



Health Equity

“It’s Being Compassionate, Not Making Assumptions”: Transmasculine and Nonbinary Young Adults’ Experiences of “Women’s” Health Care Settings



Anu Manchikanti Gomez, PhD, MSc*, Noah Hooker, MSW,
Robin Olip-Booth, MSW, Phoebe Woerner, MSW, G. Allen Ratliff, MSW

Sexual Health and Reproductive Equity Program, School of Social Welfare, University of California, Berkeley, Berkeley, California

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A B S T R A C T

Background: Transgender and nonbinary (TNB) individuals assigned female sex at birth experience discrimination, misgendering, problems with insurance, and denial of services when accessing health care. This study aimed to understand the experiences of TNB young adults in accessing “women’s” health care—a form of care that is structurally gendered that few studies have investigated.

Methods: In 2015, we conducted in-depth interviews with 20 TNB young (ages 18–29) adults assigned female sex at birth. We thematically analyzed the data.

Results: Participants described feelings of comfort and trust—and lack thereof—at every step of the health care-seeking process, including scheduling, checking in, waiting, and interactions with clinicians and other staff. Gendered language served as a constant stressor; participants—especially nonbinary participants—noted few opportunities to provide their correct pronouns and names. Participants relayed negative experiences associated with waiting rooms in “women’s” health care spaces, where TNB patients are forced to disclose their identity simply through their presence or owing to actions of staff that out them. These concerns deterred some from seeking care, with most expressing discomfort or anxiety that caused them to feel unsafe. Participants described “women’s” health care providers making assumptions about their anatomy, reproductive desires, sexual orientation, and sexual practices, as well as inappropriately and harmfully emphasizing their bodies and TNB identities during health care interactions. Clinician competence and humility engendered participants’ feelings of safety and undergirded their interest in engaging with “women’s” health care.

Conclusions: A lack of patient-centered, TNB-competent care in structurally gendered health settings exacerbates health care and health inequities for TNB young adults.

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Transgender people experience endemic barriers to health care access as a result of discrimination, fear of mistreatment, lack of clinician and staff training, and a dearth of culturally and structurally sensitive health care (Berger, Potter, Shutters, & Imborek, 2015; Kattari, Bakko, Hecht, & Kinney, 2020a; Kattari, Bakko, Langenderfer-Magruder, & Hall, 2020b). Transgender people are people whose gender does not align with social expectations for the sex they were assigned at birth, with some transgender people identifying with binary genders (woman/

man), and others identifying with nonbinary genders (e.g., genderqueer, nonbinary; Kattari, Bakko, Hecht, et al., 2020a; Kattari, Brittain, Markus, et al., 2020c). Although some nonbinary people do not identify as transgender, research has generally grouped transgender and nonbinary (TNB) people together owing to similar experiences with gender identity (Kattari, Brittain, Markus, et al., 2020c). Structural and legal factors, such as limited gender options in medical records, problems with insurance claims, lack of affordable care, and restrictions and/or regulations of legally recognized gender, negatively impact health care access for TNB people (Berger et al., 2015; James et al., 2016; Kattari, Bakko, Hecht, et al., 2020a; Kattari, Brittain, Markus, et al., 2020c). In the 2015 U.S. Transgender Survey, 33% of respondents who saw a health care provider in the last year reported at least one negative experience related to being

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* Correspondence to: Anu Manchikanti Gomez, PhD, MSc, School of Social Welfare University of California, Berkeley 120 Haviland Hall MC 7400, Berkeley, CA 94720-7400. Phone: 510-642-0722; fax: 510-643-6126.

E-mail address: anugomez@berkeley.edu (A.M. Gomez).

transgender, including needing to educate their provider in order to receive appropriate care, being asked unnecessary questions about being transgender, and being refused transition-related care; furthermore, nearly one-quarter of respondents did not seek needed care in the past year because of fear of discrimination (James et al., 2016; Kattari, Bakko, Hecht, et al., 2020a; Kattari, Bakko, Langenderfer-Magruder, et al., 2020b). These health care inequities contribute to the stark health inequities experienced by TNB people, including disproportionately high rates of HIV and other sexually transmitted infections, mental health concerns (e.g., depression, post-traumatic stress disorder, suicidality), substance use disorders, basic needs insecurities (e.g., homelessness, inadequate nutrition), and inadequate health screenings for cancers and other health conditions (Lefevor, Boyd-Rogers, Sprague, & Janis, 2019; McCann & Brown, 2020; Peitzmeier, Reisner, Harigopal, & Potter, 2014; Poteat, Scheim, Xavier, Reisner, & Baral, 2016; Reisner et al., 2016).

For TNB people assigned female sex at birth (AFAB), receiving routine and acute reproductive and gynecological health care often requires going to “women’s” health settings, where the culture is centered around a gendered experience that is not authentic for TNB people (Kattari, Bakko, Langenderfer-Magruder, et al., 2020b; Kattari, Brittain, Markus, et al., 2020c; Wingo, Ingraham, & Roberts, 2018). In the few studies of TNB people’s experiences with services traditionally labeled “women’s” health care, findings largely mirror the broader literature on health care experiences of TNB people (Berger et al., 2015; Kattari, Brittain, Markus, et al., 2020c; Wingo et al., 2018). TNB people AFAB report discrimination, misgendering, misuse of pronouns, problems with insurance, and denial of services (Bakko & Kattari, 2020; Kattari, Bakko, Langenderfer-Magruder, et al., 2020b; Poteat, German, & Kerrigan, 2013). Additionally, they describe clinicians who seem to be uncomfortable providing them care and lack adequate training and knowledge about the reproductive health needs of TNB people (Kattari, Brittain, Markus, et al., 2020c; Kattari, Atteberry-Ash, Kinney, Walls, & Kattari, 2019; Mitu, 2016; Obedin-Maliver, 2015; Obedin-Maliver & Makadon, 2015). Little research with TNB people focuses on health care traditionally falling under the umbrella of “women’s” health, including pelvic examinations, Pap smears, family planning, and bladder, breast, and gynecological care (Kattari, Brittain, Markus, et al., 2020c; Obedin-Maliver, 2015; Wingo et al., 2018). One study found inadequate Pap smears and cervical cancer screening for TNB people AFAB (Peitzmeier et al., 2014). The American College of Obstetricians and Gynecologists and the World Professional Association for Transgender Health have stressed the importance of obstetricians/gynecologists providing appropriate medical care to TNB people AFAB and have noted insufficient quality of care and training (American College of Obstetricians and Gynecologists, 2011; 2017; Benestad, 2011).

Inadequate training in the health of TNB people AFAB is demonstrated by a survey of 141 OB-GYNs, in which 80% of respondents reported receiving no training on the care of, 68% did not feel comfortable providing care for, and 16% were unwilling to perform Pap smears on transgender individuals (Unger, 2015). The gap between clinician experiences and patient needs is further illustrated in a survey of 113 transgender individuals in New York City that showed that the most important factors in the decision to access care at Planned Parenthood included assurance that staff had sensitivity training, the implementation of antidiscrimination policies, and the availability of transgender-specific care, such as hormone therapy (Porsch,

Dayananda, & Dean, 2016). Furthermore, the lack of attention to reproductive health can place TNB people AFAB at risk for undesired pregnancy. For example, a study on the family planning needs of transgender men revealed that 18% of transgender men believed testosterone was a reliable contraceptive, with 6% of participants reporting that their doctor had given them this information (Light, Wang, & Gomez-Lobo, 2017; Light, Wang, Zeymo, & Gomez-Lobo, 2018). In one qualitative study of TNB young adults’ experiences of reproductive health care, participants described clinicians’ lack of familiarity with the needs of TNB patients, manifesting in harmful assumptions about participants’ bodies, sexual partners, and gender identities (Gomez, Đó, Ratliff, Crego, & Hastings, 2020). This lack of knowledge meant clinicians failed to provide high-quality contraceptive care. Notably, little research focuses explicitly on the experiences of nonbinary people, who may have unique needs and preferences regarding “women’s” health care (Kattari, Brittain, Markus, et al., 2020c; Kattari et al., 2019).

Although multiple studies consider the health care experiences of transgender adolescents, there is minimal research exploring the ways experiences of and barriers to health care may change across the stages of adulthood (Gomez et al., 2020; Nahata, Tishelman, Caltabellotta, & Quinn, 2017; Vance, Halpern-Felsher, & Rosenthal, 2015). Systemic barriers play a critical role in the provision of appropriate health care and can introduce special challenges for young people in accessing “women’s” health care. In addition to the socioeconomic inequities TNB people experience, including employment and housing discrimination, transgender young adults are more likely to experience homelessness, to be subjected to a higher number of health-related risks, and to report intimate partner violence and polyvictimization than their cisgender peers (Berger et al., 2015; James et al., 2016; Rimes, Goodship, Ussher, Baker, & West, 2017; Sterzing, Ratliff, Gartner, McGeough, & Johnson, 2017). Such stressors can impede discussions about reproductive options that are critical for making informed decisions about hormonal or surgical treatments. For young TNB people interested in family building, financial insecurity can restrict access to assisted reproductive technology, such as fertility preservation (Mitu, 2016). In addition to the stress that TNB people experience while trying to access health care, one study with pregnant and post-partum transgender people found that participants reported depression associated with gender dysphoria (Berger et al., 2015).

This study aimed to explore the experiences of TNB young adults AFAB in health care services that traditionally fall under the umbrella of “women’s” health and how health care professions, providers, and settings can create more inclusive, patient-centered services.

Methods

The Transgender Reproductive Health Study sought to explore the reproductive and “women’s” health care experiences of TNB young adults AFAB. We conducted in-depth interviews between March and May 2015 with individuals who 1) were ages 18 to 29, 2) identified as transgender, genderqueer, nonbinary, men, or another gender identity that was not a woman, 3) were assigned female sex at birth, 4) lived in Northern California, and 5) had accessed reproductive health services in the past year or had experienced pregnancy or had sex with a cisgender man in the prior 3 years. We recruited participants via Facebook posts, community networks, Craigslist, and flyers in businesses, social

service agencies, and clinics serving LGBTQ clients. Upon interview completion, participants received a \$25 gift card. The Committee for the Protection of Human Subjects at the University of California, Berkeley approved the study protocol.

The first author and principal investigator (a cisgender, South Asian American woman in her 30s) and a social work graduate student researcher (a Vietnamese American transgender person in their early 20s) collaboratively designed and executed the study. This partnership integrated the principal investigator's expertise in reproductive and "women's" health and the graduate student researcher's lived experience and professional background as a social worker serving TNB clients. Both had extensive training in qualitative methods before launching this study; the graduate student researcher conducted most interviews. Throughout data collection and the initial analysis, the researchers engaged in reflexive conversations to attend to their respective positionalities and the impact of such on the research design, data collection, and analysis.

Before being interviewed in person or via videoconference, participants completed a survey assessing demographic data and information about their experiences accessing "women's" health care services, hormone use, and gender alignment surgeries. Participants reported their self-described gender identities, with the option to select more than one of the provided options and/or to write in additional identities. The semistructured interview guide included questions regarding family and personal history, gender and sexual identity, conceptions of family, contraceptive use and needs, experiences and decision-making in accessing "women's" health services, needs and knowledge regarding reproductive health, and experiences of pregnancy and birth. We completed field notes immediately following each interview to record initial impressions and compelling emergent themes. Twenty participants comprised the final sample, with 19 interviews digitally recorded and transcribed verbatim. One participant declined to be recorded because he was undergoing medical transition and was not comfortable with his voice being recorded in its current pitch; in this case, the interviewer took detailed notes to capture as many of the participant's own words as possible.

The second, third, and fourth authors—all graduate students in social work at the time—conducted analytic activities after being trained by and under the supervision of the first author. The second through fifth authors all have professional social work experience working with TNB young people. The second author is a White trans man in his late 30s and a medical social worker. The third author is a White, queer, gender-nonconforming person in her early 40s. The fourth author is a White, queer, cisgender woman in her early 30s. The fifth author is a White, queer, nonbinary man in his mid-30s. Throughout the meaning making process, the team reflected on professional and lived experiences navigating reproductive and "women's" health care settings and raised issues of overidentification and bias with one another as part of practicing reflexivity.

The analysts listened to audio recordings of interviews while reading through the transcripts for quality assurance and to gain deeper familiarity and a felt sense of each interview. The analysis process began with summative memo writing, using the "Sort and Sift, Shift and Think" approach (Maietta, 2006); each of the three analysts wrote reflective memos about the same two interviews, reviewing one another's memos and consulting as a group to ensure consistency of the method before individually writing memos for remaining interviews. After listening to, reading transcripts of, and writing memos for all interviews, we

drafted a codebook, generating deductive codes based on the interview guide and drawing on the iterative analysis activities. Deductive codes included such topics as safety, "women's" health care, and pregnancy. One inductive code captured participants' experiences with clinicians making identity-based assumptions, which was not a direct topic of inquiry in the interview but frequently mentioned in response to questions about negative care experiences. The three analysts each independently coded the two same interview transcripts, reviewed each other's coding choices, and met to reflect upon and resolve differences to enhance coding consistency. We finalized the codebook after this initial round of coding, clarifying and refining code definitions, removing redundant codes, and refining standards for code application. We used Dedoose, a web-based mixed methods analysis tool, to code all transcripts.

We reviewed the coded data and examined overlap of codes and overall occurrence of codes to begin drawing patterns from the data. Through an iterative consensus process using discussion and visual aids, we organized codes into topic areas and eventually into the themes presented here. The team used compare and contrast analysis within and between interviews to refine themes, and each of the three analysts coded transcripts for which they had not written memos to support triangulation. To test and confirm our findings, we explored outliers to better understand patterns of commonality and pursued rival explanations and negative evidence as we drew conclusions (Miles, Huberman, & Saldaña, 2014). Results are organized by identified codes and include direct quotes from participants to elaborate on deductive coding; quotes are described by age, as well as participants' self-described gender identity and pronouns. Participant quotes include descriptors of gender identity provided during interviews. For some participants, the identity provided during the interview was different than their survey data.

Results

The mean age for participants was 26.5 years ($SD = 2.67$; Table 1). Most participants ($n = 13$) identified their gender identity in the survey as transgender or trans man, four identified as nonbinary or genderqueer, four identified as a man, and two wrote in a gender identity (trans guy, trans masculine). Regarding participants' medical transitions, 14 participants were currently using hormones, 2 had used hormones in the past but were not currently, and 4 had never used hormones. Seven participants had undergone at least one gender alignment surgery; one participant had undergone sex reassignment surgeries.

Interviews with participants revealed themes present in interactions with clinicians in "women's" health care, including gynecological, obstetric, sexual, and reproductive health settings. The themes that emerged describe a range of largely negative experiences with clinicians in relation to gendered language, disclosure of identity, assumptions of identity and embodiment, and competence and humility with TNB patients.

Gendered Language

All participants discussed the ubiquitous use of gendered language and terminology in the health care environment, which served as a constant stressor. Examples of gendered language included questions on sex or gender on forms and the use of names and pronouns in clinical interactions and patient records, as well as the broader gendered nature of "women's" health care.

Table 1
Transgender Reproductive Health Study Participant Characteristics

Participant Characteristics	N
Gender identity*	
Trans man	13
Nonbinary or genderqueer	4
Man	4
Another gender identity	2
Sexual orientation	
Straight/heterosexual	1
Gay/lesbian	3
Bisexual	1
Queer	13
Pansexual	1
Asexual	1
Race/ethnicity*	
White	12
Black	1
Latinx	1
Asian or Pacific Islander	1
Multiracial	5
Health insurance	
Private	11
Public	7
Uninsured	2
Medical transition status	
Currently using hormones	14
Previous but not current use of hormones	2
No use of hormones	4
Completed at least one gender alignment surgery	7
Completed sex reassignment surgery	1
Services ever accessed	
Pap smear	18
Contraception prescription	13
Pregnancy test	9
Emergency contraception	5
Abortion	3

Note: $n = 20$.

* Participants could provide more than one gender identity and racial/ethnic group identification.

As one 23-year-old genderfluid participant described: “Everything that’s written out there is like, *women’s health* this, *women’s health* that, and there’s no need to gender it, you know? You can give a presentation about sexual health and say, *the clitoris* this, and still keep it at these medical terms without gendering things.” Notably, the issue of gendered language is widely understood to be a barrier to the provision of quality health care for TNB people AFAB (Kattari, Brittain, Markus, et al., 2020c; Wingo et al., 2018). Our analysis highlighted the interaction between gendered language and structurally gendered “women’s” health care settings, which amplified participants’ disenfranchisement and hesitance to engage in this care. For example, a 29-year-old trans man noted the combination of being misgendered with having conversations about “women’s” health issues that were not comfortable and the desire to see a known and valued clinician for this type of care.

Knowing that I’m going to be misgendered, ‘cause it’s going to happen, and knowing that they’re probably going to ask me about, like, getting my Pap and that kind of health that I’m usually not comfortable talking to strangers about, Dr. A would be different, someone [who I] have a personal connection with and I know will respect my identity and will just be straightforward about it, rather than [making] me uncomfortable.

Participants described the lack of opportunities to provide their correct pronouns and names; nonbinary participants noted

the near-universal lack of relevant gender options on forms. Furthermore, when participants did provide their correct pronouns and names, staff and clinicians frequently overlooked the information on subsequent visits. Limited options in electronic health records and failure by staff to identify correct pronoun usage before patient interactions perpetuated these problems. A 23-year-old trans masculine participant relayed an experience with a clinical supervisor who agreed to note the participant’s correct pronouns in their electronic health record: “But the next week, I get a call, and it’s ‘Miss,’ and [it] didn’t make a difference whatsoever.” In the few cases in which clinicians used accurate pronouns, participants described decreased stress. For example, one 27-year-old trans man noted how distressing the use of gendered terms were when referring to his body and the ways in which clinicians’ awareness of language could alleviate this distress, stating, “One doctor asked me if there were terms I preferred for my body...I really liked that, that she was aware that I might not want her to say the terms that she’s used to saying as a gynecologist.”

Disclosure of Identity

Participants discussed the importance of having control over how their gender identity is shared in clinical settings. They relayed negative experiences associated with waiting rooms in reproductive health care spaces that are dedicated to the health needs of patients AFAB, where TNB patients are forced to disclose their identity simply through their presence at a clinic or being revealed as patients by staff and therefore AFAB. For some participants, concerns about these experiences deterred them from seeking care, and most expressed discomfort or anxiety that caused them to feel unsafe. One 22-year-old nonbinary participant expressed satisfaction with their current university-based clinician but anticipated stress when they would have to find a new clinician upon graduation:

The idea of having to sort of roll my eyes when I go in to see a gynecologist and having to deal with the people at the front desk not knowing what to do with me, like, “Why would this guy...why is this guy here seeing this doctor?” And that’s worrisome. Unless I’m sneaking in, I can’t hide the fact that I’m going to be arriving at a “women’s” doctor’s office with a bunch of other ladies or female-representing people. That scares me.

Some participants expressed feeling greater comfort with settings specializing in transgender care, where patients shared circumstances and needs. Others described discomfort with the kind of disclosure such clinics can bring. Referencing a clinic that serves women and TNB people, a 26-year-old trans man said, “[The clinic] is a women’s clinic. You have to either be female or a trans man, so if you see anyone in that clinic with a beard and deeper voice, he’s trans, no stealth, [compared to] my clinic, my doctor that I go to sees a range of people.” (“Stealth” refers to a person’s ability or decision to not present as TNB in some or all of their daily lives; Meier & Labuski, 2013.)

Assumptions of Identity and Embodiment

Participants described feeling uncomfortable with reproductive health care providers making assumptions about them during health care interactions, including incorrect assumptions about anatomy, reproductive desires, sexual orientation, and sexual practices. These assumptions were rooted in sex-

essentialist notions that a participant's gender conveyed meaning about their body and anatomy, inherently ignoring and invalidating TNB identities. For example, a 29-year-old trans guy described his experience seeking treatment for a sexually transmitted infection: "They were asking me, 'Is it on the head or the shaft? On the testicles or the penis?' And I was like, 'My labia?' They were very confused with that answer." For this participant, his clinician's correct perception of him as a man led to incorrect assumptions about his body and resulted in him avoiding seeking care outside of known and trusted clinics: "There are assumptions about me having a penis when I go in for things involving a vulva." To avoid these harmful assumptions, he chose to attend clinics in neighborhoods understood locally to be safer and more inclusive of transgender identity, where clinicians are expected to be more knowledgeable about transgender health.

Participants voiced feeling particularly disrespected when clinicians inappropriately emphasized their TNB identity during health care interactions. Many lost trust in clinicians who made comments or asked questions about participant experiences of being transgender that were irrelevant to the care being sought. When the same 27-year-old trans man described what made him feel unsafe during health care interactions, he said, "If [clinicians] start asking me questions that have nothing to do with why I'm there, about my identity, about my sexual orientation, or sexuality." A 28-year-old nonbinary participant described being asked "questions that aren't suited," saying, "One time I was having a breast exam, and [the clinician asked], 'Have your breasts always been this small or did they shrink while you've been on hormones?'" Questions like this that appeared to privilege clinicians' curiosity over patients' health care needs led participants to feel othered and dehumanized.

Several participants shared instances of explicit clinician prejudice around their gender identity. This prejudice manifested through insensitive and pejorative statements and perspectives of transgender identity and harmful clinical interactions about unexpected features of their bodies that emerged from these prejudices. For example, a 29-year-old trans man described interacting with a nurse who realized he was transgender after he completed paperwork. He recalled the nurse saying, "Oh, you marked the ones about periods," and he responded "Yeah, because I have those parts inside of me," to which the nurse replied, "Oh! What made you do that? Oh my god, you're so young. Did something happen to you?" He concluded, "And I'm like WHOA! Just take my blood pressure." Many participants conveyed similar experiences of unpredictable and harmful clinician behavior that led to a sense of wariness and mistrust when entering health care environments and reluctance for future health care engagement.

Competence

Some participants described insufficient clinician competence as a barrier to health care access and engagement. Participants highlighted the critical importance of clinicians showing sensitivity and flexibility with terminology while acknowledging their TNB identity in a nonvoyeuristic manner. Clinicians' awareness of and interaction with participants' bodies and anatomy without essentializing their experiences was widely viewed as fundamental for fostering trust with patients. In addition to establishing a trusting relationship, clinician and staff knowledge proved critical for effective treatment of TNB patients. One 29-year-old man cited staff ignorance as the reason

for his disengagement from care, saying, "I tried to access a mammogram once, but the technician said no after a long conversation...the technician said that if you have top surgery, you won't get breast cancer, but I was like, 'No, you're obviously wrong'...I haven't rescheduled since then."

Inadequate training was especially salient for participants who previously or currently resided in rural or suburban areas. Those who desired care from clinicians trained in transgender health care frequently travelled considerable distances. The same 27-year-old trans man who sought care at a transgender clinic voiced frustration about this problem, saying, "I had to travel [on two different public transportation systems] for three hours, one way, just to get to Oakland for all my appointments that I had there... I could have gone to a surgeon in Santa Clara, but they wouldn't have been as transgender-knowledgeable or friendly." For these patients, maintaining health care access proved challenging, disproportionately affecting those who relied on public transportation.

In addition to systemic and health care setting barriers, many participants delayed care because of anticipated stressors related to clinician competence, whether they had had negative experiences in the past or they had heard about such experiences from community members. One 29-year-old trans man participant reported not being able to get a Pap smear: "I had some painful experiences, so I've had them stop [the procedure], or I just won't go to the appointment. Or they don't have a female doctor so I won't go, you know, and I'm topless. Or I can't get someone to go with me, and I have a fear of going by myself."

Clinician experience caring for TNB patients was also viewed as critical for successful patient care. Some participants found that their clinician's competence regarding TNB health made them feel more secure and confident. In one case, a 25-year-old trans man described feeling that his physician was supportive of him when she corrected a nurse's use of incorrect pronouns during childbirth: "I did have a situation where the surgeon came in to do the C-section, and one of the nurses said, 'She's ready.' And [the physician] said, 'He's a guy, and if you say that again, I will ask you to be replaced with someone else.'" A 29-year-old man described his last Pap smear, noting that he experienced dysphoria during the procedure but felt validated by his clinician's awareness and counseling: "They acknowledged that as valid. And not as something strange or irregular. They treated me like an intelligent and responsible adult." Likewise, a 22-year-old nonbinary trans participant recalled how a clinician's statements signaled competence and fostered his feeling of safety:

She articulates that she understands, so she talks about, "Oh, I know that because you're on testosterone, you can be more dry or you can be more prone to tearing," so stuff like that. She let me know that she knows what she's doing, so I don't feel like they're just blindly going at it. You know, she makes a mention of the things that she knows and wants to prevent so that I don't get hurt, and that's really nice.

The perception that clinicians understood and respected these participants' identities and health care needs undergirded a feeling of safety, a key component of clinician competence that was central to their desire to access care.

Humility

Actions that communicated clinicians' openness and compassion signaled their humility, which engendered participants' comfort with health care seeking. Participants suggested

that thoughtful, relevant, open-ended questions about the needs and care preferences of individual patients were critical. In describing a favored clinician, another 27-year-old trans man said, “That’s why I love Dr. C. H. [says], ‘I learn the most from my patients.’ That should be every doctor, because, like he said, ‘I just don’t know.’ Doctors don’t know because we’re not telling them, and they’re not asking us.” Participants stressed the importance of clinicians asking questions and not assuming that all TNB patients have the same needs, as a 29-year-old man emphasized: “There’s more than one way to be trans.” When asked what helps him to feel safe in health care interactions with clinicians, a 26-year-old trans man said: “It’s being compassionate. Not making assumptions.” Throughout the interviews, participants placed a high value on clinician humility and friendliness, desiring clinicians who are well-versed in TNB-specific health care needs.

Discussion

This analysis exposed ways that TNB young adults AFAB experienced structurally gendered health care settings traditionally under the umbrella of “women’s” health. Participants described feelings of comfort and trust—and lack thereof—that influenced every step of the health care seeking process, including scheduling, checking in, waiting, and interactions with clinicians and other staff. Our analysis suggested that TNB patients often arrive in health care environments with a sense of trust or mistrust based on the experiences leading up to the visit. Clinician and clinic use of gendered language, consideration of disclosure, humility, and competence regarding TNB health issues were identified as pivotal in influencing participants’ feelings of safety and comfort. Nearly all participants noted feeling uncomfortable when clinicians made false assumptions that essentialized their identities, bodies, and experiences. In some instances, discomfort arose from clinicians’ assumptions that participants were or were not TNB, whereas for others it was caused by clinicians making inappropriate generalizations based on participants’ TNB identity. Participants experienced discomfort when they perceived clinicians to be unqualified to treat their needs owing to lack of knowledge about or experience with a diversity of TNB bodies and health care needs. These data highlight the ways that TNB patients AFAB are confronted with structurally gendered “women’s” health settings that limit their access to appropriate sexual, reproductive, and preventive health care. Given that participants were all young adults, these experiences are particularly significant because they may undergird disengagement from critical health care throughout the life course (Gómez & Wapman, 2017). When combined with other structural determinants of health care access (e.g., rural and other medically underserved settings), these findings demonstrate the critical need for geographically accessible TNB competent clinicians who are able to attend to health care that TNB patients may be unable or uncomfortable receiving in “women’s” health settings.

This study identified some positive factors for participants while receiving gendered health care. Participants felt more at ease when they sensed clinicians were comfortable with and knowledgeable about TNB bodies and used relevant and respectful questions to inquire into their health care needs. These findings highlighted environmental factors that increased participants’ sense of comfort and belonging, such as the availability of inclusive intake forms and restrooms, and when waiting areas included visual indicators of being a TNB-friendly space. Our

analysis resonates with national survey findings regarding general health care experiences of TNB people, illuminates interactions that lead to uncomfortable care experiences, and echoes findings of other qualitative studies that have inquired into the health care needs of TNB young adults (Gomez et al., 2020; Kattari et al., 2019; Vance et al., 2015). This study adds new depth and texture to this emerging body of qualitative work by revealing how these needs are intensified in the vulnerable and highly gendered realm of services typically termed “women’s” health care.

This study contributes an analysis on the roles that clinician humility and competence play in building trust with TNB young adults AFAB. Participants named the need for clinicians to take a non-assumptive learner’s stance in approaching conversations with TNB patients, while also entering interactions prepared with TNB-specific health care knowledge. The desire for clinicians to hold both humility and competence is not unique to TNB young adults, and practices such as not making assumptions about sexual partners and practices would likely improve experiences of non-TNB patients as well. This study was successful in recruiting young TNB adults and eliciting in-depth stories of vulnerable health care experiences. Importantly, this analysis captures participants’ persistence in seeking health care despite uncomfortable and alienating experiences, with most participants actively pursuing settings and clinicians who were better prepared to serve them. This helps to explain the rich information shared about negative and positive experiences in accessing care and helps to position TNB young adults as perseverant self-advocates. Indeed, all participants showed enthusiasm in describing what works and offered suggestions for improving care. Although this study and similar research have focused on TNB people’s experiences in health care settings, more research is needed to shed light on the protective and supportive factors that contribute to improved health and well-being in the lives of TNB people, particularly among Black, Indigenous, and people of color, immigrants, and non-English speakers, as well as nonbinary people specifically (Kattari, Brittain, Markus, et al., 2020; Obedin-Maliver, 2015).

This study is not without limitations. Although descriptive data were collected in pre-interview surveys, racial and ethnic identity, education level, and economic position were not explored deeply as intersecting factors in the interview guide or in the analysis. The sample was also majority White and, in this way, this study replicates the weaknesses of similar studies of TNB health experiences, which have given voice to experiences of TNB people with greater social privilege. Participants resided in or near the San Francisco Bay Area; they frequently contrasted their experiences accessing health care in this region with care experiences in other states and regions, suggesting that this geography has more TNB-affirming and -specific care options. Although the sample included a handful of individuals of nonbinary gender, we lacked sufficient data to distinguish their experiences with “women’s” health care from the broader sample. Finally, it is important to note that society and medicine are engaging more intentionally with the needs of TNB people; as such, these findings may be less applicable in places where TNB-affirming care has progressed, particularly since these data were collected in 2015, although the structurally gendered nature of “women’s” health care persists. However, considering participants’ descriptions of their care as more affirming in Northern California than in other areas, these results remain particularly relevant for less affirming areas.

Implications for Practice and/or Policy

This study highlights how “women’s” health care settings and clinicians can alienate TNB young adults AFAB, perpetuate health and health care inequities in this vulnerable population, and intensify already existing barriers in their health care access (e.g., availability of clinicians, travel distance). Intervening upon the structures that unnecessarily gender this health care (e.g., clinical education and practice guidelines) can shift care in these settings to better meet the needs of TNB patients AFAB. It is critical that clinicians who specialize in TNB health are competent in providing relevant preventive care, such as Pap smears and breast examinations, for their patients who prefer being seen in these settings and/or avoid “women’s” health care settings. Rather than training in “women’s” health, clinical education must attend to the range of people with specific health care needs as a step toward undoing the existing structurally gendered paradigm. Policy interventions that aim to advance health care access and quality for TNB patients AFAB must address the need for TNB-competent “women’s” health care providers, as well as geographically accessible, broadly trained TNB-competent clinicians who are prepared to provide patients high-quality care that attends to their holistic health needs.

We identified several important changes for “women’s” health care settings that could reduce barriers in access to appropriate care for TNB patients AFAB, echoing the recent recommendations of Moseson et al. (2020). Emerging recommendations from this and other research reinforce the need for TNB-specific care training for clinicians and staff and changes to the physical environments and cultural norms in which TNB patients access health care (Kattari, Brittain, Markus, et al., 2020c). Clinical environments should be structured to allow for private interactions and support discretion in waiting and intake areas, gender-neutral restrooms should be available with proper signage, and these environments should incorporate posters, literature, and other visual indicators of welcome for TNB patients. Forms and medical records should include appropriate names, pronouns, gender, and sex assignment. Clinicians and other staff should be properly trained on the delivery of reproductive and other gendered health care to people with diverse identities and bodies, including an elimination of assumptions regarding who accesses such care. Health care settings and clinicians must take on these responsibilities rather than placing the burden of education on their TNB patients. Further, clinicians and other staff should always be respectful of individual patients’ needs and preferences, asking relevant open-ended questions and respecting patients’ answers. When health care structures, practices, and settings are intentionally adjusted to provide services for the people who need them, without assuming who those people might be, TNB people can have the opportunity to receive high-quality care that acknowledges their identities and meets their needs.

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References

- American College of Obstetricians and Gynecologists. (2011). Committee opinion No. 512: Health care for transgender individuals. *Obstetrics & Gynecology*, 118(6), 1454-1458.
- American College of Obstetricians and Gynecologists. (2017). Committee opinion No. 685: Care for transgender adolescents. *Obstetrics & Gynecology*, 129(1), e11-e16.
- Bakko, M., & Kattari, S. K. (2020). Transgender-related insurance denials as barriers to transgender healthcare: Differences in experience by insurance type. *Journal of General Internal Medicine*, 35(6), 1693-1700.
- Benestad, E. E. P. (2011). WPATH standards of care. *Obstetrics & Gynecology*, 118(6), 1454-1458.
- Berger, A. P., Potter, E. M., Shuttters, C. M., & Imborek, K. L. (2015). Pregnant transmen and barriers to high quality healthcare. *Proceedings in Obstetrics and Gynecology*, 5(2), 1-12.
- Gomez, A. M., Đđ, L., Ratliff, G. A., Crego, P. I., & Hastings, J. (2020). Contraceptive beliefs, needs, and care experiences among transgender and nonbinary young adults. *Journal of Adolescent Health*, 67(4), 597-602.
- Gómez, A. M., & Wapman, M. (2017). Under (implicit) pressure: Young Black and Latina women’s perceptions of contraceptive care. *Contraception*, 96(4), 221-226.
- James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). The Report of the 2015 U.S. Transgender Survey. National Center for Transgender Equality. Available: transequality.org. Accessed: July 4, 2020.
- Kattari, S. K., Atteberry-Ash, B., Kinney, M. K., Walls, N. E., & Kattari, L. (2019). One size does not fit all: Differential transgender health experiences. *Social Work in Health Care*, 58(9), 899-917.
- Kattari, S. K., Bakko, M., Hecht, H. K., & Kinney, M. K. (2020a). Intersecting experiences of healthcare denials among transgender and nonbinary patients. *American Journal of Preventive Medicine*, 58(4), 506-513.
- Kattari, S. K., Bakko, M., Langenderfer-Magruder, L., & Holloway, B. T. (2020b). Transgender and nonbinary experiences of victimization in health care. *Journal of Interpersonal Violence*. 0886260520905091.
- Kattari, S. K., Brittain, D. R., Markus, A. R., & Hall, K. C. (2020c). Expanding women’s health practitioners and researchers’ understanding of transgender/nonbinary health issues. *Women’s Health Issues*, 30(1), 3-6.
- Lefevor, G. T., Boyd-Rogers, C. C., Sprague, B. M., & Janis, R. A. (2019). Health disparities between genderqueer, transgender, and cisgender individuals: An extension of minority stress theory. *Journal of Counseling Psychology*, 66(4), 385-395.
- Light, A., Wang, L.-F., & Gomez-Lobo, V. (2017). The family planning needs of young transgender men. *Journal of Pediatric and Adolescent Gynecology*, 30(2), 274.
- Light, A., Wang, L.-F., Zeymo, A., & Gomez-Lobo, V. (2018). Family planning and contraception use in transgender men. *Contraception*, 98(4), 266-269.
- Maietta, R. C. (2006). State of the art: Integrating software with qualitative analysis. In Curry, L., Shield, R., & Wetle, T. (Eds.), *Improving Aging and Public Health Research: Qualitative and Mixed Methods*. New York, NY: American Public Health Association and the Gerontological Society of America.
- McCann, E., & Brown, M. J. (2020). Homeless experiences and support needs of transgender people: A systematic review of the international evidence. *Journal of Nursing Management*, 29(1), 85-94.
- Meier, S. C., & Labuski, C. M. (2013). The demographics of the transgender population. In *International handbook on the demography of sexuality* (pp. 289-327). Switzerland: Springer Science + Business Media.
- Miles, M. B., Huberman, A. M., & Saldaña, J. (2014). *Qualitative data analysis: A methods sourcebook*. London: SAGE Publications.
- Mitu, K. (2016). Transgender reproductive choice and fertility preservation. *AMA Journal of Ethics*, 18(11), 1120.
- Moseson, H., Zazanis, N., Goldberg, E., Fix, L., Durden, M., Stoeffler, A., & Obedin-Maliver, J. (2020). The imperative for transgender and gender nonbinary inclusion: Beyond women’s health. *Obstetrics & Gynecology*, 135(5), 1059-1068.
- Nahata, L., Tishelman, A. C., Caltabellotta, N. M., & Quinn, G. P. (2017). Low fertility preservation utilization among transgender youth. *Journal of Adolescent Health*, 61(1), 40-44.
- Obedin-Maliver, J. (2015). Time for OBGYNs to care for people of all genders. *Journal of Women’s Health*, 24(2), 109-111.
- Obedin-Maliver, J., & Makadon, H. J. (2015). Transgender men and pregnancy. *Obstetric Medicine*, 9(1), 4-8.
- Peitzmeier, S. M., Reisner, S. L., Harigopal, P., & Potter, J. (2014). Female-to-male patients have high prevalence of unsatisfactory paps compared to non-transgender females: Implications for cervical cancer screening. *Journal of General Internal Medicine*, 29(5), 778-784.
- Porsch, L. M., Dayananda, I., & Dean, G. (2016). An exploratory study of transgender New Yorkers’ use of sexual health services and interest in receiving

- services at Planned Parenthood of New York City. *Transgender Health*, 1(1), 231–237.
- Poteat, T., German, D., & Kerrigan, D. (2013). Managing uncertainty: A grounded theory of stigma in transgender health care encounters. *Social Science & Medicine*, 84(May), 22–29.
- Poteat, T., Scheim, A., Xavier, J., Reisner, S., & Baral, S. (2016). Global epidemiology of HIV infection and related syndemics affecting transgender people. *JAIDS Journal of Acquired Immune Deficiency Syndromes*, 72, S210–S219.
- Reisner, S. L., Poteat, T., Keatley, J., Cabral, M., Mothopeng, T., Dunham, E., & Baral, S. D. (2016). Global health burden and needs of transgender populations: A review. *The Lancet*, 388(10042), 412–436.
- Rimes, K. A., Goodship, N., Ussher, G., Baker, D., & West, E. (2017). Non-binary and binary transgender youth: Comparison of mental health, self-harm, suicidality, substance use and victimization experiences. *International Journal of Transgenderism*, 20(2-3), 230–240.
- Sterzing, P. R., Ratliff, G. A., Gartner, R. E., McGeough, B. L., & Johnson, K. C. (2017). Social ecological correlates of polyvictimization among a national sample of transgender, genderqueer, and cisgender sexual minority adolescents. *Child Abuse & Neglect*, 67, 1–12.
- Unger, C. A. (2015). Care of the transgender patient: A survey of gynecologists' current knowledge and practice. *Journal of Women's Health*, 24(2), 114–118.
- Vance, S. R., Halpern-Felsher, B. L., & Rosenthal, S. M. (2015). Health care providers' comfort with and barriers to care of transgender youth. *Journal of Adolescent Health*, 56(2), 251–253.
- Wingo, E., Ingraham, N., & Roberts, S. C. M. (2018). Reproductive health care priorities and barriers to effective care for LGBTQ people assigned female at birth: A qualitative study. *Women's Health Issues*, 28(4), 350–357.

Author Descriptions

Anu Manchikanti Gomez, PhD, MSc, is Associate Professor and Director of the Sexual Health and Reproductive Equity (SHARE) Program in the School of Social Welfare at the University of California, Berkeley (UCB). Her scholarship advances the understanding and promotion of sexual and reproductive health equity.

Noah Hooker, MSW, is a medical social worker at Saint Francis Memorial Hospital in San Francisco, California. At the time this research was conducted, he was an MSW student at the UCB School of Social Welfare.

Robin Olip-Booth, MSW, is a school-based mental health clinician working in the Berkeley Unified School District in Berkeley, California. At the time this research was conducted, she was an MSW student at the UCB School of Social Welfare.

Phoebe Woerner, MSW, LCSW, is a school adjustment counselor with the Gill-Montague Regional School District in Turners Falls, Massachusetts. At the time this research was conducted, she was an MSW student at the UCB School of Social Welfare.

G. Allen Ratliff, MSW, LCSW, is a Graduate Student Researcher with the SHARE Program and a PhD Candidate in the School of Social Welfare at UCB. His research focuses on social-ecological dynamics of interpersonal and structural violence in young transgender and nonbinary people, people experiencing homelessness, and systems-involved people.