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Kristie L. Seelman

Georgia State University, kseelman@gsu.edu

Andre Vasi

Georgia State University, avasi1@student.gsu.edu

Shanna K. Kattari

The University Of Michigan, skattari@umich.edu

Luis R. Alvarez-Hernandez

University of Georgia, sswphd@uga.edu

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**Predictors of Healthcare Mistreatment Among Transgender and Gender Diverse
Individuals: Are There Different Patterns by Patient Race and Ethnicity?**

Kristie L. Seelman¹, Andre Vasi², Shanna K. Kattari³, and Luis R. Alvarez-Hernandez⁴

¹School of Social Work, Georgia State University

²School of Public Health, Georgia State University

³School of Social Work, University of Michigan

⁴School of Social Work, University of Georgia

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Author Note

Kristie L. Seelman <https://orcid.org/0000-0002-4064-2927>; Twitter handle: @kristie_seelman

Shanna K. Kattari <https://orcid.org/0000-0003-3489-7058>; Twitter handle: @DrShannaK

Luis R. Alvarez-Hernandez <https://orcid.org/0000-0001-8695-5817> Twitter handle:

@Alvarez_LuisR

Correspondence concerning this article should be addressed to Kristie L. Seelman,
School of Social Work, Georgia State University, PO Box 3992, Atlanta, GA 30302-3992. Email:
kseelman@gsu.edu

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Abstract

Using data from the 2015 United States Transgender Survey, this study investigates which patient sociodemographic characteristics and psychosocial risks are associated with likelihood of transgender mistreatment in healthcare and how patterns vary for patients of color. Numerous predictors, including alignment of identity documents, were associated with healthcare mistreatment. Among subgroups of transgender patients of color, psychosocial risks were more consistently significant than sociodemographic characteristics in predicting mistreatment. National and international health organizations are called to enact clear policies that affirm transgender patients and patients of color and establish a commitment to effectively serving these populations within their ethical codes.

Keywords: transgender, healthcare, mistreatment, race and ethnicity, identity documentation, intersectionality

Introduction

Transgender and gender diverse¹ (TGD) patients often face stigma in healthcare settings. To develop interventions to address this issue, social workers and other health care professionals need to understand which subgroups of patients (e.g., by race, ethnicity, disability status) are most likely to experience mistreatment and the psychosocial risks that correlate with such experiences (e.g., having a history of experiencing other forms of violence). The present study utilizes data from the 2015 United States Transgender Survey (USTS) to explore this topic, including looking at predictors of mistreatment by patient race and ethnicity.

Mistreatment in Healthcare

One-third of respondents in the 2015 USTS, the largest survey of TGD individuals ever conducted in the U.S. ($N=27,715$), had at least one negative experience in healthcare in the past year due to being transgender (James et al., 2016). Such experiences included being refused treatment or having to educate their healthcare provider about trans people (James et al., 2016). Moreover, 23% of USTS participants said they had avoided seeing a provider in the past year due to the fear of mistreatment (James et al., 2016). Authors of another study identified six distinct forms of healthcare mistreatment: (1) gender insensitivity (e.g., misgendering the patient); (2) displays of discomfort; (3) denial of services; (4) receiving substandard care (e.g., rough exams); (5) verbal abuse; and (6) forced care (e.g., being made to undergo procedures; Kosenko, Rintamaki, Raney, & Maness, 2013). Many individuals in this population experience a variety of these types of mistreatment in health care settings, from misgendering to denial of care (Kattari & Hasche, 2016), as well as sexual violence, sexual harassment, and verbal abuse

¹ The terms *transgender* and *trans* describe individuals whose sex and gender assigned to them by others do not align with their true gender. The term *gender diverse* refers to a broad spectrum of genders beyond the gender binary, including identities such as genderqueer, agender, and Two Spirit. At times, gender diverse people are grouped with trans individuals; however, not all gender diverse people identify as belonging to the trans community.

(Kattari & Hasche, 2016; Kattari et al., 2020b). Even the type of insurance a TGD individual has can be related to the quality of their healthcare experiences (Bakko & Kattari, 2020).

Stigma is a huge issue when it comes to TGD individuals accessing health care (Poteat, German, & Kerrigan, 2013) and is one social determinant that helps explain the health disparities experienced by TGD individuals (Hughto, Reisner, Pachankis, 2015). One such example is that the mistreatment of TGD persons in healthcare settings is associated with depression and suicidality among patients (Poteat, German, & Kerrigan, 2013). However, when a TGD person has a more inclusive primary care provider, they are more likely to have more positive mental health outcomes (Bakko & Kattari, 2020; Kattari et al., 2016). Given the high rates of mistreatment in healthcare spaces for TGD patients, it is important to use an intersectional approach, as grounded in Black feminist thought (Crenshaw, 1990). *Intersectionality* emphasizes that each person has numerous identities that, in combination, affect our lived experiences, including our experiences of oppression. To understand the healthcare experiences of TGD individuals who hold multiple marginalized identities across race, gender, and other sociodemographic categories, an intersectional approach can be used to help center and distinguish the ways that multiple dimensions of oppression impact a TGD patient's level of access to affirming care.

Differential Risks for Mistreatment by Race and Ethnicity

Related to the discussion of intersectionality, the bodies and sexualities of communities of color in the U.S. have been the target of healthcare mistreatment, including eugenic practices against Native Americans (Rutecki, 2011), African Americans (Monroe & Alexander, 2005), and Puerto Ricans (Denis, 2016). TGD people of color (POC) are less likely than White TGD individuals to report having health insurance (Gehi & Arkles, 2007; Kenagy & Bostwick, 2005)

and a primary care provider (Kenagy, 2005), yet more likely to experience discrimination in healthcare settings (Grant et al., 2011). TGD POC are also more likely to be denied care and experience discrimination in a variety of settings, from physician's offices and the emergency room to mental health care and substance use treatment (Kattari et al., 2015; Kattari et al., 2017b). In general, many racialized TGD individuals are more likely to experience denial of care than their White counterparts (Kattari et al., 2020a), and these differences vary across racial groups. TGD Latinx individuals, for example, have reported discrimination, refusal of treatment, and harassment when accessing medical care, which leads many of them to not seek medical care when needed (James & Salcedo, 2017; Salcedo & Padron, 2013).

Current Study

Although there is a growing knowledge base about TGD individuals' experiences of discrimination, harassment, and abuse in healthcare settings and patients that may be most at risk of such mistreatment, most studies of this topic either use small, regional samples or have limited ability to explore how predictors of mistreatment may differ across racial and ethnic subgroups (beyond broad comparisons between White TGD individuals and POC at-large). Further, there is a need for looking at the importance of identity documentation alignment (whether name and gender markers on identity documents are correct) in relation to TGD healthcare mistreatment, since a documentation mismatch or change may prompt a transphobic response from providers. The current study intends to address these gaps via the following research questions:

1. Which sociodemographic characteristics and psychosocial risk factors are associated with TGD patient mistreatment in healthcare in the past year?

2. How does identity documentation alignment (having a correct name and/or gender on one's identification documents) relate to the likelihood of healthcare mistreatment in the past year?
3. Are there different patterns in the relationship between sociodemographic and psychosocial factors and TGD healthcare mistreatment by patient race and ethnicity?

Methods

Study Design

In 2015, the National Center for Transgender Equality (NCTE) carried out the USTS, an online survey that included questions about health and healthcare experiences among other topics (James et al., 2016). Measures were developed and selected based on the lived experiences of trans people and the expertise of researchers. The survey was available online for 34 days in both English and Spanish. Individuals were recruited through collaborations with several hundred community partner organizations. Respondents had to identify as transgender/trans, genderqueer, nonbinary, or another identity on the trans spectrum, and be aged 18 years or older. The final sample of 27,715 adults came from all 50 states, Washington, D. C., and several U.S. territories (for more about methodology, see James et al., 2016). The current study analyzes de-identified USTS data and was designated as not human subjects research by Georgia State University.

Measures

Dependent variable: Healthcare mistreatment. The dependent variable (healthcare mistreatment in the past year) was a dichotomous measure of whether respondents had ever experienced any of the following forms of discrimination, abuse, or violence in a healthcare setting in the past year: having to teach a doctor about trans care; having a doctor refuse to give trans-related care, refuse to give other care, ask invasive questions, use harsh or abusive

language, or be physically rough or abusive; or being verbally harassed, physically attacked, or having unwanted sexual contact in a healthcare setting.

Sociodemographic predictor variables: The following sociodemographic variables were analyzed in bivariate chi-square analyses or t-tests due to their importance to healthcare experiences and relevance to our research questions: (a) current health insurance (yes/no); (b) gender identity (trans women, trans men, genderqueer or nonbinary and assigned female at birth (NB/AFAB), or genderqueer or nonbinary and assigned male at birth (NB/AMAB)); (c) sexual orientation (lesbian/gay/queer/same-gender-loving/not listed², asexual, bi/pansexual, or heterosexual/straight); (d) race and ethnicity (Alaska Native/American Indian alone; Asian/Native Hawaiian/Pacific Islander alone; Biracial/Multiracial/not listed; Black/African American alone; Latinx/Hispanic alone; White alone; Middle Eastern/North African alone); (e) spiritual/religious identity (Christian or other); (f) age; (h) Census region (Northeast, Midwest, West, or South); (i) poverty status (living at or near poverty, or not living in poverty); (j) disability status (yes/no); and (k) education level (no college, or some college or more). For the logistic regression models analyzing patterns by patient race and ethnicity, we added an age squared variable because experiences of discrimination often have a curvilinear relationship to patient age (for example, see Author, 2013).

Psychosocial risk predictor variables. Psychosocial risk variables were selected based upon likely association with healthcare mistreatment and relevance to our research questions, including: (a) how many healthcare providers knew one was trans (1=none know I am trans; 2=some know; 3=most know; 4=all know); (b) how many identity documents and records list

² Since the “not listed” sexual orientation group was not statistically different from the lesbian/gay/queer/same-gender-loving group (LGQ/SGL) in terms of rate of mistreatment in healthcare, and because of the smaller group size, they were grouped with the reference group in our variable coding. For brevity, the “not listed” group is referenced to as “other” in reported results.

one's correct name (none, some, or all³); (c) how many identity documents and records list one's correct gender (none, some, or all); (d) suicidal ideation in the past 12 months (yes/no); (e) suicide attempt in the past 12 months (yes/no); (f) psychological distress measured as a composite score (0-24) from the 6-item Kessler Psychological Distress scale (K6); (g) victimization in the past year for any reason by anyone (yes/no); (h) lifetime occurrence of intimate partner violence victimization (yes/no); (i) lifetime occurrence of unwanted sexual contact (yes/no); and (j) lifetime occurrence of engagement in sex work (yes/no).

Data Analysis

SPSS version 25 was used for data analyses. We removed respondents whose gender identity was “cross dresser” (because they may have different experiences in healthcare settings compared to other TGD respondents) as well as those whose place of residence did not fall into one of the primary U.S. census regions⁴ (e.g., those living in U.S. territories) because of their small sample size. Bivariate chi-square analyses and t-tests were run to examine associations between each sociodemographic and psychosocial risk variable and healthcare mistreatment. Multivariate logistic regression models were created to answer the third research questions of interest, with healthcare mistreatment as the outcome.

Results

Descriptive Statistics

About one-third of those who had accessed healthcare in the past year reported one or more forms of mistreatment (33.8%, $n=7,712$). Table 1 provides an overview of descriptive

³ In bivariate analyses, the rates of healthcare mistreatment were very similar (difference of 1.7%) for the “none of my IDs and records list the name I prefer” and “all of my IDs and records list the name I prefer” groups, while the “some IDs match” group had a greater rate of mistreatment (more than 15% higher than the other groups). For this reason, the “none” and “all” groups were merged for multivariate models.

⁴ Washington, D.C. was categorized as part of the “South” census region within the USTS dataset.

statistics for each of the variables of interest, as well as chi-square tests of association or t-tests between healthcare mistreatment and the predictor variables.

| Insert Table 1 approximately here |

Research Questions 1 & 2. Gender identity was significantly associated with experiencing healthcare mistreatment ($p < .001$) with post-hoc tests indicating that trans men were most likely to experience mistreatment, followed by trans women, NB/AFAB, and NB/AMAB. Sexual orientation was significantly associated with healthcare mistreatment ($p < .001$) with significant group differences between asexuals, bi/pansexuals, lesbian/gay/queer/same-gender-loving/others (LGQ/SGL/other), and heterosexual/straight respondents; asexual and heterosexual/straight respondents had the lowest rates of healthcare mistreatment. For race and ethnicity, there was a significant association with experiencing mistreatment in healthcare ($p < .001$); those who were Alaska Native/American Indian alone had the highest rate of healthcare mistreatment (48.2%), significantly different from all other groups except Middle Eastern/North African (39.8%). Participants who were Asian/Native Hawaiian/Pacific Islander had lower rates of mistreatment than Bi/Multiracial/Not listed respondents and White respondents.

Geographic region was statistically associated with experiencing healthcare mistreatment ($p < .001$), with greater mistreatment experienced by respondents who lived in the West compared to the Northeast, South, and Midwest regions. Currently living in poverty was statistically associated with experiencing healthcare mistreatment ($p < .001$), with significant differences between those at or near poverty (35.8%) and those who were not (33.4%). Disability status was strongly associated with experiencing healthcare mistreatment ($p < .001$) with significant differences in rates of mistreatment between those with a disability (41.4%) and those without

(30.7%). Education level was associated with experiencing healthcare mistreatment ($p < .001$), with 34.7% of those with some college and 28.8% of those without education experiencing healthcare mistreatment.

Outness to healthcare providers was significantly associated with experiencing healthcare mistreatment ($p < .001$), with those who are not out experiencing the least reported mistreatment (11.1%) and those who were mostly out experiencing the greatest (47.5%). All four levels of outness were significantly different from each other in their association with healthcare mistreatment. Suicide attempt and ideation in the past year were both associated with experiencing healthcare mistreatment ($p < .001$), with greater risks of mistreatment among those indicating suicidality. Past year victimization ($p < .001$), intimate partner violence (IPV; $p < .001$), and unwanted sexual contact in one's lifetime ($p < .001$) were associated with experiencing healthcare mistreatment, with those who had experienced these forms of abuse having higher rates of mistreatment in healthcare. Lifetime engagement in sex work for money was also associated with experiencing healthcare mistreatment ($p < .001$), with those who had participated experiencing significantly higher risks of healthcare mistreatment.

Related to Research Question 2, whether one's ID matched one's name and gender identity were both statistically associated with experiencing healthcare mistreatment ($p < .001$), with all groups significantly different from each other. Those who had some IDs match their name had the highest proportion of experiencing mistreatment in healthcare (46.5%) while those who had none matching their name had the lowest (29.2%). Similarly, for IDs matching with gender identity, those who had some IDs matching their gender experienced the highest proportion of healthcare mistreatment (46.8%) while those who had none had the lowest (29.2%).

Inferential Statistics

Research Question 3. To answer research question 3, logistic regression models were constructed to examine mistreatment in healthcare for five⁵ race and ethnicity subgroups (see Table 2). For the subgroups of TGD adults of color, very few sociodemographic variables were statistically significantly associated with mistreatment in healthcare. However, several of the psychosocial risk variables were significant across multiple race and ethnicity groups.

| Insert Table 2 approximately here |

For the Asian/Native Hawaiian/Pacific Islander subgroup ($N=554$), those with greater odds of reporting healthcare mistreatment in the past year included trans men (compared to trans women; $AOR=1.83$), patients whose trans identity was known to more providers ($AOR=1.44$), those experiencing greater psychological distress ($AOR=1.07$), and those who experienced any type of victimization in the past year ($AOR=2.11$). Asexuals in this population had 65% lower odds ($AOR=0.35$) of reporting mistreatment in healthcare compared to those who identified as LGQ/SGL/other.

For the Biracial/Multiracial/not listed subgroup ($N=1,045$), those with increased odds of healthcare mistreatment in the past year included trans men (compared to trans women; $AOR=1.98$), those with a disability ($AOR=1.39$), those with more providers who knew they were trans ($AOR=1.66$), those who attempted suicide in the past year ($AOR=2.50$), those who were currently experiencing psychological distress ($AOR=1.05$), and those who had experienced any type of victimization in the past year ($AOR=2.42$). Age squared was significant at the $p<0.01$ level, suggesting that with each unit increase in age in years, there is a slightly decreasing, curvilinear relationship to likelihood of healthcare mistreatment.

⁵ Due to small group sizes, we were unable to include the Alaska Native/American Indian and Middle Eastern/North African groups in this analysis.

For the Black/African American subgroup ($N=532$), those with greater odds for mistreatment in the past year included those living in the West and South regions (compared to the Northeast; AOR=2.30 and 1.81 respectively), those with more providers who knew they were trans (AOR=1.30), those currently experiencing psychological distress (AOR=1.06), and those who experienced any form of victimization in the past year (AOR=2.96). For the Latinx subgroup ($N=962$), only psychosocial risk variables were found to be significantly associated with mistreatment in healthcare. Those who had more providers who knew they were trans (AOR=1.70), those with only some IDs/records that matched one's preferred name (1.82), and those who experienced any victimization in the past year (AOR=1.69), any IPV in one's lifetime (AOR=1.52), and any unwanted sexual contact in their lifetime (AOR=1.40) had greater odds of healthcare mistreatment.

Among White respondents ($N=16,141$), numerous demographic and psychosocial risks were significantly associated with mistreatment in healthcare in the past year. Those without health insurance were 15% less likely (AOR=0.85) to experience mistreatment in healthcare than those with insurance. White trans men were more likely (AOR=1.54) while White NB/AMAB were 21% less likely (AOR=.79) than White trans women to experience mistreatment. White asexuals, bi/pansexuals, and straight individuals were less likely than White LGQ/SGL/other respondents to experience mistreatment (AOR=0.74, 0.84, and 0.75 respectively). Age squared was statistically significantly associated with healthcare mistreatment (AOR=0.99). White individuals in Midwest, West, and South had greater odds of experiencing healthcare mistreatment than White individuals in the Northeast (AOR=1.12, 1.11, and 1.22 respectively). Those with a disability had 1.5 times the odds of experiencing mistreatment than those without a

disability, while those with at least some college education had 1.28 times the odds of experiencing mistreatment than those with no college education.

All of the psychosocial risk factors were statistically significantly associated with healthcare mistreatment among White respondents. For every step increase in the proportion of providers who know one is trans, the odds of healthcare mistreatment increased by 1.65 times. Those who had only some IDs that match their correct name had 1.21 times the odds of experiencing mistreatment than those with all or no IDs matching their name. Those who had all or some IDs listing their correct gender had 1.35 and 1.33 times the odds of experiencing mistreatment respectively than those with no IDs listing their correct gender. Those who had suicidal ideation or a suicide attempt in the past year had 1.26 and 1.28 times the odds of mistreatment respectively than those with no suicidal ideation or no attempt. White respondents who reported greater psychological distress (AOR=1.03), any form of victimization in the past year (AOR=1.90), any IPV (AOR=1.27) or experiences of unwanted sexual contact in one's lifetime (AOR=1.22), or who had ever engaged in sex work for money (AOR=1.28) all had greater odds of experiencing healthcare mistreatment in the past year.

Discussion

TGD patients' experiences in healthcare settings can vary substantially based upon their additional risks for marginalization in healthcare and other psychosocial factors. Our findings indicate that all of the sociodemographic variables except health insurance status (yes/no) and spiritual/religious identity (Christian/not Christian) were significantly associated with healthcare mistreatment, including gender identity, sexual orientation, race, ethnicity, geographic location, poverty, disability, educational level, and age. Moreover, the post-hoc tests showed that certain socio-demographic groups were at greater risk of experiencing mistreatment, including trans

men and trans women; LGQ/SGL/other adults; Alaska Native/American Indian and Middle Eastern/North African populations; those who lived in the West; those living in poverty; those with a disability; and those with at least some college education. These findings add to the literature regarding intersectional experiences of oppression and within-group differences in healthcare experiences among TGD populations, including past studies indicating increased risks for poor healthcare treatment among Alaska Native/American Indian populations, those who are trans men or trans women, and those with disabilities (Grant et al., 2011; Kattari et al., 2017a; Shires & Jaffee, 2015). Past studies suggesting that trans men may be more likely to delay needed healthcare also suggest this population anticipates stigma within healthcare experiences (Kcomt et al., 2020). There has been scant research in the past about regional differences in experiences of TGD discrimination in healthcare, with some past work suggesting those in the South and West report higher rates of discrimination in accessing doctors and hospitals (Kattari et al., 2015). The present study finds higher rates of healthcare mistreatment among TGD patients in the West, though deeper analyses indicate that regional differences vary by patient race and ethnicity.

All psychosocial risk variables (outness to healthcare providers, psychological distress, suicidal ideation and attempt, past year victimization, IPV in lifetime, unwanted sexual contact in lifetime, lifetime engagement in sex work, and IDs matching a person's name and gender identity) were significantly associated with healthcare mistreatment. Post-hoc tests indicated that among those at greater risk for healthcare mistreatment were those who: were more out to healthcare providers; reported greater psychological distress; reported suicidality in the past year; or experienced past year victimization, or IPV or unwanted sexual contact in one's lifetime. Such findings generally align with past research indicating that trans individuals who are more out or

who have a history with other psychosocial risk factors are also at greater likelihood of experiencing discrimination in a variety of settings, including healthcare (e.g., Bockting et al., 2013; Seelman, 2013). These findings highlight the importance of improving healthcare settings as part of intersectional efforts to address the overall risk and disparities of health for TGD populations and effectively serve some of the highest risk groups of TGD patients.

This study finds that having at least some IDs matching one's correct name and having at least some IDs matching one's correct gender are associated with healthcare mistreatment; this held true for White respondents (for both name and gender match) and for Latinx respondents (for name match) even when controlling for other factors, including having providers know that one is TGD. Past research by Shires and Jaffee (2015) found that, among FTM adults, having some or all documents and records listing a preferred gender was associated with discrimination in healthcare, though this was not further explored by patient race or ethnicity; further, the present study finds that those with only some records matching may be at particular risk for mistreatment. Perhaps documentation that draws attention to someone's status as TGD - such as when there is a mismatch between documents - may prompt a transphobic response from providers. Further, Latinx patients may experience heightened risk for mistreatment in relation to name mismatch both connected to their TGD status and their ethnicity, given that identity documentation mismatches may prompt xenophobic responses from medical staff related to the patient's perceived immigration status. These findings indicate the importance of teaching healthcare providers and medical social workers, as well as medical office staff including those at the front desk, about identity documentation issues and how to be culturally responsive when a documentation mismatch "outs" a patient as TGD.

The logistic regression models showed some differences in the predicted risk of healthcare mistreatment by patient race and ethnicity and various sociodemographic and psychosocial risk factors, highlighting that mistreatment in healthcare settings does not look the same for all TGD patients, though there are some common patterns. Across all racialized and ethnic groups, two risk factors were associated with greater odds for healthcare mistreatment: more providers knowing a person was TGD, and a person experiencing any victimization in the past year. The relationship between greater outness (or being identified as TGD) of a patient in healthcare settings and increased healthcare discrimination is a pattern documented in previous research (e.g., Kattari & Hasche, 2016; Shires & Jaffee, 2015). Perhaps once a provider is aware of a person's gender identity, their interactions with that person changes depending on their own transphobic views or lack of knowledge about affirming care.

Another common association with healthcare mistreatment across groups was psychological distress, except for Latinx respondents. Although Latinx TGD experience high rates of serious psychological distress to the point that 45% have ever attempted suicide compared to 37% of White TGD individuals and 4.6% of the U.S. population (James et al., 2016; James & Salcedo, 2017), they may have not seen a healthcare provider for assistance and therefore were not captured by the dependent variable. Research has found that Latinx TGD individuals have developed resilience through their social support (Cerezo, et al., 2014), including their relationships with other TGD Latinx individuals (Rhodes et al., 2015).

An additional finding of interest was differences in risks for healthcare mistreatment by patient race and ethnicity across different Census regions. For Black and African American TGD adults, those living in either the South or the West were at greater risk for mistreatment than those in the Northeast. These regions were similarly identified as having greater barriers to

affirmative healthcare treatment by Kattari and colleagues (2015), indicating potential need for targeting interventions (and related funding) in these regions to improve provider and staff knowledge about TGD patients, particularly in settings that tend to serve Black and African American patients and/or that are located in regions with a high proportion of Black and African American residents. For White TGD patients, every region had higher rates of patient mistreatment compared to the Northeast region. There is a need for targeting TGD-affirming healthcare interventions (and funding for them) beyond the Northeast region.

All predictor variables were significant for White respondents, while only four to seven predictors were significant among POC. Given that the questions on the USTS asked “In the past year, did you have any of these things happen to you, as a trans person, when you went to see a doctor or healthcare provider,” it is likely that POC may have struggled in separating out whether things happened to them because of their gender and transgender status or because of their race and ethnicity, making it harder to answer these items. This possibility is reinforced by the fact that those who were out in healthcare settings, across all groups, were more likely to experience mistreatment. Individuals of color who were not out about their transgender status may have been more likely to assume their mistreatment was based on their race and ethnicity (which are usually more visible to others). More research is needed, including qualitative interviews with TGD Black, Indigenous, and other POC to better understand this intersection of oppression and how it is operationalized in healthcare settings.

Limitations

The current study utilized a convenience sample that may not have reached TGD subgroups that are less connected to community organizations or do not have regular Internet access. Our analyses only focus on experiences in healthcare in the past year, so we could not

examine patterns of mistreatment across the life course. Third, our study was limited by small sample sizes that led to removing Alaska Native, American Indian, Middle Eastern, and North African participants from sub-analyses, a notable issue given the oppression faced by these groups. Fourth, small sample sizes also required us to merge participants who were Asian, Native Hawaiian, and Pacific Islander, and bisexuals and pansexuals, even though the experiences of these groups are not homogenous. Fifth, we created a category that made lesbian, gay, queer, same-gender-loving, and “other” participants one group, which makes it difficult to parse out experiences of intersectionality, like those of queer women of color. Sixth, we also collapsed healthcare mistreatment into one variable, which may hide some unique risks for the more violent forms of mistreatment (e.g., physical assault) among racial and ethnic groups. Finally, although most of the survey’s measures of healthcare mistreatment are worded to focus on the behaviors of a doctor or other healthcare provider, several of the measures of more explicit violence (verbal harassment, physical attack, sexual contact) simply ask if any such experiences occurred “in a healthcare setting.” This lack of specificity means that some of the mistreatment captured by our dependent variable may have been at the hands of staff, such as receptionists, or other patients or clinic guests. Nonetheless, there is value in ensuring that training in TGD-affirming care is provided to all employees in medical offices and that policies designed to prevent and address harassment and violence are effectively implemented, regardless of whether the perpetrator is a provider, staff member, or a patient or guest.

Conclusions

Any form of harm in healthcare settings should be cause for alarm. While much research regarding the TGD population has noted increased risks of discrimination and victimization in healthcare settings for TGD POC (Kattari et al., 2015; 2017b; 2020c; Rodriguez et al., 2018),

there is limited research that examines these predictors nationally within subgroups of POC using an intersectional perspective. The demonstrated differences in this study indicate a deep need for providers to understand the potential impact that the interaction of TGD identities and marginalized racial and ethnic identities have on the healthcare treatment of patients and the need for interventions that address the differences of experiences and risks across race and ethnicity. There is no one-size-fits-all educational content that can be added to training programs. Rather, in addition to basic information about these populations, providers need to be taught skills such as empathy, critical thinking, and rapport building that will allow them to better understand and serve TGD patients.

Additionally, recent research has noted that transphobia may be a better predictor of providers mistreating patients than a lack of education (Stroumsa et al., 2019). This likely rings true for racism and xenophobia and mistreatment of patients of color. Sometimes, simply educating people will not reduce their bias against marginalized communities. Therefore, it is crucial for national and international health organizations to put forth clear policies that affirm TGD and POC, establish a commitment to effectively serving these and other marginalized groups within their ethical codes, stop providers who are consistently harming these communities from continuing to practice, and build a pipeline for the recruitment of future medical practitioners who are TGD and POC. More oversight should be built into healthcare spaces, as well as opportunities for TGD individuals, POC, and other marginalized persons to share information about providers who are affirming of all identities.

Declaration of Interest

The authors declare that they have no conflicts of interest.

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Table 1. Variable Frequencies and Bivariate Associations with Healthcare Mistreatment

Sociodemographic categorical variables	Overall sample, % (n)	% Experiencing Healthcare Mistreatment (n)	χ^2 test, (df)
Any healthcare mistreatment (n = 22,812)			
No	66.2 (15,100)		
Yes	33.8 (7,712)		
Healthcare insurance (n = 26,832)			
Has insurance	87.5 (23,479)	33.8 (6,968)	0.340(1)
No Health Insurance	12.5 (3,353)	34.4 (733)	
Gender Identity (n = 26,897)			
Trans woman	34.3 (9,219)	35.9 (2,866) ^a	613.840 (3)***
Trans man	29.5 (7,929)	42.6 (2,964) ^b	
Nonbinary and genderqueer/AFAB	29.1 (7,828)	24.6 (1,584) ^c	
Nonbinary and genderqueer/AMAB	7.1 (1,921)	20.6 (298) ^d	
Sexual orientation (n = 26,897)			
Asexual	10.9 (2,945)	24.9 (587) ^a	147.540 (4)***
Bi/pansexual	33.1 (8,891)	32.2 (2,388) ^b	
Lesbian/Gay/SGL or queer	38 (10,212)	37.5 (3,326) ^c	
Heterosexual/straight	11.3 (3,032)	33 (884) ^d	
Not listed	6.8 (1,817)	35.2 (527) ^{b,c}	
Race/ethnicity (n = 26,897)			
Alaska Native/American Indian alone	1.2 (314)	48.2 (133) ^a	48.860 (6)***
Asian/NH/PI alone	2.8 (763)	26.2 (167) ^b	
Biracial/multiracial/not listed	5.7 (1,528)	35.5 (441) ^c	
Black/African American alone	2.9 (777)	32.8 (210) ^{b,c}	
Latinx/Hispanic alone	5.3 (1,427)	31.3 (362) ^{b,c}	
White alone	81.6 (21,958)	33.9 (6,356) ^c	
Middle Eastern/North African alone	0.5 (130)	39.8 (43) ^{a,b,c}	
Spiritual/religious identity (n = 26,844)			
Christian	18 (4,825)	32.8 (1,386) ^a	2.379 (1)
Not Christian	82 (22,019)	34 (6,314) ^a	
Geographic region (n = 26,897)			
Northeast	20.7 (5,555)	32.3 (1,570) ^a	39.891 (3)***
Midwest	20.7 (5,571)	33.2 (1,559) ^a	
West	31.1 (8,374)	36.7 (2,618) ^b	
South	27.5 (7,397)	32.1 (1,965) ^a	
Poverty (n = 25,512)			
No	66.5 (16,971)	33.4 (4,928) ^a	12.315 (1)***
Yes, at or near poverty	33.5 (8,541)	35.8 (2,498) ^b	

Disability Status (<i>n</i> = 26,840)			
No	71.4 (19,166)	30.7 (4,956) ^a	242.933 (1)***
Yes	28.6 (7,674)	41.4 (2,745) ^b	
Education Level (<i>n</i> = 26,897)			
At least some college	84.1 (22,633)	34.7 (6,761) ^b	44.070 (1)***
No college education	15.9 (4,264)	28.8 (951) ^a	
		% Experiencing	
		Healthcare	
		Mistreatment (<i>n</i>)	χ^2 test, (<i>df</i>)
Psychosocial categorical variables	Overall sample, % (<i>n</i>)		
Out to healthcare providers (<i>n</i> = 24,273)			
None know that I am trans	31.1 (7,535)	11.1 (656) ^a	2066.883 (3)***
Some know that I am trans	16.2 (3,939)	36.6 (1,310) ^b	
Most know that I am trans	12.7 (3,079)	47.5 (1,374) ^c	
All know I am trans	40 (9,720)	44.6 (4,091) ^d	
IDs matching name (<i>n</i> = 26,836)			
All IDs match preferred name	28 (7,524)	30.9 (2,027) ^a	512.315 (2)***
Some IDs match preferred name	21.9 (5,890)	46.5 (2,511) ^b	
None of IDs match preferred name	50 (13,422)	29.2 (3,162) ^c	
IDs matching gender identity (<i>n</i> = 26,805)			
All IDs match gender identity	11.3 (3,035)	34.4 (938) ^a	531.830 (2)***
Some IDs match gender identity	20.6 (5,523)	46.8 (2,414) ^b	
None of IDs match gender identity	68.1 (18,247)	29.2 (4,347) ^c	
Suicide attempt (past 12 mos.; <i>n</i> = 26,873)			
No	92.5 (24,846)	32.8 (6,907) ^a	136.374 (1)***
Yes	7.5 (2,027)	46.7 (796) ^b	
Suicidal ideation (past 12 mos.; <i>n</i> = 26,865)			
No	50.7 (13,615)	29.4 (3,442) ^a	206.872 (1)***
Yes	49.3 (13,250)	38.4 (4,263) ^b	
Past year victimization for any reason (<i>n</i> = 26,761)			
No	40.8 (10,912)	24.1 (2,252) ^a	667.366 (1)***
Yes	59.2 (15,849)	40.6 (5,421) ^b	
Lifetime IPV (<i>n</i> = 26,372)			
No	65.5 (17,278)	28.7 (4,189) ^a	460.860 (1)***
Yes	34.5 (9,094)	42.9 (3,348) ^b	
Unwanted sexual contact (lifetime; <i>n</i> = 26,841)			
No	53.3 (14,294)	27.9 (3,371) ^a	408.109 (1)***
Yes	46.7 (12,547)	40.5 (4,329) ^b	

Engagement in sex work for money
(lifetime; $n = 26,880$)

No	89.7 (24,098)	32.2 (6,569) ^a	235.871 (1)***
Yes	10.3 (2,782)	47.9 (1,137) ^b	

Interval/Ratio Variables	Descriptive Statistics	Group Means by Healthcare Mistreatment (n)	t-test
Age	$n = 26,897$ $M = 30.7$ $SD = 13.06$ Range = 18-100	Yes: 31.90 (7,712) No: 30.78 (15,100)	-6.072***
Kessler-6 distress score	$n = 26,408$ $M = 10.77$ $SD = 6.01$ Range = 0-24	Yes: 11.21 (7,573) No: 10.15, (14,851)	-12.578***

*** $p < .001$.

Note: Superscript a-d denotes subset categories whose proportions significantly differ at the $p < .05$ level. AFAB = assigned female at birth; AMAB = assigned male at birth; SGL = same-gender-loving; NH/PI = Native Hawaiian/Pacific Islander; IPV = intimate partner violence.

Table 2. Logistic Regression Models Predicting Mistreatment in Healthcare, by Patient Race/Ethnicity

	Any Mistreatment in Healthcare				
	Asian/NH/PI (N = 554)	Bi/Multiracial/Not Listed (N = 1,045)	Black/ African American (N = 532)	Latinx (N = 962)	White (N = 16,141)
Sociodemographic Variables	AOR (95% CI)	AOR (95% CI)	AOR (95% CI)	AOR (95% CI)	AOR (95% CI)
No health insurance (ref. group: has insurance)	1.69 (0.78, 3.64)	0.92 (0.55, 1.52)	0.86 (0.46, 1.62)	0.83 (0.49, 1.41)	0.85* (0.75, 0.97)
Trans man (ref. group: trans women)	1.83* (1.03, 3.27)	1.98*** (1.32, 2.96)	1.19 (0.69, 2.03)	1.33 (0.91, 1.96)	1.54*** (1.40, 1.69)
NB/AFAB (ref. group: trans women)	0.91 (0.47, 1.75)	1.54^ (0.95, 2.49)	0.49^ (0.24, 1.01)	0.85 (0.50, 1.43)	1.06 (0.94, 1.19)
NB/AMAB (ref. group: trans women)	0.48 (0.16, 1.47)	0.55 (0.26, 1.15)	0.65 (0.23, 1.86)	0.86 (0.38, 1.92)	0.79** (0.65, 0.94)
Asexual (ref. group: LGQ/SGL/Other)	0.35* (0.14, 0.90)	0.99 (0.56, 1.73)	0.81 (0.30, 2.21)	0.88 (0.57, 1.37)	0.74*** (0.65, 0.85)
Bi/pansexual (ref. group: LGQ/SGL/Other)	0.69 (0.42, 1.14)	0.86 (0.62, 1.19)	0.72 (0.42, 1.21)	1.00 (0.70, 1.43)	0.84*** (0.77, 0.91)
Straight (ref. group: LGQ/SGL/Other)	0.64 (0.33, 1.26)	0.80 (0.46, 1.39)	0.80 (0.47, 1.38)	0.88 (0.57, 1.37)	0.75*** (0.66, 0.85)
Spiritual affiliation (ref. group: Christian)	1.40 (0.78, 2.49)	0.82 (0.53, 1.25)	1.20 (0.77, 1.86)	1.31 (0.91, 1.90)	1.01 (0.92, 1.11)
Age	1.00 (0.88, 1.14)	1.15** (1.06, 1.25)	1.02 (0.91, 1.15)	1.05 (0.95, 1.15)	1.03** (1.01, 1.05)
Age Squared	1.00 (9.99 x 10 ⁻¹ , 1.00)	9.98 x 10 ⁻¹ ** (9.97 x 10 ⁻¹ , 9.99 x 10 ⁻¹)	1.00 (9.98 x 10 ⁻¹ , 1.00 x 10 ⁻¹)	9.99 x 10 ⁻¹ (9.98 x 10 ⁻¹ , 1.00)	9.997 x 10 ⁻¹ ** (9.995 x 10 ⁻¹ , 9.999 x 10 ⁻¹)
Midwest Region (ref. group: Northeast)	1.59 (0.72, 3.55)	0.97 (0.60, 1.57)	1.90^ (0.97, 3.74)	0.94 (0.54, 1.65)	1.12* (1.01, 1.25)
West Region (ref. group: Northeast)	1.62^ (0.92, 2.85)	1.19 (0.80, 1.77)	2.30* (1.18, 4.48)	1.04 (0.68, 1.59)	1.11* (1.01, 1.23)

South Region (ref. group: Northeast)	1.59 (0.78, 3.24)	0.70 (0.45, 1.11)	1.81* (1.02, 3.20)	1.46 (0.93, 2.30)	1.22*** (1.10, 1.36)
Poverty Status (ref. group: not at/near poverty)	1.02 (0.63, 1.64)	1.24 (0.91, 1.70)	0.70 (0.43, 1.15)	0.87 (0.61, 1.22)	1.00 (0.92, 1.09)
Disability (ref. group: no disability)	1.46 (0.88, 2.42)	1.39* (1.00, 1.94)	1.45 (0.91, 2.32)	1.23 (0.86, 1.77)	1.50*** (1.38, 1.63)
College Education (ref. group: no college education)	1.19 (0.55, 2.58)	1.54^ (0.99, 2.39)	1.00 (0.54, 1.86)	1.10 (0.71, 1.69)	1.28*** (1.14, 1.44)
Psychosocial Risk Variables	AOR (95% CI)	AOR (95% CI)	AOR (95% CI)	AOR (95% CI)	AOR (95% CI)
Out to healthcare providers	1.44** (1.15, 1.80)	1.66*** (1.43, 1.92)	1.30* (1.06, 1.60)	1.70*** (1.45, 1.98)	1.65*** (1.59, 1.71)
Some IDs match name (ref. group: All or no IDs match)	1.59 (0.87, 2.93)	1.21 (0.81, 1.80)	1.13 (0.66, 1.95)	1.82** (1.16, 2.85)	1.21*** (1.09, 1.33)
All IDs match gender (ref. group: No IDs match)	1.24 (0.58, 2.62)	1.16 (0.70, 1.93)	1.21 (0.63, 2.32)	1.13 (0.69, 1.83)	1.35*** (1.20, 1.52)
Some IDs match gender (ref. group: No IDs match)	0.62 (0.31, 1.26)	1.02 (0.66, 1.57)	1.08 (0.62, 1.89)	0.95 (0.59, 1.54)	1.33*** (1.19, 1.48)
Suicide ideation – past year (ref. group: no)	1.00 (0.59, 1.71)	0.93 (0.66, 1.31)	1.07 (0.65, 1.76)	1.15 (0.80, 1.65)	1.26*** (1.16, 1.38)
Suicide attempt – past year (ref. group: no)	1.60 (0.78, 3.27)	2.50*** (1.52, 4.13)	1.38 (0.65, 2.94)	0.95 (0.54, 1.65)	1.28*** (1.11, 1.48)
Psychological Distress	1.07** (1.03, 1.12)	1.05** (1.02, 1.08)	1.06** (1.02, 1.11)	1.03^ (1.00, 1.06)	1.03*** (1.02, 1.04)
Victimization – past year (ref. group: no)	2.11** (1.30, 3.44)	2.42*** (1.70, 3.45)	2.96*** (1.83, 4.77)	1.69** (1.20, 2.37)	1.90*** (1.76, 2.06)
IPV – lifetime (ref. group: no)	0.89 (0.53, 1.48)	1.04 (0.76, 1.43)	1.16 (0.74, 1.83)	1.52* (1.09, 2.10)	1.27*** (1.18, 1.38)

Unwanted sexual contact – lifetime (ref. group: no)	1.46 (0.92, 2.33)	1.18 (0.85, 1.64)	1.30 (0.84, 2.01)	1.40* (1.01, 1.93)	1.22*** (1.13, 1.32)
Sex work for money – lifetime (ref. group: no)	1.05 (0.51, 2.14)	1.57 (1.04, 2.36)	1.07 (0.62, 1.85)	0.87 (0.55, 1.38)	1.28*** (1.13, 1.44)

[^] $p < .10$. * $p < .05$. ** $p < .01$. *** $p < .001$.

Note: AOR = Adjusted odds ratios; NH = Native Hawaiian; PI = Pacific Islander; OR = odds ratio; CI = confidence interval; NB/AFAB = nonbinary assigned female at birth; NB/AMAB = nonbinary assigned male at birth; LGQ/SGL = lesbian, gay, queer, or same-gender-loving; IPV = intimate partner violence. Constant not displayed here.