell no.

Liza continued to describe her emotional response to the interaction, which involved confusion, crying, and feeling "violated." After this encounter, Liza did not complete proscribed lab work, nor did she get her original health needs met; she ceased care with this provider and did not seek a new one. The provider's response to the disruption of Liza's embodied nonconformity falls into the category for which it is named: *sorting out*. This category of response is comprised of actions taken by providers in an attempt to fit nonconforming patients into binary biomedical categories in which sex/gender/sexuality normatively align; out of all patients, Liza experienced the most extreme (and embodied) case of sorting out.

When providers asked questions about patients' sexuality in order to sort out gender, they revealed the interdependent nature of the gender and sexual norms they used to make sense nonconformity. For example, Jason, 23, a Latino trans man, experienced *denial* after embodied disruption, which (similar to Pablo) occurred in the period of his life before he regularly passed for male. Jason made an appointment with a psychiatrist at a clinic that targeted HIV positive patients, in part because he assumed this setting employed clinicians familiar with LGBTQ identities. First, despite the fact that he had written his preferred name on the intake form, the provider called him out of the waiting room by the wrong name. Jason relayed the exchange that followed: "[I said] 'No actually, I'm male,' and she was like, 'But you have a husband,' and I

was like, 'Yeah, I know, I'm gay, I'm a gay man,' and she was like, 'But you were born a woman?'" Their conversation continued in the waiting room, in front of other patients, as told by Jason:

> So she stops fussing about my gender and we get into her office and I explain a little bit about my life. First off she tells me, "Well, you still look like a woman, so, yeah, I misgendered you,"… Which was just *extremely* rude…she said I was very young, so young in fact that I couldn't really know for sure that I was trans… She was willing to learn and she'd never met a trans man before, but she was just so extremely rude, kept insisting that I was so young to be transitioning and I couldn't be sure, and that I still looked like a woman anyway.

Jason was twenty-one at the time of this encounter. His provider responded to disruption with *denial*, a process through which providers position themselves as the experts on patients' gender, and leverage medical authority to invalidate patients' identities and knowledge. By the provider's judgment, Jason fails to normatively embody his gender identity (he looks "like a woman"), and is too young to "know" his identity, which she cites as grounds for denial. Trans patients taking testosterone often reported that medical providers responding to disruption in this manner also frequently denied them care for basic health needs. For example, one patient sought care for chronic kidney infections but was denied by multiple urologists once they realized the patient was transgender. Providers typically cited ignorance about trans healthcare as the reason for denying care, regardless of whether or not patients' concerns pertained to gender-affirming care. In Jason's and other cases when providers responded to disruption with denial, providers also typically treated patients' non-gender specific concerns as suspicious, as though nonconformity undermined their credibility as patients. After this encounter, Jason stopped

seeing this psychiatrist, and as a result he went without previously prescribed medication for a period of months.

Riley, 32, a Filipino American trans man, also reported experiencing denial after disruption in an intensive outpatient mental health treatment program:

> In my first session [with this therapist] I told her I was trans and I was having a lot of trouble with it, because I was afraid and I didn't know what kind of impact it was going to have on my life, but that I had just figured this out. And she was basically like, "Well, I don't really know a whole lot about that, so let's focus on your depression..."

Yet in their next encounter, the provider's attitude had changed, Riley recalled:

> It was pretty apparent that she had looked into it just a very little bit. And … it felt like she was going line by line, asking me about my relationship to my body, my sex life, whether or not I'm able to look at myself in the mirror, whether or not I'm able to wash myself in the shower, whether I masturbate, whether I let partners touch me. And then, by that reasoning, had concluded that I was actually not trans. Because I let partners touch me and because I can shower. And her way of describing to me that she didn't believe me was that like, well *these people* do this and this and this, and *these people* can barely do this and that, and so I do not think that this is what you're going through. Like, you're actually just very depressed and like, you know, looking for solutions, basically.

In these ways and more, providers responded to disruption by medicalizing and denying patients' identities and as a result, access to treatment for their medical needs.

Denial often overlapped or coincided with *disciplining* reactions, through which providers actively disciplined patients whose embodiments and identities deviated from hegemonic categories of sex/gender/sexuality. Providers commonly engaged in multiple forms of

reactions to disruption within one encounter; disciplining reactions, however, were often interpreted to be more overtly degrading, stigmatizing, and distressing than other reactions. For example, when Pablo (again, 33, a Latino trans man) sought care for extreme uterine pain, he obtained a referral from his primary care provider at an LGBT clinic. During his encounter with the specialist in a setting gendered specifically for women, Pablo experienced embodied disruption when he was perceived to be a cis man. First, a provider responded by disengaging, and later by disciplining. In Pablo's own words:

> So I went in for an internal ultrasound, and [they] call me by my first name, my whole name, my first given name. [The waiting area] was gendered… they were like, "Hi, what are you here for?" And I said, "I'm here for this"…They were kind of confused, like, what are you doing here? I was passing. And then they were like, "Oh, you're one of *them*." And then they knew [I was trans]. They took me to a place to change that was down the hall… so to get back, I had to go with a backpack, barefoot, [in a medical gown] through the halls… to get to this place to wait. Then I'm waiting with the other women, gals, and the provider comes, and says my [given] name, and so I get up. And she's like, "No, no, no," said [my given name] again, and I'm like, "That's me." And she was like, just, usually people, this is why I keep going to [the LGBT health clinic] because they're not doing this overt, terrible, shit. She was just like stuck, couldn't move, talk, anything, and then was like, "You're a man?"

Next, Pablo said, the provider disengaged: **"**And she was like, 'Oh, oh, oh,' and then just turned and walked. And I'm like, so I guess I should follow? So I followed. The person came, did [an ultrasound], just like kind of staring at me, kind of not looking at me at all, like it was either stare, stare, stare, or not even look …"After the exam, this provider returned and engaged in a

disciplinary response. Pablo continued:

> She came back, the exam is over, so I'm lying down, with a paper, bottomless…and she comes back, sits down and is like, "Can I ask you a question?" And I'm like, "Sure," in my head I'm like, Obviously you have to ask me a question. And she was like, "Why would you do this to yourself? Why would you do this to yourself?" And I said, "I don't know how to answer that question." And she said, "So, were you always like this?" And I said, "Oh, no." She's like, "Why would you choose this? Why did you choose this?" She asked that at different times, I don't know what came first, but basically, what she was mining for was like: when did you start cutting up your body. And, why? And then she said that people were born the way that God intended, so in her religion this was unacceptable, and she wondered why I would go against God.

Pablo next emphasized his embodied vulnerability while the provider, "over him," subjected him to her moral interpretation of his nonconformity, saying:

> …first of all, I felt, vulnerable doesn't even describe it. The internal exam is very painful, in and of itself, so I was cramping, and I'm like disgusting down there, full of all the goo and stuff, and I'm laying down, and she's over me, she was holding something… something left to do, maybe it was minor, but I just felt stuck, like I couldn't leave, because there was still this thing to do, I don't remember what, and all the powerlessness, oh my God, I felt really vulnerable.

Finally, the provider disengaged, which Pablo calls the "real fucked up part." Pablo said:

> After she was done asking her questions, she turned and left, and didn't say, "You're done, you can leave, you're finished, thank you for coming, sorry for asking," nothing, just turned and left… I felt like a specimen that she like probed and prodded,

metaphorically and then physically, and I was like, I'm done with this facility, and left. Pablo's narrative illustrates the process through which mis/recognition leads to embodied disruption, and the multiple ways providers respond to disruption—here, disciplining and disengagement. After this encounter, Pablo did not get his health needs met, there or elsewhere.

The exception to the rule of distressful experiences of embodied disruption within health settings occurred when patients were *recognized* and then *affirmed* by providers. These experiences occurred typically (but not exclusively) within LGBT health settings, or within typical settings with a provider perceived or known to be LGBTQ-identified. Within affirming encounters, providers neither sorted patients nor presumed their embodied identities; instead, patients were typically asked how they identify in light of gender and sexuality. In doing so, providers' authority was leveraged to position patients as the expert of their own gender and sexual identities within medical interactions, patients health needs were typically met, and patients continued seeking needed and preventative care.

Race Across racial identities, participants reported similar experiences of embodied disruption. Respondents of color discussed experiences of racial discrimination in health settings, but only one participant connected racial discrimination to embodied disruption. Corey, Black, 32, who identified as a nonbinary trans man, was mis/recognized while receiving emergency care. Corey felt uncertain about what aspects of his identity prompted ill-treatment after disruption, saying: "I think there are interactions where it's really difficult to tell what's affecting the treatment…I don't know what problem you're having with me, but you're having a problem." Similarly, Dana, Black, 25, nonbinary, felt their pain was not taken seriously by providers. Dana said: "I wonder if the reasons why my pain is not believed is maybe because of my class background, my race, and the gender that they're perceiving me as." Dana and other participants

of color, however, did not link intersectional uncertainty to experiences of mis/recognition and disruption.

Gender Participants described embodied disruption across gender identities, but analyses revealed that participants' gender embodiments and identities shaped the ways they managed actual or anticipated mis/recognition. Because embodiment and performance play roles in how disruption unfolds, based on their different positions to gender norms, cis, trans, and nonbinary individuals sometimes used different strategies to avoid disruption. For example, Jenn, white, 46, who identified as butch woman, said that because her voice is high, she uses it to feminize her gender performance in order to prevent or alleviate disruption in health settings:

> I think people feel like you're trying to trick them or something, or it's just so confusing for them to not be able to ascertain the gender that they almost can't communicate until that has been established, so I've learned to immediately speak, and also smile. I think both because that's more of a feminine, or female, behavior, and also because people like to be smiled at.

Jenn therefore sorts herself for providers, by signaling that her gender is female despite her nonconforming gender expression.

Somewhat similarly, in an effort to avoid disruption, passing trans participants typically did not disclose their trans status—except with LGBTQ providers or in LGBT health settings, wherein provider knowledge about and acceptance of trans identities was assumed, or when examinations would reveal their embodiments. When disruption did occur, trans men could not reposition themselves within the bounds of normative schemas the ways that cis women could. As such, passing trans patients were more vulnerable to denial and disciplining after disruption, as illustrated in Pablo's stories. Trans men with (intentionally) nonconforming gender

expressions, in addition to those who had not yet received affirming-care or did not pass, were more susceptible to denial, as described by Jason and Riley. Finally, nonbinary participants—who embody identities that defy binary gender all together—were rarely recognized by providers, even after explaining their identities. Given nonbinary people are unable to sort themselves into preexisting categories of gender, when they wished to avoid confusion and disruption, they typically withheld identities from providers. These nuances illustrate that although GNC cis women, trans men, and nonbinary patients do not conform to medical constructs of sex/gender/sexuality and share overlapping experiences of mis/recognition and disruption in medical encounters, their different legibilities and proximities to normative schemas differentially shapes their abilities to manage or avoid mis/recognition.

Discussion

LGBTQ individuals who are gender nonconforming (GNC)—defined, in this study, as those likely to be categorized as other than straight or cis by an onlooker—report more discrimination and avoid healthcare more often than their conforming peers (Cruz, 2014; Hiestand et al., 2007; Miller and Grollman, 2015). In order to reveal the role nonconformity plays in LGBTQ experiences of stigma in healthcare encounters, this study analyzes interviews with a sample of 34 racially diverse GNC LGBQ adult cis women, trans men, and nonbinary individuals. Findings demonstrate the occurrence of *embodied disruption*, which illustrates how patients' embodied nonconformity to binary medical constructs disrupts ordinary medical interactions, and how provider reactions prevent GNC patients from meeting their health needs. In response to disruption, providers draw upon hegemonic schemas of binary sex/gender/sexuality—namely, that gender identity, sexual identity, presentation, and (constructions of) biological sex align in two discrete and measurable ways—as they

mis/recognize and then disengage, sort, deny, and/or discipline patients. Such responses function to realign patients within medical paradigms of binary gender. These experiences distress patients; more distressful encounters typically result in ceased care and unaddressed health concerns. By revealing the embodied, interpersonal process through which structural stigma in the form of societal norms of sex/gender/sexuality (Hughto et al., 2015) employed in medical settings distress GNC LGBTQ individuals during healthcare encounters, this study extends knowledge about how the medicalization of gender and sexuality stigmatize and disadvantage LGBTQ patients.

Stress literatures suggest that such cascades negatively impact the health of GNC patients through two processes: acute experiences of stress from felt discrimination and stigma (Hatzenbuehler, 2009; Meyer, 1995), and the negative biopsychosocial consequences of unaddressed mental and physical health concerns (Seelman et al., 2017; Romellani et al., 2018). Findings support studies suggesting that conformity and nonconformity are key to understanding why—and which—LGBTQ individuals experience heightened levels of stigma and discrimination (Cruz, 2014; Miller and Grollman, 2015; Grant et al., 2011), but further advance knowledge by illuminating the disruptive and embodied process through which such events occur, and for whom. For example, experiences of embodied disruption were similar across racial identities, which diverges from past findings demonstrating that some trans people of color experience more anti-trans discrimination than their white peers (Kattari et al., 2015). Reports of intersectional uncertainty—confusion about what aspects of their identities spurred providers' mistreatment—suggests that LGBTQ GNC people of color instead experience racial discrimination in addition to disruption. Given this study was conducted in a racially diverse, heavily democratic mid-Atlantic city, future research should consider whether LGBTQ people of

color report experiencing racialized forms of embodied disruption in different sociopolitical contexts.

Differences by gender further illuminate how embodiment and identity shape LGBTQ patients' management of stigma in health settings. Participants used different strategies to manage or avoid disruption, depending on their positions in relation to gender ideologies. Findings suggest, for example, that compared to GNC cis women, passing trans men embody nonconformity in ways that prompt more stigmatizing provider-reactions, and visibly nonconforming trans men and nonbinary individuals may experience more denial. This study therefore reinforces Poteat and colleagues (2013) finding that providers manage their "uncertainty" about transgender patients by using interpersonal stigma to reestablish their authority as medical experts, but also extends it by including GNC cis women and nonbinary people, and demonstrating how embodied disruption triggers uncertainty. By doing so, this study illustrates how provider reactions to nonconformity stigmatize different GNC LGBTQ people in the doctor's office.

Study findings also raise urgent questions for future research. That participants reported less disruption and less distressing and more affirming reactions in LGBT health contexts and with LGBT providers suggests that these settings may construct and employ different medical schemas of sex/gender/sexuality that do not "other" GNC patients' embodiments. It is beyond the scope of this study, however, to determine if this is the case, and if so, how alternative schemas are constructed and enacted. Study findings do indicate that in order to prevent disruption, medical schemas of gender must be fundamentally redefined to reflect the diversity embodied by GNC people. Though current trends in interventions to reduce stigmatization of LGBTQ individuals in health settings prioritize minor, patient-facing accommodations (for

example, the addition of "other" boxes under "Gender" questions on intake forms) as well as educational interventions in medical curricula (for example, a sixty minute "Transgender 101" training in medical school), study results suggest that such interventions will only be effective in so far as they deconstruct provider assumptions about gender. If medical norms of gender/sex/sexuality are indeed forms of structural stigma (Hughto et al., 2015), which is a fundamental cause of health (Hatzenbuehler, Link, & Phelan, 2013), then unless interventions successfully challenge hegemonic medical norms of sex and gender, providers will continue to reify stigmatizing norms through interpersonal interactions with GNC patients.

The present study findings therefore push scholars and providers to consider how larger institutional- and organizational-level factors determine interpersonal and embodied experiences of stigma in context. In line with theorists arguing that medical schemas of sex/gender/sexuality importantly shape the experiences of individuals navigating medical and medicalized systems (Almeling, 2011; Epstein, 1996; Fausto-Sterling, 2000), this study interprets individual experiences of stigma as crystallizations of systemic medical delineations of sex/gender. By revealing processes through which such schemas constrain the health and well-being of groups in conflict with dominant constructs, study findings shed important insight into what may occur during medical interactions with other types of "disruptive" populations. A deeper understanding of how contexts—including alternative contexts—shape experiences for GNC and other LGBTQ groups, however, paired with an examination of the experiences of groups not included in this study, is necessary for further refining our understanding of how dominant paradigms are embedded and enacted to the detriment of disruptive populations.

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