

Psychological Wellbeing of Trans and Nonbinary People Assigned Female at Birth in the US: Gender Minority Stressors, Social Support, and Gender-Affirming Behaviors

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Trans and gender diverse people live in a cisnormative society where their minoritized status compromises their psychological health. We examined associations between social support, intimate relationship satisfaction, gender minority stressors, gender-affirming behaviors, and psychological wellbeing in a convenience sample of 81 predominantly white trans and nonbinary people assigned female at birth and living in the US. Gender non-affirmation, negative expectations for the future, nondisclosure, and transnegativity were associated positively with anxiety and depression, and negatively with life satisfaction. Overall social support correlated negatively with psychological distress. Gender-affirming behaviors (e.g., hormone use, gender-affirming surgeries) did not predict anxiety and depression. However, life satisfaction scores were higher in those who underwent gender-affirming surgeries and legal gender marker changes. Gender non-affirmation scores were lower in those who had made legal gender marker changes in the total sample and in trans men who took hormones. Compared to nonbinary participants, trans men were more likely to be

using hormones and to report lower gender non-affirmation scores. These results support other research on the associations between gender minority stressors and psychological wellbeing. Social support may ameliorate these stressors. Furthermore, people with nonbinary gender identities may differ in important ways from those with binary trans identities.

KEYWORDS trans men; nonbinary people; psychological health; gender minority stressors; gender-affirming behaviors

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Cisgenderism, the systemic discrimination and stigmatization of trans, nonbinary, and other gender-diverse (TGD) people is ubiquitous in Western cultures. One form of cisgenderism, cisnormativity, is an ideology that assumes gender is determined by the sex assigned at birth (Hyde et al. 2019; Martin and Slepian, 2021; Morgenroth et al. 2021; Parker, Horowitz, and Brown 2022; Tan et al. 2020), and that “privileges cisgender people” (Tan et al. 2020, 1474) while minoritizing and marginalizing TGD individuals (Ansara and Hegarty 2012, 2014). TGD people experience other forms of cisgenderism including misgendering, significant obstacles to accessing health care, being denied access to the restroom or toilet of their choice, and being pathologized because of their gender identity (Ansara and Hegarty 2014; James et al. 2016; Rogers 2021). Under former President Trump, the Department of Health and Human Services proposed a definition of *sex* that would have essentially defined people who identify as a gender other than the one assigned at birth out of existence (Green, Benner, and Pear 2018). Stigmatization of TGD people continues with cisgenderism becoming enshrined in anti-trans laws in the United States (American Civil Liberties Union 2024).

Not surprisingly, cisgenderism can have severe consequences for TGD people’s health. One framework for understanding the effects of minoritization on people’s health is the minority stress model (Brooks 1981; Meyer 2003). Testa and colleagues (2015) expanded the framework to include stressors that were specific to TGD people, such as non-affirmation of one’s gender identity. Recent researchers have recommended incorporating protective factors into the framework, such as social support (Frost and Meyer 2023; Tan et al. 2020). A primary purpose of this study was to examine minority stress factors associated with the psychological wellbeing of TGD people in the U.S. who were assigned female at birth (AFAB). Specifically, we investigated cisgenderism as exemplified by non-affirmation of and discomfort in disclosing one’s gender identity, negative expectations for the future, and internalized transnegativity. In addition, we examined factors that may ameliorate the effects of cisgenderism including social support, intimate relationship satisfaction and gender-affirming behaviors such as legal gender marker changes and surgeries. Finally, few studies have examined the associations between gender-affirming behaviors and cisgenderist experiences such as gender non-affirmation; therefore, we also explored these associations.

PSYCHOLOGICAL WELLBEING OF TGD PEOPLE

Compared to cisgender people, TGD people experience higher rates of psychological distress such as depression, anxiety, and suicidal ideation and attempts (Hendricks and Testa 2012; James et al. 2016; Pinna et al. 2022; The Trevor Project 2023). Cisgenderist experiences including stigmatization and marginalization contribute to this psychological distress.

One type of stigmatization is gender non-affirmation which happens when a trans person's "internal sense of gender identity is not affirmed by others" (Testa et al. 2015, 66). Romantic partners may engage in non-affirming behaviors such as minimizing a TGD person's gender identity in public (Pulice-Farrow, Brown, and Galupo 2017). TGD individuals may experience gender non-affirmation because of legislation or other policies that create obstacles to accessing gender-affirming health care or changing gender markers on legal documents (Malta et al. 2020; Puckett et al. 2018). Gender non-affirmation is associated with psychological distress (Barr et al. 2022; Ralston et al. 2022). TGD people who can engage in gender-affirming behaviors, such as hormone treatments, surgeries, or changing gender markers on legal documents, report less psychological distress and a better quality of life than those who cannot engage in such behaviors (Almazan and Keuroghlian 2021; Baker et al. 2021; Glynn et al. 2016; Hughto et al. 2020; Scheim, Perez-Brumer, and Bauer 2020; Tomita, Testa, and Balsam 2019; Turban et al. 2020). Furthermore, Hollister (2023) found that TGD people who engaged in gender-affirming behaviors such as hormone treatment, surgeries, name change, and gender marker change, reported lower gender non-affirmation scores than those who did not.

Because of cisgenderism, deciding when and if to disclose one's gender identity can be difficult. Nondisclosure can be protective, especially if a TGD person anticipates negative or hostile reactions from others (Gorman et al. 2022; Kade 2021; Rood et al. 2017; Testa et al. 2015). In addition, some trans men may not disclose their gender identity to certain people because they are easily recognized as men and/or they no longer think that being trans is important information others need to know about them (Kade 2021). Nevertheless, some TGD people who do not disclose their gender identity may experience psychological distress (Hughto et al. 2020; Livingston et al. 2020; McKay and Watson 2020) and less life satisfaction (Flynn and Bhambhani 2021).

Experiences with cisgenderism may lead TGD individuals to expect negative future events or reactions. Rood and colleagues (2016) found that expectations of being rejected were common among TGD individuals, and that these expectations were associated with anxiety, stress, and depressive mood. In addition, negative expectations for the future predict anxiety and depression in TGD people (Ralston et al. 2022; Testa et al. 2015). Cisgenderism engaged in by a TGD person's intimate partner is a crucial aspect of intimate partner violence (IPV) (Rogers 2021). For example, Taber and colleagues (2023) found that cisgenderism in the form of identity-specific IPV, such as sabotaging transition by hiding or destroying hormones, predicted more negative expectations, which in turn predicted poorer psychological health in trans and gender non-conforming young adults.

Stigmatization, marginalization, and pathologization of TGD people can lead them to experience self-blame and low self-esteem, which can result in negative appraisals and even loathing of their gender identity (Bockting et al. 2020). This experi-

ence is termed internalized transnegativity (Testa et al. 2015). Research from several countries has found that internalized transnegativity significantly predicts psychological distress (Barr et al. 2022; Bockting et al. 2020; Garro et al. 2022; Inderbinen et al. 2021; Lee et al. 2020; Ralston et al. 2022; Scandurra et al. 2018; Taber et al. 2023; Veale, Tan, and Byrne 2022) and less life satisfaction (Flynn and Bhambhani 2021).

Social support can ameliorate some of the effects of cisgenderism, as well as create safe spaces for TGD people. Support from family and peers (Glynn et al. 2016; Gorman et al. 2022; Johnson and Rogers 2020; Kia et al. 2021; Milton and Knutson 2023) is associated with better psychological health. In addition to family and peer support, TGD people with supportive partners report better psychological health than those with unsupportive partners (Giammattei 2015; Malpas 2006; St. Amand et al. 2013). As mentioned earlier, unsupportive partners may engage in cisgenderism such as misgendering, denigration of the TGD person's desirability as an intimate partner, and preventing hormone use (James et al. 2016; Peitzmeier et al. 2019; Pulice-Farrow, Brown, and Galupo 2017). TGD individuals who undergo hormone treatments and/or gender-affirming surgeries may experience additional stressors in their intimate relationships (Marshall et al. 2020), including the intimate partner(s) feeling frustrated or confused with how changes in their TGD partner will affect their own gender identity and sexual orientation (Cook-Daniels 2015; Giammattei 2015; Levitt and Ippolito 2014; Pulice-Farrow, Brown, and Galupo 2017). Nevertheless, supportive partners can buffer psychological distress in TGD people undergoing gender-affirming medical treatments (St. Amand et al. 2013).

CURRENT STUDY

Results from multiple studies demonstrate significant associations between cisgenderist experiences and TGD individuals' psychological wellbeing. Furthermore, social support, supportive intimate partner relationships, and gender-affirming behaviors may buffer these negative experiences. Our sample focused on TGD people in the U.S. who were assigned female at birth. We predicted that psychological wellbeing, specifically low levels of depression and anxiety and high levels of life satisfaction, would be associated with less gender non-affirmation, nondisclosure, negative expectations, and internalized transnegativity; more family support and satisfaction with one's intimate partner relationship; and engaging in gender-affirming behaviors, such as legal gender marker changes and surgeries. We also hypothesized that engaging in gender-affirming behaviors would predict less gender non-affirmation. Finally, we compared the experiences of AFAB individuals who identified as trans men with those who indicated nonbinary identities and explored associations between gender-affirming behaviors and gender minority stressors.

METHOD

This study was determined to be exempt by the university Institutional Review Board. The first author identifies as a Filipino American, cisgender, heterosexual woman. The second author identifies as a white, cisgender, heterosexual woman. The third author identifies as a white trans man.

Participants

Participants included TGD individuals 18 years or older in the U.S. who spoke English. We sent the survey link to medical clinics and legal services that serve TGD people, faculty in gender and LGBTQIA+ studies programs at US universities, and social media sites that targeted LGBTQIA+ communities and their allies. Informed consent was obtained from all participants.

A total of 172 people responded to the survey. Data were excluded for the following reasons: participants younger than 18 years old ($n = 6$); no information on gender identity ($n = 5$); identified as cisgender ($n = 5$); were assigned male at birth (AMAB, $n = 18$); wrong answers on attention checks ($n = 1$); and excessive missing data ($n = 56$). The final sample included 81 participants with usable data.

The average age of participants was 25 years ($SD = 6.22$, range 18–49 years). Most participants identified as white (90.1%), 2.5% Hispanic/Latinx, 2.5% Asian/Asian American, and 4.9% multiracial. Relationship status included 11.1% married, 8.6% engaged, 12.3% living together but not married, 23.5% dating someone, 1.2% separated, 7.4% polyamorous, 25.9% single but interested in dating someone, and 9.9% single but not interested in dating someone. Most identified as bisexual (35.8%); 14.8% gay; 11.1% heterosexual; 2.5% lesbian; 9.9% queer; 9.9% pansexual; 7.4% asexual; 1.2% each gay/asexual, pansexual/queer, polyromantic/asexual, panromantic/demi, or dates “women, AFAB, and AMAB trans people”; and 2.5% indicated not liking labels. Most identified as male (28.4%) or trans men (43.2%); 16% as nonbinary; 3.7% as transmasculine, 2.5% as nonbinary trans men; and 1.2% each as genderfluid, transmasculine nonbinary, genderqueer, genderfluid/transmasculine, or gender nihilist/transmasculine. Around 65.4% had some college or a college degree, 13.6% a graduate degree or some graduate education, 16% a high school diploma, and 4.9% had less than a high school diploma. Reported income levels were 59.3% below \$25,000, 30.9% between \$25,001 and \$50,000, and 9.9% above \$50,001.

Measures

Demographic questionnaire

We gathered information on age, education level, relationship status, ethnicity, gender assigned at birth, current gender identity, sexual orientation, and income level. One item assessed perception of current overall support on a scale of 1 (strongly disagree) to 5 (strongly agree): “I currently have a strong support system.”

To assess gender-affirming behaviors, we asked participants whether they were taking hormones, had gender-affirming surgeries, had changed their name, had changed their gender markers on legal documents, and were expressing their gender in their clothing, hair style, etc. Responses were coded as 0 (no), 1 (yes), and 2 (want to/in process).

Cisgenderist experiences

We used subscales from the Gender Minority Stress and Resilience Measure (Testa et al. 2015) to assess internalized transnegativity, gender non-affirmation, negative expectations for the future, and gender identity nondisclosure. Each subscale used Likert-type responses ranging from 0 (strongly disagree) to 4 (strongly agree).

The internalized transphobia subscale consists of eight items, e.g., “I resent

my gender identity or expression.” Scores could range from 0 to 32 with higher scores indicating more internalized transnegativity. Internal reliability was good at $\alpha = .90$ (Testa et al. 2015) and .91 for the current sample.

The gender non-affirmation subscale consists of six items, e.g., “I have difficulty being perceived as my gender.” Scores could range from 0 to 24 with higher scores indicating more non-affirmation. Internal reliability was good at $\alpha = .93$ (Testa et al. 2015) and .92 for the current sample.

The negative expectations subscale consists of nine items, e.g., “If I express my gender identity/history, others wouldn’t accept me.” Scores could range from 0 to 36 with higher scores indicating more negative expectations. Internal reliability was good at $\alpha = .89$ (Testa et al. 2015) and .88 for the current sample.

The nondisclosure subscale consists of five items, e.g., “Because I don’t want others to know my gender identity/history, I modify my way of speaking.” Scores could range from 0 to 20 with higher scores indicating more nondisclosure. Internal reliability was good at $\alpha = .80$ (Testa et al. 2015) and .88 for the current sample.

Family support

We used the six-item Family of Origin subscale from the Daily Heterosexist Experiences Questionnaire (Balsam, Beadnell, and Molina 2013) to assess family support, e.g., “Being rejected by your father for being transgender.” Participants indicated how distressed or bothered they were on a 6-point scale of severity ranging from 0 (did not happen to me) to 5 (ot happened, and it bothered me extremely). Scores were reversed such that higher scores indicated more family support and could range from 0 to 30. Internal reliability was good at $\alpha = .79$ (Balsam, Beadnell, and Molina 2013) and .75 for the current sample.

Intimate partner relationship

Satisfaction with one’s intimate partner relationship was assessed with the five-item Intimacy subscale from the Transgender Positive Identity measure (Riggle and Mohr 2015). The *LGBT* acronym in the original items was replaced with *gender identity*, e.g., “My gender identity allows me to be closer to my intimate partner.” Responses were scored from 1 (strongly disagree) to 7 (strongly agree) and could range from 5 to 35. Higher scores indicated a more positive view of their intimate partner relationship. Internal reliability was good at $\alpha = .92$ (Riggle and Mohr 2015) and .92 for the current sample.

Satisfaction with life scale

Deiner et al.’s (1985) five-item scale was used to measure participants’ satisfaction with their life, e.g., “I am satisfied with life.” This scale was scored from 1 (strongly disagree) to 7 (strongly agree) and could range from 5 to 35, with higher scores indicating greater life satisfaction. Internal reliability was good at $\alpha = .87$ (Diener et al. 1985) and .89 for the current sample.

Generalized Anxiety Disorder-7 (GAD-7)

Spitzer et al.’s (2006) seven-item measure was used to assess anxiety levels over the last two weeks, e.g., “Trouble relaxing.” Responses were on a 4-point scale ranging from 0

Table 1. Correlations for study variables for the total sample

Variable	1	2	3	4	5	6	7	8	9	10
1. GAD-7										
2. PHQ-9 ^a	.68***									
3. Life satisfaction ^a	-.43***	-.58***								
4. Family support	-.28*	-.29*	0.19							
5. Overall support	-.45***	-.52***	.60***	.35**						
6. Intimacy	-.11	-.17	.47***	-.05	.29*					
7. Internalized transnegativity	.34**	.42***	-.49***	-.27*	-.54***	-.32**				
8. Non-affirmation	.30**	.44***	-.43***	-.18	-.34**	0	.26*			
9. Nondisclosure	.41***	.23	-.28*	-.38***	-.24*	-.17	.33**	-.07		
10. Negative expectations	.31**	.29*	-.27*	-.48***	-.24*	.05	.20	.07	.46***	

Note. Sample size was 71–81. ^aPartial correlations were calculated for depression and life satisfaction, controlling for income level. * $p < .05$, ** $p < .01$, *** $p < .001$.

(not at all) to 3 (nearly every day) and could range from 0 to 21 with higher scores indicating more anxiety. Internal reliability was good at $\alpha = .87$ (Spitzer et al. 2006) and .92 for the current study.

Patient Health Questionnaire-9 (PHQ-9)

Kroenke, Spitzer, and Williams's (2001) nine-item measure was used to assess depressive symptoms over the last two weeks, e.g., "Feeling down, depressed, or hopeless." Responses were scored on a 4-point scale ranging from 0 (not at all) to 3 (nearly every day) and could range from 0 to 27 with higher scores indicating more depressive mood. Internal reliability was good at $\alpha = .86-.89$ (Kroenke, Spitzer, and Williams 2001) and .90 for the current study.

Procedure

Participants read the informed consent and then completed the demographic questionnaire. The gender non-affirmation, negative expectations, nondisclosure, internalized transnegativity, family support, intimacy, life satisfaction, GAD-7, and PHQ-9 scales were presented in a random order. Two attention-check statements were presented at different points in the survey. Participants could enter a drawing to win one of four \$50 Amazon.com gift cards. Participants who chose to enter the drawing provided their email address in a separate survey so that their data were not associated with their contact information.

RESULTS

The average score of a scale's completed items were imputed for missing values when 10% or fewer of the responses were missing. Because of small sample sizes in some of the gender identity groups, we created two groups: trans men (male or transmen) and people who reported nonbinary identities (nonbinary, genderqueer, etc.).

According to the Shapiro-Wilk test of normality, several of the variables were non-normally distributed. Therefore, we used Mann-Whitney *U*-tests to compare scores on the continuous variables between trans men and nonbinary participants, and between people engaging or not engaging in gender-affirming behaviors. Pearson correlations were calculated to examine associations among variables.

Factors Associated with Psychological Wellbeing

Age did not correlate significantly with any of the study variables. Income level correlated significantly with depression, $r(78) = -.23, p = .039$, and life satisfaction, $r(78) = .32, p = .004$; therefore, we controlled for it in the following analysis. Table 1 presents the correlations among the study variables. Anxiety and depression were positively and strongly correlated with each other and moderately to strongly with internalized transnegativity, non-affirmation, and negative expectations. Anxiety and depression were negatively and strongly correlated with life satisfaction and overall support, and moderately with family support. There was a strong positive association between anxiety and nondisclosure. Life satisfaction was associated positively and strongly with overall support and intimacy satisfaction, and negatively and moderately to strongly with internalized transnegativity, non-affirmation, negative expectations, and non-

Table 2. Medians for continuous variables for gender identity groups

Variable	Trans Men	Nonbinary people	Total	Range
Age	23	24	23	18–49
Anxiety	10.0	10.5	10.0	0–21
Depression	13.0	13.0	12.0	0–27
Life satisfaction	20.0	18.0	20.0	5–35
Family support	23.0	22.5	23.0	0–30
Overall support	4.0	4.0	4.0	1–5
Intimacy	25.0	23.0	24.0	5–35
Internalized transnegativity	13.0	12.0	12.5	0–30
Non-affirmation	11.0 _a	20.0 _b	14.5	0–24
Nondisclosure	15.5	10.0	15.0	0–20
Negative expectations	24.0	24.0	24.0	0–37

Note. Sample sizes were 54–58 for trans men and 20–23 for nonbinary people. Medians with different subscripts differed significantly.

Table 3. Percentages of participants engaging in gender-affirming behaviors

Variable	Yes	No	Want to
Hormones			
Trans men	74.1%	17.2%	8.6%
Nonbinary people	43.5%	47.8%	8.7%
Surgeries			
Trans men	34.5%	53.4%	12.1%
Nonbinary people	26.1%	60.9%	13.0%
Gender Marker Change			
Trans men	44.8%	46.9%	8.6%
Nonbinary people	17.4%	73.9%	8.7%
Name Change			
Trans men	48.3%	39.7%	12.1%
Nonbinary people	56.5%	34.8%	8.7%
Presentation			
Trans men	100%	0%	0%
Nonbinary people	95.6%	4.4%	0%

Note. Sample sizes were 58 trans men and 23 nonbinary people.

Table 4. Medians for continuous variables for taking hormones

Variables	Trans Men			Nonbinary People		
	Yes	No	Range	Yes	No	Range
Anxiety	9.5	14	0–21	12	9	4–21
Depression	9.5	14.5	0–27	13.5	10	4–24
Life satisfaction	22	16.5	5–35	19	17	5–30
Family support	23	25	0–30	15	27	7–30
Overall support	4	3.5	1–5	4	4	1–5
Intimacy	25	19.5	5–35	24	17.5	5–35
Internalized transnegativity	11.5	17	0–30	14.5	12	2–22
Non-affirmation	8 _a	18 _b	0–24	19	19	9–24
Nondisclosure	15.5	16	0–20	15 _a	7 _b	0–20
Negative expectations	25	21	4–37	26	21	0–35

Note. Yes = took hormones; No = did not take hormones. Sample sizes were as follows: Trans men Yes = 40–43, No = 9–10; Nonbinary people Yes = 9–10, No = 9–11. Medians with different subscripts within each gender identity category differed significantly.

disclosure. There were moderate to strong negative correlations between family and overall support and internalized transnegativity, nondisclosure, and negative expectations. Overall support also correlated negatively and moderately with non-affirmation and positively and moderately with family support and intimacy satisfaction. Intimacy satisfaction was negatively and moderately correlated with internalized trans negativity. Non-affirmation was correlated positively and moderately with internalized transnegativity and nondisclosure. Finally, there was a strong positive correlation between negative expectations and nondisclosure).

Using a Bonferroni adjustment for multiple tests ($p = .005$), Mann-Whitney U -tests indicated a strong effect between gender identity and non-affirmation scores with trans men reporting significantly lower scores than nonbinary participants, $U = 1054.50$, $z = 4.25$, $p < .001$, $r = .48$. None of the other comparisons were significant. See Table 2 for medians for trans men and nonbinary participants.

Gender-Affirming Behaviors

See Table 3 for the percentages of participants engaging in gender-affirming behaviors. All participants except for one nonbinary person expressed their gender identity via clothing, hairstyle, etc. We examined gender-affirming behaviors for trans men and nonbinary participants using Chi-square analyses with a Bonferroni adjustment of $p = .013$. Due to small sample sizes among those who wanted to engage in the behaviors in the future, we only included participants who indicated they had engaged/were engaging or had not engaged in the behaviors. Compared to nonbinary people, trans men were moderately more likely to be taking hormones, $\chi^2(1, N = 74) = 8.31$, $p = .004$, $\phi = .34$. The two groups did not differ significantly in gender affirming surgeries, $\chi^2(1, N = 71) = .53$, $p = .468$, $\phi = .086$; gender marker changes, $\chi^2(1, N = 74) = 5.62$, $p = .018$, $\phi = .28$; and name change, $X^2(1, N = 72) = .30$, $p = .585$, $\phi = .06$. Trans men and nonbinary people were combined for subsequent analyses, excepting for hormone use.

Table 5. Medians for continuous variables for gender-affirming surgeries, gender marker changes, and name change

Variables	Gender-Affirming Surgeries			Gender Marker Changes			Name Change		
	Yes	No	Range	Yes	No	Range	Yes	No	Range
Anxiety	9	11	0–21	11	11	0–21	11.5	9	0–21
Depression	8	13	0–26	9	13	0–27	12	11	0–27
Life satisfaction	24 _a	18 _b	5–35	22.5 _a	18 _b	5–35	20	19.5	5–35
Family support	20	24.5	0–30	23.5	23	0–30	22	25	0–30
Overall support	4	4	1–5	4.5	4	1–5	4	4	1–5
Intimacy	28	22.5	5–35	25	23	5–35	24.5	23	5–35
Internalized transnegativity	11	12.5	0–30	10	13	0–30	12	12	0–30
Non-affirmation	11	17	0–24	8.5 _a	18 _b	0–24	13	18	0–24
Nondisclosure	15	14	0–20	15	13.5	0–20	16	13	0–20
Negative expectations	25	23	0–37	23	24	0–37	23	24	0–37

Note. Yes = engaged in behavior; No = did not engage in behavior. Sample sizes were as follows: Surgeries Yes = 25–26, No = 40–45; Gender Marker Changes Yes = 27–30, No = 40–44; Name Change Yes = 37–41, No = 28–31. Medians with different subscripts for each type of gender-affirming behavior differed significantly.

We used Mann-Whitney *U*-tests with a Bonferroni correction ($p = .005$) to examine differences in the study variables between participants who had engaged/were engaging and were not engaging in gender-affirming behaviors. See Tables 4 and 5 for the medians.

Trans men taking hormones had significantly and moderately lower non-affirmation scores than trans men not taking hormones, $U = 81.00$, $z = -2.73$, $p = .005$, $r = .38$. There was a strong association between taking hormones and nondisclosure scores among nonbinary people with those taking hormones having significantly higher scores than those not taking hormones, $U = 75.00$, $z = 3.06$, $p = .001$, $r = .72$. There was a strong association between gender-affirming surgeries and life satisfaction scores; those who had gender-affirming surgeries reported more life satisfaction than those who had not, $U = 884.00$, $z = 3.80$, $p < .001$, $r = .45$. Compared to participants who had not changed gender markers, participants who had scored significantly and moderately higher on life satisfaction, $U = 896.50$, $z = 2.83$, $p = .005$, $r = .33$, and significantly and strongly lower on non-affirmation $U = 279.50$, $z = -4.10$, $p < .001$, $r = .48$. None of the other hormone, gender-affirming surgeries, and gender marker change comparisons were significant. Also, none of the name change comparisons were significant.

DISCUSSION

Gender non-affirmation, negative expectations for the future, and internalized transnegativity had significant and moderate to strong positive associations with anxiety and depression, as well as dissatisfaction with life. These results confirm what other researchers have found regarding the toll that cisgenderism can have on TGD individuals' psychological wellbeing (Barr et al. 2022; Bockting et al. 2020; Inderbinen et al. 2021; Ralston et al. 2022; Taber et al. 2023; Testa et al. 2015).

Consistent with other research, nondisclosure of one's gender identity was a strong predictor of anxiety and a moderate predictor of less life satisfaction (Hughsto et al. 2020; Flynn and Bhambhani 2021). However, contrary to other findings (Hughsto et al. 2020; McKay and Watson 2020), depression was not associated with nondisclosure. Nondisclosure of one's gender identity may be used to shield a person from negative experiences (Gorman et al. 2022; Rood et al. 2017). Perhaps, in our sample, nondisclosure was protective against depressive mood but not anxiety.

Although family support had moderate associations with anxiety and depression, the largest effect sizes were seen for the overall support measure. Overall support was also strongly associated with life satisfaction. Additionally, family and overall support were moderately to strongly predictive of less nondisclosure and internalized transnegativity, and fewer negative expectations (Testa et al. 2017); however, only overall support moderately predicted less gender non-affirmation. These results suggest that although family support may be important for some TGD individuals, other forms of social support may be even more important. Participants may perceive overall support in multiple ways including support from friends, online support networks, therapists, and intimate partners. Johnson and Rogers (2020) found that TGD community involvement provided peer support, hence creating safe spaces for TGD people, normalizing the trans experience, and empowering trans people to help others. This, in turn, may improve psychological health (see also Gorman et al. 2022; Kia et al. 2021;

Pulice-Farrow et al. 2023).

Satisfaction with one's intimate relationship did not predict anxiety or depression. Du Bois et al. (2021) found that being in an intimate relationship predicted less depression in trans women, but not trans men; however, they did not assess relationship satisfaction. We found that intimacy satisfaction had strong positive associations with life satisfaction and moderate negative associations with internalized transnegativity. Intimacy satisfaction may reflect support from one's intimate partner(s), which in turn may ameliorate negative feelings about one's gender identity. For example, Kline and Randall (2021) found that less internalized transnegativity was associated with more sexual satisfaction among trans men. We cannot determine whether participants' internalized transnegativity preceded or developed during their relationship(s). TGD people may internalize negative messages about their gender identity from their partners (Pulice-Farrow, Brown, and Galupo 2017), resulting in internalized transnegativity that leads to dissatisfaction with their intimate relationship(s). Alternatively, dissatisfaction with one's intimate relationship(s) may lead to internalized transnegativity.

Contrary to other research (Almazan and Keuroghlian 2021; Baker et al. 2021; Glynn et al. 2016; Hughto et al. 2020; Scheim, Perez-Brumer, and Bauer 2020; Tomita, Testa, and Balsam 2019; Turban et al. 2020) engaging in gender-affirming behaviors, specifically hormone use, surgeries, legal gender marker changes, and name change, was not associated with anxiety or depression. Unfortunately, we could not compare people who wanted to but had not yet engaged in gender-affirming behaviors because of small sample sizes. In addition, we did not ask participants who had not engaged in gender-affirming behaviors whether they wanted to engage in those behaviors, and we did not ask about types of surgeries participants had undergone. Both of these factors may be important in predicting psychological wellbeing (Almazan and Keuroghlian 2021; Tomita, Testa, and Balsam 2019).

Nevertheless, having gender-affirming surgeries was a strong predictor and making legal gender marker changes was a moderate predictor of more life satisfaction. In addition, there was a moderate effect for hormone use with trans men who used hormones reporting more gender affirmation than trans men who did not use hormones; this was not the case for nonbinary participants (see also Hollister 2023). This result should be interpreted cautiously because of the small number of trans men who were not using hormones. However, testosterone produces dramatic physical changes including increased facial and body hair and a deeper voice (Irwig 2017). These physical changes may make it easier for trans men to present as their gender identity which may lead to more gender-affirmation from others. Such physical changes may be less desirable or not as important among nonbinary participants. Indeed, consistent with other findings, nonbinary participants were less likely to report using hormones than trans men (James et al. 2016; Lane, Waljee, and Stroumsa 2022; Puckett et al. 2018). However, another reason for lower hormone use among nonbinary people in our sample could be obstacles to obtaining gender-affirming care. For example, nonbinary and genderqueer people report being disrespected and misunderstood, as well as pressured to adhere to a binary transgender label by health care providers (Lykens, LeBlanc, and Bockting 2018).

Interestingly, there was a large effect for non-disclosure and hormone use for

nonbinary people, but not trans men. Non-binary people were more likely to disclose their gender identity if they were not taking hormones. Perhaps the dramatic physical changes that accompany testosterone use make it harder for a nonbinary person to disclose their nonbinary identity. However, again, these results should be interpreted cautiously because of the small number of nonbinary participants. One factor we did not examine is the different reasons people may have for disclosing or not disclosing their gender identity. Disclosure depends on the person(s) to whom one is disclosing, the expectations for positive or negative outcomes after disclosure, as well as the importance of gender identity to oneself (Kade 2021). Finally, regardless of gender identity, making legal gender marker changes strongly predicted lower gender non-affirmation scores (Hollister 2023). This result reinforces the importance of recognizing and legitimizing diverse gender identities, which in turn allows TGD people to access health care and other services more easily (Malta et al. 2020; Scheim, Perez-Brumer, and Bauer 2020).

The only minority stressor that exhibited a strong difference between trans men and nonbinary participants was gender non-affirmation, with nonbinary people reporting more non-affirmation. This finding is consistent with other research (Hollister 2023; Jäggi et al. 2018; Testa et al. 2017). Trans men may experience some benefits because of their binary trans identity that AFAB nonbinary people do not. For example, Johnson et al. (2023) found that, compared to binary trans people, nonbinary individuals reported experiencing more invalidation of their gender identity because it did not fit in a binary conceptualization of gender. This invalidation may come from cisgender people who adhere to a cisnormative ideology, as well as from other trans people who feel that nonbinary people are not trans enough (Pulice-Farrow, Brown, and Galupo 2017). Invalidation of a person's gender identity not only happens at the individual level but is also systemic as evidenced by the plethora of anti-trans bills introduced across the U.S. (American Civil Liberties Union 2023). Because of this overt attempt to invalidate TGD identities, researchers should consider reframing non-affirmation as anti-affirmation.

Limitations, Future Research, and Implications

Our participants were a convenience sample of mainly white, relatively well-educated, English-speaking young adults from the U.S.; therefore, results may not generalize to other TGD people in the U.S. or other countries. In the 2015 U.S. Transgender Survey, James et al. (2016) found that trans people of color were more likely than white trans people to report less family support, more psychological distress and poverty, and they were more likely to be uninsured, unable to access health care, and drop out of college. Furthermore, trans people with less formal education reported more psychological distress (James et al. 2016). Age may influence the experiences with psychological distress and gender minority stressors (Puckett et al. 2022; Scandurra et al. 2021; Tan, Ellis et al. 2020), as well as interact with gender identity in determining when people medically and/or socially transition (Tatum et al. 2020). More research is needed on how other identities, such as social class and culture, intersect with gender identity to influence stigmatization and experiences with cisgenderism (Tan et al. 2020; Ralston et al. 2022). Finally, our sample was biased toward people who had access to health clinics, university programs, and social media sites with an LGBTQIA+ focus. This may

have affected the diversity of our sample regarding gender identities, sexual identities, age, ethnicity, race, and native language.

Our study focused on people who were AFAB; therefore, results may not generalize to people who are intersex or were AMAB. Researchers have noted differences between people who are AFAB and AMAB, including psychological health indices and experiences with minority stressors and gender-affirming behaviors (Poquiz et al. 2021; Puckett et al. 2018; Puckett et al. 2022; Tan, Ellis et al. 2020; Tatum et al. 2020). Although we found some differences between binary trans men and nonbinary participants, the number of nonbinary participants was relatively small and heterogeneous with regard to self-identification. This heterogeneity may have obscured differences between diverse gender identities. Finally, our analyses may have obscured important differences among sexually-diverse people. TGD people with stigmatized sexual orientations may experience gender minority stressors, social support, and psychological health differently than those with a heterosexual orientation (Dyar et al. 2020; Eisenberg et al. 2019; Pulice-Farrow et al. 2023).

Although overall support was a strong predictor of psychological health and some of the gender minority stressors, it was assessed with only one item. Furthermore, it is important to examine other sources of support besides the family, including friends, online groups, and TGD communities (Gorman et al. 2022; Johnson and Rogers 2020; Kia et al. 2021), given that a relatively high percentage of TGD people experience rejection from their family of origin (James et al. 2016). In addition, two items on the family support measure asked about mothers and fathers; some of our participants may have other parent-figures that do not fit this heterosexual configuration. Furthermore, the family support measure did not examine 'chosen families' which can include family-of-origin members as well as friends, neighbors, intimate partners, and others, and which can be important to the wellbeing of TGD people (Cassidy 2020; Levin et al. 2020). Our measure of intimate relationship satisfaction was worded to indicate one partner, making it potentially difficult for participants with more than one partner to respond. Excluding non-monogamous relationships, such as polyamory, from measures of relationship satisfaction further stigmatizes an already marginalized group and ignores the substantial proportion of people in the U.S. who are in polyamorous relationships (Moors 2023; Moors, Gesselman, and Garcia 2021). Furthermore, compared to people in monogamous relationships, people in polyamorous relationships are more likely to identify with TGD identities (Balzarini et al. 2019). Although we included the six people who indicated they were in a polyamorous relationship in the analyses, their experiences with intimacy, psychological health, and cisgenderism may differ from those in monogamous relationships.

The gender minority stress model has provided an important framework for understanding factors that contribute to the wellbeing of people with stigmatized gender identities. However, Diamond and Alley (2022) postulate that minority stress by itself cannot explain health problems of TGD people. Specifically, TGD people live in a cisnormative society where experiencing threats to one's gender identity, such as non-affirmation and negative expectations for the future, can result in feelings of unsafety, or not feeling socially accepted, included, protected, connected, or recognized (Diamond and Alley 2022). Feelings of unsafety may lead to constant vigilance for expected future threats that can contribute to poor health. In the U.S., many anti-trans

bills have been proposed or passed (American Civil Liberties Union 2024) and political rhetoric has overtly stigmatized TGD people, making TGD people feel more unsafe and anxious about their future wellbeing (DuBois et al. 2023; Horne et al. 2022). It is important for psychologists, and other health professionals and social scientists, to critically examine cisgenderism in their professions (Ansara and Hegarty 2012, 2014; Johnson 2015; van Anders et al. 2023) so that they can conduct more ethical and just research and provide better care to TGD individuals. However, it is equally important to advocate for systemic social change in institutional and political arenas in order to meaningfully address cisgenderism and cisnormativity and create safe social spaces for everyone.

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