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ORIGINAL ARTICLES

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Prioritizing Trans Autonomy over Medical Authority in Gender-Affirming Care: The Role of Risk and Uncertainty

Kai Jacobsen
is a MA student in the Department of Sociology and Anthropology at Carleton University. They hold a BA Honors in Sociology and Gender Studies from the University of Victoria.
✉ kaijacobsen@cmail.carleton.ca

Historically, gender-affirming medical care has been provided through an assessment-based model of care that prioritizes the clinician's expertise and authority over the trans individual's desires or lived experience, whichhas been widely critiqued by trans communities. More recently, informed consent approaches that de-emphasize formal mental health assessments are becoming increasingly common in gender-affirming care. However, previous research has found that many gender-affirming care providers continue to practice gatekeeping despite using the language of informed consent. In this article, I analyze the tensions between medical authority and patient autonomy in the recently updated 8th edition of the World Professional Association for Transgender Health (WPATH) Standards of Care (SOC-8). I find that while the SOC-8 generally supports informed consent models, when faced with heightened risk or uncertainty, the SOC-8 reverts to an assessment-based model of care that reinforces medical authority and compromises trans people's autonomy. I argue that without deconstructing the assumed authority and expertise of healthcare providers, we cannot achieve fully equitable and accessible gender-affirming care. Specifically, gender-affirming care providers must practice epistemic humility and value trans peoples' lived experience as legitimate sources of knowledge. I suggest strategies for teaching clinicians to value trans people's autonomy and embodied knowledge.

KEYWORDS gender-affirming care; transgender; informed consent; medical authority; decision-making; autonomy
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Gender-affirming care—used here to refer to medical interventions such as hormones and surgery for transgender people seeking to change their body to better affirm their gender identity—is essential to many trans people's health and wellbeing (Coleman et al. 2022). However, experiences of gatekeeping, paternalism, pathologization, and

transphobic stigma and discrimination have led many trans people to mistrust health care providers (Fraser, Brady, and Wilson 2021; MacKinnon et al. 2020; Riggs et al. 2019; Shook et al. 2022; shuster 2021). A recurring tension in gender-affirming care is balancing health care providers' medical authority and expertise with patients' autonomy and self-knowledge. In this article, I investigate how the recently updated global clinical guidelines for gender-affirming care—the 8th edition of the World Professional Association for Transgender Health's (WPATH) Standards of Care (SOC-8)—deal with this tension. I find that while the guidelines generally emphasize the importance of patient autonomy, the SOC-8 reverts to prioritizing medical authority over patient autonomy when faced with heightened uncertainty or risk. I argue that to provide truly equitable gender-affirming care that centers trans people's self-determination, clinicians must practice epistemic humility and recognize trans peoples' embodied knowledge as legitimate, valid, and important.

Anyone accessing health care services is subjected to medical authority, but trans people's lives are especially controlled by medical authority. Gender-affirming medical care is necessary for many trans people's ability to live as their authentic self with integrity (Rowland, 2023). While many individuals rely on medical interventions to live, gender-affirming care is unique in that it impacts an individual's embodied gender expression in a culture where gender is seen as an essential and inextricable part of an individual's personhood and humanity (Martin and Mason 2022). Further, the legacy of psychopathologizing transness casts undue suspicion on trans people's self-knowledge and grants clinicians the epistemic power to (dis)believe trans people's asserted gender identity. As such, I argue that medical authority exerts disproportionate power over trans lives.

I begin by briefly outlining the history of gender-affirming care and the shift from older gatekeeping models of care to newer informed consent models. I highlight how uncertainty leads to conflict between medical authority and patient autonomy in gender-affirming care. I then carefully analyze of the SOC-8 and find that despite the contemporary shift towards informed consent models of care, the SOC-8 continues to prioritize clinicians' authority over trans people's self-determination when faced with heightened uncertainty or risk. I argue that equitable access to gender-affirming care is not possible until we deconstruct medical authority used to control trans lives. Finally, I consider the implications of my argument for future clinical practice and research.

HISTORY OF GENDER-AFFIRMING CARE

Gender-affirming hormones and surgeries have existed since at least the early 20th century (Gill-Peterson 2018). However, the foundation of the contemporary model of access to gender-affirming medical care in North America did not emerge until the 1950s and 60s. Endocrinologist Dr. Harry Benjamin is widely credited with pioneering gender-affirming care in North America (Gill-Peterson 2018; shuster 2021). His 1966 book *The Transsexual Phenomenon* presented a typology of trans people along with treatment recommendations. According to Benjamin (1966), only individuals with extreme distress related to their assigned gender and strong cross-gender identification should be allowed to access gender-affirming care. To differentiate these "true transsexuals"

from "fetishistic transvestites," (Benjamin 1966, 23), Benjamin began referring patients to psychiatrists for assessment (Marrow 2023a; 2023b; shuster 2021; Velocci 2021). In part, these psychiatric evaluations were used to determine the patient's likelihood of successfully assimilating into cisnormative society after transitioning (Marrow 2023a; 2023b; shuster 2021; Velocci 2021). Beans Velocci (2021) and Elliot Marrow (2023a; 2023b) have argued that Benjamin and his colleagues also used psychiatric evaluations to ensure patients were unlikely to regret their decisions and therefore to avoid future lawsuits. As such, while Benjamin's 'true transsexual' diagnostic criteria were in theory about authenticating gender identity, in practice the criteria bolstered doctors' professional credibility and protected them from legal liability (Marrow 2023a; 2023b; shuster 2021; Velocci 2021).

Also in the 1960s, several university-based gender-affirming care clinics opened in the US (Magrath 2022; Marrow 2023b). These clinics conducted extensive and invasive assessments for patients seeking gender-affirming care and often required participation in unethical and demeaning research (Marrow 2023b). Before accessing hormones or surgeries, patients had to pass the 'real life test' of living in their chosen gender role for months or years—a requirement that persisted for decades (Amengual et al. 2022; Marrow 2023b). Consistent with Benjamin's protocol, patients were expected to fully assimilate into cisnormative society by adopting a gender-normative job, being in a heterosexual relationship, and concealing their transgender status (Marrow 2023b; shuster 2023; Velocci 2021). These criteria permitted very few trans people to access gender-affirming care and excluded many trans people because of their race, class, mental illness, substance use, or sexuality (Marrow 2023b; shuster 2023; Velocci 2021). Further, the criteria emphasized binary gender roles and normative femininity and masculinity (shuster 2021; 2023).

By the 1980s, many university-based gender clinics closed as transphobia and negative publicity grew (Magrath 2022; Marrow 2023b). In 1979, the Harry Benjamin International Gender Dysphoria Association (HBIGDA) was founded and published the first Standards of Care (SOC) (Amengual et al. 2022; Marrow 2023b). The SOC codified and standardized the assessments used by clinics, which made gender-affirming care more widely accessible through private practice providers while retaining strict gatekeeping protocols (Marrow 2023b). Periodic revisions to the SOC gradually relaxed requirements while maintaining the real-life test, mental health evaluation, and diagnostic criteria (Amengual et al. 2022). Now in their 8th edition, the SOC are published by WPATH—the renamed HBIGDA—and are widely used across the globe. While the real-life test is no longer used, trans people must still complete a mental health or readiness assessment before accessing gender-affirming care (Coleman et al. 2022).

While adult access to gender-affirming medical care has increased in recent decades, youth access has been inconsistent and rare. For much of the 20th century, psychotherapeutic approaches focused on 'treating' childhood gender deviance to prevent adult transsexuality (Gill-Peterson 2018). By the 1970s, some clinicians began to offer gender-affirming care to post-pubescent adolescents, but access was limited and often structured along racialized and classed lines (Gill-Peterson 2018). In the late 1990s, a group of Dutch clinicians began prescribing puberty-suppressing medications to trans youth after extensive longitudinal assessment (de Vries and Cohen-Kettenis 2012). Pausing puberty gave the youth time to solidify their gender identity before begin-

ning hormones at age 16 and surgery at age 18 (de Vries and Cohen-Kettenis 2012). The Dutch approach emphasized "watchful waiting" and assumed that most gender-expansive young people would grow into cisgender adults (de Vries and Cohen-Kettenis 2012). The model was adopted internationally by a growing number of youth gender clinics, some of whom later adapted the Dutch protocol and developed the gender affirmative model (Hidalgo et al. 2013; Keo-Meier and Ehrensaft 2018). This model offers medical interventions as one part of holistic supports for affirming the child's gender expression in developmentally appropriate ways (Hidalgo et al. 2013; Keo-Meier and Ehrensaft 2018). Unlike the Dutch protocol, the gender affirmative supports social transition at all ages and does not model prescribe minimum ages for hormones or surgery (Hidalgo et al. 2013; Keo-Meier and Ehrensaft 2018). The gender affirmative model informs the SOC-8 clinical guidance for youth and has been endorsed by many professional organizations (Coleman et al. 2022; Ehrensaft 2021).

CONTEMPORARY APPROACHES TO GENDER-AFFIRMING CARE

The SOC has become a guiding text for clinicians who provide gender-affirming care. While the SOC allows for flexible interpretation across clinics and jurisdictions, it has still cemented a transnormative narrative that has been recirculated for decades as trans people learn from their peers what clinicians expect to hear. (Bradford and Syed 2019; Riggs et al. 2019; shuster 2021). To conform to this narrative, many trans people emphasize childhood gender nonconformity and feelings of dysphoria and distress during mental health and readiness assessments and hide any doubt or uncertainty (Bradford and Syed 2019; Fraser, Brady, and Wilson 2021; Johnson 2019; Spade 2003). Nonbinary people face added pressure to prove they are 'trans enough' to access care, given the history of requiring normative binary gender expression to access care (Fraser, Brady, and Wilson 2021; Kinney and Cosgrove 2022; Lampe 2023; Occhino and Skewes 2020). Many trans people do not view mental health and readiness assessments as a safe therapeutic space and describe feeling defensive and powerless against clinicians who can grant or deny them access to life-changing care (Dewey 2015; Fraser, Brady, and Wilson 2021; Horton 2022; Lane 2018; Shook et al. 2022). While recent editions of the SOC emphasize that mental health providers should focus on supporting patient readiness rather than evaluating gender identity (Coleman et al. 2022), many trans people remain distrustful of health care providers (Dewey 2015; Fraser, Brady, and Wilson 2021).

Though phrases like "true transsexual" are no longer used, stef shuster (2021, 99) has argued that clinicians conducting readiness and mental health assessments for gender-affirming care still focus on identifying worthy patients:

> No longer within the discourse of "sane" or "insane," the distinction is now more covertly asserted through the language of "risk," which continues to be established based on whether or not a patient has physical or mental health issues or is perceived to develop them when initiating trans-related medical interventions.

Indeed, research has found that readiness and mental health assessments are particularly fraught for trans people with psychiatric diagnoses, as some clinicians doubt these individuals' self-identification and instead attribute their gender dysphoria to

their diagnosis (MacKinnon et al. 2021; 2020; Lane 2018). In these assessments, "risk" becomes a key tool to enact medical authority, gatekeeping, and injustice.

Clinicians' concerns about risk are often tied to legal liability. Several researchers have found that some gender-affirming care providers structure their clinical practices to prevent medical malpractice lawsuits from patients who regret their medical decisions (Blasdel et al. 2022; Dewey 2015; Lane 2018; MacKinnon et al. 2021; shuster 2021). These clinicians tend to closely follow the SOC guidelines and may require additional psychiatric evaluations for patients who they perceive as being at risk of regretting gender-affirming care (Dewey 2015; Lane 2018; MacKinnon et al. 2021). As media attention on individuals who detransition or regret their gender-affirming care choices surges, legal liability and fear of regret may increasingly impact clinical practice (MacKinnon et al. 2021).

Clinicians' fear of regret reflects a broader tendency to value medical authority over trans people's embodied knowledge. Devaluing trans people's self-knowledge is an example of epistemic injustice—unjustly discrediting the knowledge of a person or community (Enxuga 2022; Fricker 2007). Since gender-affirming care is rarely covered in medical education, trans people often know much more about their own healthcare than their typically-cisgender clinicians. However, health care providers' position as medical experts means that their knowledge is assumed to be authoritative and accurate, even when it is based on transphobic stereotypes and ignorance. Consequently, trans people's knowledge is frequently treated as suspicious, subjective, biased, and unreliable, while clinician's knowledge is treated as trustworthy, objective, expert, and reliable. As such, a trans person expressing a desire and readiness for gender-affirming care is seen as insufficient evidence to provide that care; instead, an external assessment must validate the trans person's identity and desires.

As I have shown, the logic of requiring mental health assessments for gender-affirming care is inextricable from the historical pathologization of transness. Cisgender patients regularly receive many of the same hormonal and surgical interventions as trans people without any mental health assessment (Latham 2017; Schall and Moses 2023). However, a few other surgeries require preoperative psychological assessment, such as bariatric weight-loss surgery and organ transplants (Bailey et al. 2021; Sogg, Lauretti, and West-Smith 2016). However, the justifications for these assessments differ from their use in gender-affirming care. In bariatric surgery, preoperative assessments are used to identify and manage psychosocial risk factors which are known to significantly impact postoperative outcomes (Sogg et al. 2016). Similarly, organ transplants rely on a very limited supply of organs, and as such, psychosocial assessments are used to identify candidates with the strongest likelihood of postoperative success (Bailey et al. 2021). Nonetheless, assessments for organ transplants and bariatric surgery also raise similar ethical challenges related to epistemic injustice and medical authority (Parker and Chin 2020; Rouleau, Rash, and Mothersill 2016). Unique to gender-affirming care, though, is the use of psychological assessment to prevent patient regret (MacKinnon et al. 2021) However, there is no evidence that these assessments predict or prevent regret (Ashley, Parsa, et al. 2023). Further, only about 1% of patients regret gender-affirming surgery (Bustos et al. 2021), compared to 14% of patients who had any other type of surgery (Wilson, Ronnekleiv-Kelly, and Pawlik 2017). The preoccupation with preventing gender-af-

firming care regret reflects a deeper lack of trust in trans people to define their identity and make decisions for themselves.

To avoid the problems with assessments, some gender-affirming care providers have implemented an informed consent model of care (ICM) (Cavanaugh, Hopwood, and Lambert 2016; Gerritse et al. 2021). Informed consent is a crucial part of all medicine and involves communication between a clinician and a patient about the risks, benefits, and alternatives of a medical intervention (Shah et al. 2022). ICMs for gender-affirming care differ from this more general definition in that they prioritize informed consent over other considerations in clinical decision-making (Cavanaugh, Hopwood, and Lambert 2016; Gerritse et al. 2021). Specific protocols vary between clinics, with some ICMs still involving mental health professionals in patient assessment but not requiring a formal readiness letter, and others not requiring any mental health assessment at all (Ashley, St. Amand, and Rider 2021). ICMs task healthcare providers with educating and supporting the patient's decision-making, rather than acting as gatekeepers (Gerritse et al. 2021). In doing so, ICMs are thought to value patient self-knowledge and reduce barriers to care. However, not all ICMs prioritize patient autonomy equally, and balancing patient autonomy with medical authority remains an ongoing debate in gender-affirming care.

EVIDENCE, EXPERTISE, AND UNCERTAINTY IN GENDER-AFFIRMING CARE

As ICMs gain popularity, shuster (2021) has argued that many gender-affirming care providers perform the language of informed consent while still acting in ways that prioritize their own authority and expertise over their patients' autonomy. shuster (2021) has argued that one key reason for this is that clinicians feel they are operating with limited evidence and great uncertainty regarding the risks and benefits of gender-affirming care. While gender-affirming care is an established field of science and medicine and is endorsed by many major medical organizations (Coleman et al. 2022), randomized-controlled trials of gender-affirming care are ethically and methodologically difficult and existing evidence is largely comprised of observational research designs (Ashley et al. 2023). In particular, research on the long-term outcomes of various hormonal and surgical interventions is lacking (Coleman et al. 2022). The SOC have historically relied on expert consensus and clinicians' professional experience, with later editions increasingly drawing on published scientific research (Coleman et al. 2022). The SOC-8, released in September 2022, employs the most evidence-based and scientifically rigorous methodology to date, with recommendations based on systematic reviews and approved through a Delphi consensus method (Coleman et al. 2022). Still, the guidelines identify numerous topics where more research is needed to develop an evidence-based guideline.

In addition to the limitations of the research evidence, medical education rarely prepares clinicians to serve trans clients. Medical school curriculums typically devote little or no time to gender-affirming care (Obedin-Maliver et al. 2011; Tollemache, Shrewsbury, and Llewellyn 2021). Consequently, physicians may not be comfortable prescribing hormones or referring patients to gender-affirming surgeons, unless they seek out additional education on their own (Christopherson et al. 2022; Kent et al. 2022; Shires et al. 2018b; 2018a). Given this lack of education, gender-affirming care

providers often turn to their intuition to resolve their discomfort with risk and uncertainty (shuster 2021). However, clinicians' assessment of risks and benefits may not align with their patients' priorities. Pervasive anti-trans stigma may lead clinicians to emphasize the potential risks of gender-affirming care over potential benefits (Cavanaugh, Hopwood, and Lambert 2016; Poteat, German, and Kerrigan 2013). Conversely, many trans people do not trust health care providers and feel pressure to demonstrate unhesitating certainty with no doubts or worries about their treatment (Dewey 2015). However, clinicians may interpret a patient's reluctance to discuss treatment risks as a sign of unrealistic expectations or as a threat to the clinician's expertise. These differing interpretations of a patient's behavior may spawn mutual mistrust and disrupt the therapeutic relationship. Unarticulated differences between clinicians' and patients' perceptions of risk and uncertainty are an ongoing source of tension in gender-affirming care.

Previous qualitative interviews with gender-affirming care providers have found that clinicians interpret the SOC in a variety of ways (Dewey 2015; Dewey, Oppenheim, and Watson 2023; Gerritse et al. 2021; Lane 2018; Poteat, German, and Kerrigan 2013; shuster 2021). Some providers treat the SOC guidelines as a strict rulebook and cite the guidelines as justification for delaying or denying gender-affirming care (Dewey, Oppenheim, and Watson 2023; Lane 2018; shuster 2021). Others emphasize the SOC's flexibility and view the guidelines as a general roadmap to guide decision-making and individualized care (Dewey, Oppenheim, and Watson 2023; shuster 2021). Given the wide variation in interpretations of the SOC guidelines, clinicians appear to cite the SOC to legitimate their work as aligned with best practices, regardless of what the SOC actually says (Dewey, Oppenheim, and Watson 2023; shuster 2021). However, even the most flexible and patient-centered clinicians who view themselves more as supporters than gatekeepers still wield significant power over trans people's ability to access life-saving medical care (Dewey, Oppenheim, and Watson 2023; shuster 2021).

Existing research has primarily focused on how clinicians interpret the DSM-5 and the SOC-7, and the revised SOC-8 has yet to be examined. As the field of gender-affirming care evolves and the political and scientific climate shifts rapidly, clinicians' strategies for dealing with uncertainty may change. As such, the role of risk and uncertainty in gender-affirming care requires further scholarly attention.

ANALYSIS OF WPATH SOC-8

The SOC-8 represents a significant step forward in gender-affirming care. Broadly, the new guidelines shift away from the assessment-based gatekeeping model of care. The SOC-8 mentions informed consent models as an emerging area of research and "supports the role of informed decision-making and the value of harm reduction approaches" (Coleman et al. 2022, 6). The guidelines repeatedly emphasize individualized, patient-centered care and recommends a "collaborative decision-making" approach that "recognizes the lived experience and self-knowledge of the TGD [transgender and/or gender-diverse] person and the clinical knowledge of the assessing health care professional" (Coleman et al. 2022, 31). On the surface, these quotes suggest that the SOC-8 has left paternalism and gatekeeping behind. However, a careful read of the SOC-8 highlights several areas where the guidelines return to emphasizing assessment.

Adolescent Chapter

The first of these areas is Chapter 6 on Adolescents, where the guidelines recommend additional assessment for some youth seeking gender-affirming care based on perceived heightened risk. The chapter recommends that all youth seeking gender-affirming medical care should undergo a "comprehensive biopsychosocial assessment," ideally conducted by a multidisciplinary team (Coleman et al. 2022, 48). In contrast, assessments for adults do not have to be multidisciplinary and may be relatively brief depending on the patient's needs and complexity (Coleman et al. 2022). The SOC-8 suggests that for youth who have complex mental health histories, autistic traits, or did not experience gender incongruence as a child, "a more extended assessment process may be useful" (Coleman et al. 2022, 51). This extended process "may include additional time and structured opportunities for the young person to practice the skills necessary for medical decision-making" (Coleman et al. 2022, 62). While the guidelines recommend that assessments should be "collaborative and supportive" (Coleman et al. 2022, 50), previous research suggests that trans youth do not experience assessments as safe or supportive environments (Fraser, Brady, and Wilson 2021; Horton 2022; Shook et al. 2022; Strauss et al. 2022). Many trans youth describe feeling defensive and powerless and needing to prove that they are 'trans enough' to pass the clinician's tests (Fraser, Brady, and Wilson 2021; Shook et al. 2022; Horton 2022). If adolescents feel they must prove their gender and desire for gender-affirming care to clinicians, it may be difficult for them to practice and develop skills in medical decision-making in the context of a high-stakes assessment.

The SOC-8 recommends that adolescents should only receive gender-affirming care when their "experience of gender diversity/incongruence is marked and sustained over time." (Coleman et al. 2022, 60). This requirement has been previously articulated as youth being "insistent, persistent, and consistent" about their gender identity (Hidalgo et al. 2013, 286). Yet the guidelines also note that adolescents must demonstrate the "emotional and cognitive maturity" necessary to understand the long-term consequences of medical interventions (Coleman et al. 2022, 61). In particular, the guidelines suggest that clinicians should consider whether the adolescent has "thought through the implications of what they might do if their priorities around gender do change in the future" (Coleman et al. 2022, 62). Simultaneously then, young people seeking gender-affirming care must demonstrate consistent and persistent desires, yet also have a plan for the possibility that their desires will not be consistent and persistent in the future. This places adolescents in an impossible double bind, where their unhesitating certainty could be used as evidence of being both ready and not ready for a gender-affirming medical intervention.

Trans historian Jules Gill-Peterson (2018) has argued that the contemporary moral panic surrounding trans youth is driven by larger societal discourses that frame youth as precious, pristine resources that must be carefully shaped and guided towards successful normative futures and away from 'deviant' trans futures. As such, a logic of protectionism and risk aversion guides the SOC-8 to recommend extensive assessment of all youth seeking gender-affirming care, but especially those whose identities, diagnoses, or life experiences do not neatly align with existing clinical research on trans youth. The Adolescent chapter conceptualizes risk and uncertainty as significant threats to good medical practice that should be managed through patient assessment.

An alternative approach to managing risk and uncertainty is providing additional supports rather than additional assessments. Rather than asking whether a youth can do a particular skill, clinicians could ask what supports a youth needs to be able to do that skill. Such supports could be provided concurrent with gender-affirming medical interventions rather than as a prerequisite. For example, if a youth struggles with future-oriented thinking and hopelessness, clinicians might support the youth to reflect on their desires for the future as their body begins to change with hormone therapy. As trans people often experience reduced suicidality and increased hope for the future after beginning hormones (Allen et al. 2019; Baker et al. 2021; Chen et al. 2023; Green et al. 2022), this approach would capitalize on the mental health benefits of gender-affirming care to develop the youth's skills. Further, providing supports outside of the high-pressure assessment setting and without tying them to access to gender-affirming care may enable youth to engage with the supports more fully. This strategy would fulfill the SOC-8 guidelines' goal of providing additional supports to neurodivergent youth without burdening them with additional assessments.

Nonbinary Chapter

Another area where the SOC-8 recommends a comprehensive, multidisciplinary assessment is in the Nonbinary chapter. The SOC-8 recommends that surgeons should "consult a comprehensive, multidisciplinary team of professionals in the field of transgender health" when patients request an "individually customized" surgery (Coleman et al. 2022, 133). The text defines these surgeries as "1) a procedure that alters an individual's gender expression without necessarily aiming to express an alternative, binary gender; 2) the 'non-standard' combination of well-established procedures; or 3) both" (Coleman et al. 2022, 133). The SOC-8 does not provide examples of individually customized surgeries, and the vague wording suggests that some surgeons may require additional assessment for *all* patients seeking to express a nonbinary gender, not just those seeking less common surgical procedures. The SOC-8 goes on to explain that since individually customized surgeries are backed by less research evidence than more common standardized surgeries, patients must understand the risks and uncertainties of such a procedure (Coleman et al. 2022). This approach appears to promote transparency and collaborative decision-making with the patient when there is no clear research evidence to guide the decision.

However, not all individually customized surgeries lack evidence or carry higher risks to the patient. For example, phalloplasty without urethral lengthening is associated with fewer complications than the more conventional phalloplasty without urethral lengthening (de Rooij et al. 2022). Similarly, vulvoplasty—also known as shallow-depth vaginoplasty, which creates an external vulva without an internal vaginal canal—has fewer risks than the more common full-depth vaginoplasty, yet surgeons often deny requests for this procedure because the resulting genitals do not enable penetrative sex (Milrod, Monto, and Karasic 2019; Stelmar et al. 2023). Finally, a double incision mastectomy without nipple grafts is thought to be at least as safe, if not safer than one with nipple grafts, but may be deemed unusual because it does not create a normative masculine chest (Cuccolo et al. 2019; Esmonde et al. 2019). Of course, some individually customized surgeries do come with increased risks. For example, phalloplasty with urethral lengthening without vaginectomy carries an increased risk of

urethral fistula (Al-Tamimi et al. 2018). However, I argue that a well-informed patient who understands the risks and benefits of their surgical choice should not be subjected to additional psychosocial assessments simply because their surgical preference has greater risks than a more common procedure.

Individual clinicians must decide when a multidisciplinary assessment is required. In doing so, clinicians should consider the patient's knowledge of the risks and benefits of the procedure as well as the research and clinical evidence for the specific procedure requested, rather than automatically requiring additional assessment for all nonbinary people seeking surgery or all requests for individually customized surgeries. Dewey and colleagues (2023) has found that some clinicians already use the language of multidisciplinary to justify denying gender-affirming care to clients until they are treated by a mental health professional. As such, it is reasonable to be concerned that the SOC-8 guidelines may be used to enforce transnormativity and gender binarism by subjecting nonbinary people to additional psychopathologizing assessments, even if this is not the intention of the SOC-8.

It is important to note that multidisciplinary *care* is not synonymous with multidisciplinary *assessment*. While multidisciplinary care offers different types of care from a variety of professionals, multidisciplinary assessments require multiple evaluations for a single type of care. Many trans people benefit from multidisciplinary care that does not involve additional assessments. For example, some gender-affirming care clinics in the US have developed innovative multidisciplinary surgical preparedness programs that have high patient satisfaction and fewer barriers to care compared to traditional assessment-based models (Lichtenstein et al. 2020; Poceta et al. 2019). At its best, multidisciplinary gender-affirming care should provide holistic, patient-centered supports without creating additional barriers to care.

The above analysis of the Nonbinary and Adolescent chapters of the SOC-8 demonstrates that behind the language of patient-centered and individualized care, the SOC-8 continues to conceptualize risk and uncertainty as threats to good medical practice. While all gender-affirming care providers face ethical and epistemic challenges, different strategies can have very different consequences for trans people. Determining how clinicians can best navigate these challenges and improve trans people's healthcare experiences is therefore a critical task.

FUTURE DIRECTIONS AND PROMISING PRACTICES

Efforts to improve trans experiences of health care often focus on educating clinicians about trans people and their healthcare needs through cultural competency training (Dubin et al. 2018; van Heesewijk et al. 2022). However, merely increasing providers' knowledge about trans people may be insufficient to improve medical care for trans people, given the unresolved questions of uncertainty, evidence, and authority (shuster 2021). Further, research by Stroumsa and colleagues (2019) found that higher levels of transphobia was associated with clinician's knowledge of transgender health care, but number of hours of relevant education was not, suggesting that addressing transphobic attitudes may be more important than providing education. shuster has argued that clinicians "need to become more flexible in navigating professional norms and questioning the utility of evidence-based medicine, and to begin placing more

trust in clients as the experts over their bodies and identities" (2021, 166). However, encouraging clinicians to confront the limits of their own expertise and recognize their patients' self-knowledge is challenging in a cultural context that positions doctors as the ultimate experts.

Informed consent models of gender-affirming care, as described above, represent one strategy for resolving these epistemic challenges. However, recent research by Gabriel Enxuga (2022) found that patients who accessed gender-affirming hormone therapy through ICMs and traditional assessment models both experienced epistemic injustice through invalidation and dismissal. This suggests that even when operating in an informed consent model of care, clinicians are still influenced by transnormative 'born in the wrong body' narratives. shuster's (2021) work indicates that dominant ideas of clinical authority and expertise also guide clinicians working in informed consent models and contribute to epistemic injustice. As such, implementing informed consent models of care is one important step toward improving gender-affirming care, but must be considered alongside other strategies.

One such strategy is explicitly teaching healthcare students and practitioners about epistemic issues in medicine. Weingartner and colleagues (2022) have proposed *epistemic peerhood* as a model for doing so in gender-affirming care. They argue that healthcare providers should view their patients as epistemic peers—that is, as holding knowledge that is equally as valuable as their knowledge as clinicians (Weingartner et al. 2022). Importantly, epistemic peerhood does not imply that clinicians and patients possess the *same* knowledge, but rather, recognizes that both forms of knowledge are needed to create the best care plan for the patient (Weingartner et al. 2022). Weingartner et al. have suggested that one way to teach epistemic peerhood in medical education settings is by bringing trans people in as guest speakers and explicitly "naming what [they] are doing: treating patients as epistemic peers and placing value on their embodied knowledge" (2022, 6). In the realm of chronic pain, Buchman and colleagues (2017) have proposed *epistemic humility* as a framework. Epistemic humility as a clinical skill encourages health care providers to critically evaluate their beliefs about authority and expertise and to identify the limits of their knowledge (Buchman, Ho, and Goldberg 2017). Buchman and colleagues (2017) argue that developing epistemic humility requires explicit training in socio-emotional and communication skills that are often absent from medical education. Including trans people as patient partners and developing curriculum to teach empathy, communication, and collaboration to clinicians are already widely recognized as important aspects of medical education about trans health care (Dubin et al. 2018; van Heesewijk et al. 2022). However, explicitly introducing the frameworks of epistemic peerhood and humility may help clinicians to deal with uncertainty in their work without perpetuating the harms of epistemic injustice and gatekeeping.

While I have argued here that pathologizing transness embeds epistemic injustice in gender-affirming care readiness assessments, epistemic injustice occurs in many other health care settings. Research has identified epistemic injustice in clinical decision-making related to organ transplantation (Parker and Chin 2020), childbirth (Villarmea and Kelly 2020), chronic pain (Buchman, Ho, and Goldberg 2017), chronic fatigue syndrome (Blease, Carel, and Geraghty 2017), and mental health care (Grim et al. 2019), among others. Future scholarship should explore the parallels between gen-

Table 1. Summary of problems identified with soc-8 and suggested approaches

Problem	Suggested Approach
Extended assessments for neurodivergent youth can be distressing and harmful	Provide additional supports concurrent to gender-affirming medical interventions rather than extending assessments
Requiring multidisciplinary assessments for "individually customized surgical requests" may increase barriers to care	Evaluate the risks and benefits of the procedure and the patient's knowledge before referring for additional assessment
Multidisciplinary assessments may increase barriers to care	Provide multidisciplinary, holistic supports that do not require additional assessments
When faced with risk or uncertainty, clinicians typically prioritize their own expertise over patient's self-knowledge, resulting in epistemic injustice for trans people	Use epistemic humility or epistemic peerhood as a framework for medical education
Increasing providers' knowledge about trans people does not address underlying issues of uncertainty, risk, and liability	Incorporate strategies for prioritizing patient autonomy and informed consent into gender-affirming care medical education
Extended assessments for neurodivergent youth can be distressing and harmful	Provide additional supports concurrent to gender-affirming medical interventions rather than extending assessments

der-affirming care and other sites of epistemic injustice in health care, and potential shared strategies for promoting epistemic humility and justice for all patients across a variety of health care settings.

Future research should investigate the effectiveness of different supports for gender-affirming care providers to deal with uncertainty. Researchers and practitioners developing educational resources for clinicians about gender-affirming care should consider evaluating epistemic humility as a learning outcome and clinical skill. MacKinnon and Ross' (2019) website *Path to Patient-Centered Care* is one example of an educational resource for clinicians on gender-affirming care that discusses strategies for prioritizing patient autonomy. Future research could investigate the learning outcomes and practice implications for clinicians who access the website.

Since the influence of the SOC-8 depends on how clinicians interpret it, the impact of the additional assessments proposed in the Nonbinary and Adolescent chapters remains to be seen. The SOC-8 may have little influence on care if providers simply continue with their usual practices. Alternatively, clinicians may turn to the SOC-8 to justify requiring extended or additional assessments for neurodivergent youth and nonbinary people. Future research should explore these possibilities.

CONCLUSION

While informed consent models are one important strategy for promoting patient autonomy and self-knowledge in gender-affirming care, additional strategies are needed to achieve fully equitable and accessible gender-affirming care. Table 1 summarizes the problems of uncertainty, risk, and assessment in the SOC-8 and the alternative approaches suggested in this article. Considering epistemic humility as a key clinical skill offers one potential path forward, but more research is needed to develop ad-

ditional strategies. To avoid repeating the historical harms of gatekeeping models of gender-affirming care, we must remain attentive and reflexive to issues of uncertainty, risk, authority, expertise, and liability seriously, and develop strategies to confront these challenges.

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REFERENCES

Allen, Luke R., Laurel B. Watson, Anna M. Egan, and Christine N. Moser. 2019. "Well-Being and Suicidality among Transgender Youth after Gender-Affirming Hormones." *Clinical Practice in Pediatric Psychology* 7 (3): 302–11. https://doi.org/10.1037/cpp0000288.

Al-Tamimi, Muhammed, Garry L. Pigot, Wouter B. van Der Sluis, Tim C. van De Grift, Margriet G. Mullender, Freek Groenman, and Mark-Bram Bouman. 2018. "Colpectomy Significantly Reduces the Risk of Urethral Fistula Formation after Urethral Lengthening in Transgender Men Undergoing Genital Gender Affirming Surgery." *Journal of Urology* 200 (6): 1315–22. https://doi.org/10.1016/j.juro.2018.07.037.

Amengual, Travis, Kaitlyn Kunstman, R. Brett Lloyd, Aron Janssen, and Annie B. Wescott. 2022. "Readiness Assessments for Gender-Affirming Surgical Treatments: A Systematic Scoping Review of Historical Practices and Changing Ethical Considerations." *Frontiers in Psychiatry* 13 (October): 1–17. https://doi.org/10.3389/fpsyt.2022.1006024.

Ashley, Florence, Neeki Parsa, til kus, and Kinnon R. MacKinnon. 2023. "Do Gender Assessments Prevent Regret in Transgender Healthcare? A Narrative Review." *Psychology of Sexual Orientation and Gender Diversity*, October. https://doi.org/10.1037/sgd0000672.

Ashley, Florence, Colton M. St. Amand, and G. Nic Rider. 2021. "The Continuum of Informed Consent Models in Transgender Health." *Family Practice* 38 (4): 543–44. https://doi.org/10.1093/fampra/cmab047.

Ashley, Florence, Diana M. Tordoff, Johanna Olson-Kennedy, and Arjee J. Restar. 2023. "Randomized-Controlled Trials Are Methodologically Inappropriate in Adolescent Transgender Healthcare." *International Journal of Transgender Health*, June, 1–12. https://doi.org/10.1080/26895269.2023.2218357.

Bailey, Pippa, Nikhil Vergis, Michael Allison, Amy Riddell, and Emma Massey. 2021. "Psychosocial Evaluation of Candidates for Solid Organ Transplantation." *Transplantation* 105 (12): e292. https://doi.org/10.1097/TP.0000000000003732.

Baker, Kellan E, Lisa M Wilson, Ritu Sharma, Vadim Dukhanin, Kristen McArthur, and Karen A. Robinson. 2021. "Hormone Therapy, Mental Health, and Quality

of Life among Transgender People: A Systematic Review." *Journal of the Endocrine Society* 5 (4). https://doi.org/10.1210/jendso/bvab011.

Benjamin, Harry. 1966. *The Transsexual Phenomenon*. Human Outreach & Achievement Institute.

Blasdel, Gaines, Avery Everhart, Colt St. Amand, Monica Gaddis, and Frances Grimstad. 2022. "How Do Prescribing Clinicians Obtain Consent to Initiate Gender-Affirming Hormones?" *Transgender Health*, June, 1–8. https://doi.org/10.1089/trgh.2021.0208.

Blease, Charlotte, Havi Carel, and Keith Geraghty. 2017. "Epistemic Injustice in Healthcare Encounters: Evidence from Chronic Fatigue Syndrome." *Journal of Medical Ethics* 43 (8): 549–57. https://doi.org/10.1136/medethics-2016-103691.

Bradford, Nova J., and Moin Syed. 2019. "Transnormativity and Transgender Identity Development: A Master Narrative Approach." *Sex Roles* 81 (5): 306–25. https://doi.org/10.1007/s11199-018-0992-7.

Buchman, Daniel Z., Anita Ho, and Daniel S. Goldberg. 2017. "Investigating Trust, Expertise, and Epistemic Injustice in Chronic Pain." *Journal of Bioethical Inquiry* 14 (1): 31–42. https://doi.org/10.1007/s11673-016-9761-x.

Bustos, Valeria P., Samyd S. Bustos, Andres Mascaro, Gabriel Del Corral, Antonio J. Forte, Pedro Ciudad, Esther A. Kim, Howard N. Langstein, and Oscar J. Manrique. 2021. "Regret after Gender-Affirmation Surgery: A Systematic Review and Meta-Analysis of Prevalence." *Plastic and Reconstructive Surgery. Global Open* 9 (3): e3477. https://doi.org/10.1097/GOX.0000000000003477.

Cavanaugh, Timothy, Ruben Hopwood, and Cei Lambert. 2016. "Informed Consent in the Medical Care of Transgender and Gender-Nonconforming Patients." *AMA Journal of Ethics* 18 (11): 1147–55. https://doi.org/10.1001/journalofethics.2016.18.11.sect1-1611.

Chen, Diane, Johnny Berona, Yee-Ming Chan, Diane Ehrensaft, Robert Garofalo, Marco A. Hidalgo, Stephen M. Rosenthal, Amy C. Tishelman, and Johanna Olson-Kennedy. 2023. "Psychosocial Functioning in Transgender Youth after 2 Years of Hormones." *New England Journal of Medicine* 388 (3): 240–50. https://doi.org/10.1056/NEJMoa2206297.

Christopherson, Lisette, Krishia McLaren, Lori Schramm, Carla Holinaty, Ginger Ruddy, Emily Boughner, Adam Clay, Michelle McCarron, and Megan Clark. 2022. "Assessment of Knowledge, Comfort, and Skills Working with Transgender Clients of Saskatchewan Family Physicians, Family Medicine Residents, and Nurse Practitioners." *Transgender Health* 7 (5): 468–72. https://doi.org/10.1089/trgh.2020.0181.

Coleman, E., A. E. Radix, W. P. Bouman, G. R. Brown, A. L. C. de Vries, M. B. Deutsch, R. Ettner, et al. 2022. "Standards of Care for the Health of Transgender and Gender Diverse People, Version 8." *International Journal of Transgender Health* 23 (sup1): S1–259. https://doi.org/10.1080/26895269.2022.2100644.

Cuccolo, Nicholas G., Christine O. Kang, Elizabeth R. Boskey, Ahmed M. S. Ibrahim, Louise L. Blankensteijn, Amir Taghinia, Bernard T. Lee, Samuel J. Lin, and Oren Ganor. 2019. "Masculinizing Chest Reconstruction in Transgender and Nonbinary Individuals: An Analysis of Epidemiology, Surgical Technique, and Postoperative Outcomes." *Aesthetic Plastic Surgery* 43 (6): 1575–85. https://doi.

org/10.1007/s00266-019-01479-2.
de Rooij, Freek P. W., Wouter B. van der Sluis, Brechje L. Ronkes, Thomas D. Steensma, Muhammed Al-Tamimi, R. Jeroen A. van Moorselaar, Mark-Bram Bouman, and Garry L. S. Pigot. 2022. "Comparison of Surgical Outcomes and Urinary Functioning after Phalloplasty with versus without Urethral Lengthening in Transgender Men." International Journal of Transgender Health 24 (4): 487–98. https://doi.org/10.1080/26895269.2022.2110548.
de Vries, Annelou L. C., and Peggy T. Cohen-Kettenis. 2012. "Clinical Management of Gender Dysphoria in Children and Adolescents: The Dutch Approach." *Journal of Homosexuality* 59 (3): 301–20. https://doi.org/10.1080/00918369.2012.653300.
Dewey, Jodie M. 2015. "Challenges of Implementing Collaborative Models of Decision Making with Trans-Identified Patients." *Health Expectations* 18 (5): 1508–18. https://doi.org/10.1111/hex.12133.
Dewey, Jodie M., Ellie R. Oppenheim, and Dennis P. Watson. 2023. "(Dis) Empowering Trans People: Depathologization Through Treatment Guidelines and Provider Decision-Making." *Humanity & Society*, March, 016059762311623. https://doi.org/10.1177/01605976231162341.
Dubin, Samuel N., Ian T. Nolan, Carl G. Streed, Richard E. Greene, Asa E. Radix, and Shane D. Morrison. 2018. "Transgender Health Care: Improving Medical Students' and Residents' Training and Awareness." *Advances in Medical Education and Practice* 9 (May): 377–91. https://doi.org/10.2147/AMEP.S147183.
Ehrensaft, Diane. 2021. "Gender Affirmative Model." In *The SAGE Encyclopedia of Trans Studies*, edited by Abbie E. Goldberg and Genny Beemyn, 286–89. London Los Angeles: SAGE Reference.
Enxuga, Gabriel. 2022. "The Authority to Claim Identity: Epistemic Justice in Gender-Affirming Healthcare." Master of Social Work Thesis, McGill University. https://escholarship.mcgill.ca/concern/theses/x346d935d.
Esmonde, Nick, Aaron Heston, Breanna Jedrzejewski, Elie Ramly, Alvin Annen, Jess Guerriero, Juliana Hansen, and Jens Berli. 2019. "What Is 'Nonbinary' and What Do I Need to Know? A Primer for Surgeons Providing Chest Surgery for Transgender Patients." *Aesthetic Surgery Journal* 39 (5): NP106–12. https://doi.org/10.1093/asj/sjy166.
Fraser, G., A. Brady, and M. S. Wilson. 2021. "'What If I'm Not Trans Enough? What If I'm Not Man Enough?': Transgender Young Adults' Experiences of Gender-Affirming Healthcare Readiness Assessments in Aotearoa New Zealand." *International Journal of Transgender Health* 22 (4): 454–67. https://doi.org/10.1080/26895269.2021.1933669.
Fricker, Miranda. 2007. *Epistemic Injustice: Power and the Ethics of Knowing*. Oxford: University Press.
Gerritse, Karl, Laura A. Hartman, Marijke A. Bremmer, Baudewijntje P. C. Kreukels, and Bert C. Molewijk. 2021. "Decision-Making Approaches in Transgender Healthcare: Conceptual Analysis and Ethical Implications." *Medicine, Health Care and Philosophy*, May. https://doi.org/10.1007/s11019-021-10023-6.
Gill-Peterson, Jules. 2018. *Histories of the Transgender Child*. Minneapolis: University Of Minnesota Press.
Green, Amy E., Jonah P. DeChants, Myeshia N. Price, and Carrie K. Davis. 2022. "As-

sociation of Gender-Affirming Hormone Therapy with Depression, Thoughts of Suicide, and Attempted Suicide Among Transgender and Nonbinary Youth." *Journal of Adolescent Health* 70 (4): 643–49. https://doi.org/10.1016/j.jadohealth.2021.10.036.

Grim, Katarina, Malin Tistad, Ulla-Karin Schön, and David Rosenberg. 2019. "The Legitimacy of User Knowledge in Decision-Making Processes in Mental Health Care: An Analysis of Epistemic Injustice." *Journal of Psychosocial Rehabilitation and Mental Health* 6 (2): 157–73. https://doi.org/10.1007/s40737-019-00145-9.

Heesewijk, Jason van, Alex Kent, Tim C. van de Grift, Alex Harleman, and Maaike Muntinga. 2022. "Transgender Health Content in Medical Education: A Theory-Guided Systematic Review of Current Training Practices and Implementation Barriers & Facilitators." *Advances in Health Sciences Education* 27 (3): 817–46. https://doi.org/10.1007/s10459-022-10112-y.

Hidalgo, Marco A., Diane Ehrensaft, Amy C. Tishelman, Leslie F. Clark, Robert Garofalo, Stephen M. Rosenthal, Norman P. Spack, and Johanna Olson. 2013. "The Gender Affirmative Model: What We Know and What We Aim to Learn." *Human Development* 56 (5): 285–90. https://doi.org/10.1159/000355235.

Horton, Cal. 2022. "'Of Course, I'm Intimidated by Them. They Could Take My Human Rights Away': Trans Children's Experiences with UK Gender Clinics." *Bulletin of Applied Transgender Studies* 1 (1–2): 47–70. https://doi.org/10.57814/20hf-7n94.

Johnson, Austin H. 2019. "Rejecting, Reframing, and Reintroducing: Trans People's Strategic Engagement with the Medicalisation of Gender Dysphoria." *Sociology of Health & Illness* 41 (3): 517–32. https://doi.org/10.1111/1467-9566.12829.

Kent, Devon, Kyler Perry, Cheryl Vanier, and Bradley Havins. 2022. "Assessing Comfort of Physicians to Provide Transgender-Specific Care." *Transgender Health* 7 (6): 533–38. https://doi.org/10.1089/trgh.2021.0074.

Keo-Meier, Colt, and Diane Ehrensaft. 2018. *The Gender Affirmative Model: An Interdisciplinary Approach to Supporting Transgender and Gender Expansive Children*. Perspectives on Sexual Orientation and Diversity. Washington, DC: American Psychological Association. https://doi.org/10.1037/0000095-000.

Kinney, M. Killian, and Darren Cosgrove. 2022. "'Truly Listen to Us': Recommendations for Health Professionals to Bolster Wellbeing of Nonbinary Individuals." *International Journal of Environmental Research and Public Health* 19 (15): 9032. https://doi.org/10.3390/ijerph19159032.

Lampe, Nik M. 2024. "Accounting for Cisnormativity: Understanding Transgender and Non-Binary Young People's Strategies to Resist and Reduce Inequality in Healthcare." *Social Currents* 11 (1): 3–21. https://doi.org/10.1177/23294965231179432.

Lane, Riki. 2018. "'We Are Here to Help': Who Opens the Gate for Surgeries?" *TSQ: Transgender Studies Quarterly* 5 (2): 207–27. https://doi.org/10.1215/23289252-4348648.

Latham, J. R. 2017. "Making and Treating Trans Problems: The Ontological Politics of Clinical Practices." *Studies in Gender and Sexuality* 18 (1): 40–61. https://doi.org/10.1080/15240657.2016.1238682.

Lichtenstein, Max, Laura Stein, Erin Connolly, Zil G. Goldstein, Tyler Martinson,

Linda Tiersten, Sangyoon J. Shin, John Henry Pang, and Joshua D. Safer. 2020. "The Mount Sinai Patient-Centered Preoperative Criteria Meant to Optimize Outcomes Are Less of a Barrier to Care Than WPATH SOC 7 Criteria Before Transgender-Specific Surgery." *Transgender Health* 5 (3): 166–72. https://doi.org/10.1089/trgh.2019.0066.

MacKinnon, Kinnon Ross, Florence Ashley, Hannah Kia, Lam June Sing Hong, Yonah Krakowsky, and Lori E. Ross. 2021. "Preventing Transition 'Regret': An Institutional Ethnography of Gender-Affirming Medical Care Assessment Practices in Canada." *Social Science & Medicine* 291 (December): 114477. https://doi.org/10.1016/j.socscimed.2021.114477.

MacKinnon, Kinnon Ross, Daniel Grace, Stella L. Ng, Suzanne R. Sicchia, and Lori E. Ross. 2020. "'I Don't Think They Thought I Was Ready': How Pre-Transition Assessments Create Care Inequities for Trans People with Complex Mental Health in Canada." *International Journal of Mental Health* 49 (1): 56–80. https://doi.org/10.1080/00207411.2019.1711328.

MacKinnon, Kinnon Ross, and Lori E Ross. 2019. "The Path to Patient-Centred Care." 2019. https://patient-centred.ca.

Magrath, Walker J. 2022. "The Fall of the Nation's First Gender-Affirming Surgery Clinic." *Annals of Internal Medicine* 175 (10): 1462–67. https://doi.org/10.7326/M22-1480.

Marrow, Elliot. 2023a. "'I Hope That as Our Selection Becomes More Accurate, the Number … Will Be Very Few': The Creation of Assessment Criteria for Gender-Affirming Care, 1960s–1980s." *Psychology of Sexual Orientation and Gender Diversity*. https://doi.org/10.1037/sgd0000633.

Marrow, Elliot. 2023b. "'Why Should Other People Be the Judge': The Codification of Assessment Criteria for Gender-Affirming Care, 1970s–1990s." *History of Psychology* 26 (3): 210–46. https://doi.org/10.1037/hop0000238.

Martin, Ashley E., and Malia F. Mason. 2022. "What Does It Mean to Be (Seen as) Human? The Importance of Gender in Humanization." *Journal of Personality and Social Psychology* 123 (2): 292–315. https://doi.org/10.1037/pspa0000293.

Milrod, Christine, Martin Monto, and Dan H. Karasic. 2019. "Recommending or Rejecting 'the Dimple': WPATH-Affiliated Medical Professionals' Experiences and Attitudes Toward Gender-Confirming Vulvoplasty in Transgender Women." *The Journal of Sexual Medicine* 16 (4): 586–95. https://doi.org/10.1016/j.jsxm.2019.01.316.

Obedin-Maliver, Juno, Elizabeth S. Goldsmith, Leslie Stewart, William White, Eric Tran, Stephanie Brenman, Maggie Wells, David M. Fetterman, Gabriel Garcia, and Mitchell R. Lunn. 2011. "Lesbian, Gay, Bisexual, and Transgender–Related Content in Undergraduate Medical Education." *JAMA* 306 (9): 971–77. https://doi.org/10.1001/jama.2011.1255.

Occhino, Molly, and Lea Skewes. 2020. "Gatekeepers for Gendersex Norms: Trans (Un)Intelligibility and (Il)Legitimacy Within the Danish Healthcare System." *NORA - Nordic Journal of Feminist and Gender Research* 28 (4): 314–28. https://doi.org/10.1080/08038740.2020.1834450.

Parker, William F., and Marshall H. Chin. 2020. "Epistemic Authority and Trust in Shared Decision Making About Organ Transplantation." *AMA Journal of Ethics* 22

(5): 408–15. https://doi.org/10.1001/amajethics.2020.408.
Poceta, Joanna, Stephanie Cousins, Conrad Wenzel, Kellyn Lakhardt, Carlo Hojilla, Lisa Marlowe, Julie Ayoob, Miranda Ritterman Weintraub, and Eve F. Zaritsky. 2019. "Effectiveness of a Gender Affirming Surgery Class for Transgender and Non-Binary Patients and Their Caregivers in an Integrated Healthcare Setting." *The International Journal of Transgenderism* 20 (1): 81–86. https://doi.org/10.1080/15532739.2018.1528920.
Poteat, Tonia, Danielle German, and Deanna Kerrigan. 2013. "Managing Uncertainty: A Grounded Theory of Stigma in Transgender Health Care Encounters." *Social Science & Medicine* 84 (May): 22–29. https://doi.org/10.1016/j.socscimed.2013.02.019.
Riggs, Damien W., Ruth Pearce, Carla A. Pfeffer, Sally Hines, Francis White, and Elisabetta Ruspini. 2019. "Transnormativity in the Psy Disciplines: Constructing Pathology in the Diagnostic and Statistical Manual of Mental Disorders and Standards of Care." *American Psychologist*, Fifty Years Since Stonewall: The Science and Politics of Sexual Orientation and Gender Diversity, 74 (8): 912–24. https://doi.org/10.1037/amp0000545.
Rouleau, Codie R., Joshua A. Rash, and Kerry J. Mothersill. 2016. "Ethical Issues in the Psychosocial Assessment of Bariatric Surgery Candidates." *Journal of Health Psychology* 21 (7): 1457–71. https://doi.org/10.1177/1359105314556160.
Schall, Theodore E., and Jacob D. Moses. 2023. "Gender-Affirming Care for Cisgender People." *Hastings Center Report* 53 (3): 15–24. https://doi.org/10.1002/hast.1486.
Shah, Parth, Imani Thornton, Danielle Turrin, and John E. Hipskind. 2022. "Informed Consent." In *StatPearls*. Treasure Island (FL): StatPearls Publishing. http://www.ncbi.nlm.nih.gov/books/NBK430827/.
Shires, Deirdre A., Daphna Stroumsa, Kim D. Jaffee, and Michael R. Woodford. 2018a. "Primary Care Providers' Willingness to Continue Gender-Affirming Hormone Therapy for Transgender Patients." *Family Practice* 35 (5): 576–81. https://doi.org/10.1093/fampra/cmx119.
Shires, Deirdre A., Daphna Stroumsa, Kim D. Jaffee, and Michael R. Woodford. 2018b. "Primary Care Clinicians' Willingness to Care for Transgender Patients." *Annals of Family Medicine* 16 (6): 555–58. https://doi.org/10.1370/afm.2298.
Shook, Alic G., Diana M. Tordoff, April Clark, Robin Hardwick, Will St. Pierre Nelson, and Ira Kantrowitz-Gordon. 2022. "Trans Youth Talk Back: A Foucauldian Discourse Analysis of Transgender Minors' Accounts of Healthcare Access." *Qualitative Health Research*, July, 104973232211148. https://doi.org/10.1177/10497323221114801.
shuster, stef. 2021. *Trans Medicine: The Emergence and Practice of Treating Gender*. NYU Press.
shuster, stef. 2023. "The Assertion of Reproductive and Social Control in Mid-Twentieth-Century US Transgender Medicine." *Gender & History*, 1–16. https://doi.org/10.1111/1468-0424.12727.
?:.v cxSogg, Stephanie, Jennifer Lauretti, ap-ol nd Lisa West-Smith. 2016. "Recommendations for the Presurgical Psychosocial Evaluation of Bariatric Surgery Patients." *Surgery for Obesity and Related Diseases* 12 (4): 731–49. https://doi.org/10.1016/j.soard.2016.02.008.

Spade, Dean. 2003. "Resisting Medicine/Remodeling Gender." *Berkeley Women's Law Journal* 18: 15–37.

Stelmar, Jenna, Shannon M. Smith, Grace Lee, Michael Zaliznyak, and Maurice M. Garcia. 2023. "Shallow-Depth Vaginoplasty: Preoperative Goals, Postoperative Satisfaction, and Why Shallow-Depth Vaginoplasty Should Be Offered as a Standard Feminizing Genital Gender-Affirming Surgery Option." *The Journal of Sexual Medicine* 20 (11): 1333–43. https://doi.org/10.1093/jsxmed/qdad111.

Strauss, Penelope, Sam Winter, Zoe Waters, Dani Wright Toussaint, Vanessa Watson, and Ashleigh Lin. 2022. "Perspectives of Trans and Gender Diverse Young People Accessing Primary Care and Gender-Affirming Medical Services: Findings from Trans Pathways." *International Journal of Transgender Health* 23 (3): 295–307. https://doi.org/10.1080/26895269.2021.1884925.

Stroumsa, Daphna, Deirdre A. Shires, Caroline R. Richardson, Kim D. Jaffee, and Michael R .Woodford. 2019. "Transphobia Rather than Education Predicts Provider Knowledge of Transgender Health Care." *Medical Education* 53 (4): 398–407. https://doi.org/10.1111/medu.13796.

Tollemache, Nicholas, Duncan Shrewsbury, and Carrie Llewellyn. 2021. "Que(e) Rying Undergraduate Medical Curricula: A Cross-Sectional Online Survey of Lesbian, Gay, Bisexual, Transgender, and Queer Content Inclusion in UK Undergraduate Medical Education." *BMC Medical Education* 21 (1): 100. https://doi.org/10.1186/s12909-021-02532-y.

Velocci, Beans. 2021. "Standards of Care: Uncertainty and Risk in Harry Benjamin's Transsexual Classifications." *TSQ: Transgender Studies Quarterly* 8 (4): 462–80. https://doi.org/10.1215/23289252-9311060.

Villarmea, Stella, and Brenda Kelly. 2020. "Barriers to Establishing Shared Decision-making in Childbirth: Unveiling Epistemic Stereotypes about Women in Labour." *Journal of Evaluation in Clinical Practice* 26 (2): 515–19. https://doi.org/10.1111/jep.13375.

Weingartner, Laura A., Ryan M. Combs, Carrie A. Bohnert, Hallie R. Decker, and Emily J. Noonan. 2022. "Epistemic Peerhood as a Model To Improve Gender-Affirming Care in Medical Education." *Teaching and Learning in Medicine*, October, 1–10. https://doi.org/10.1080/10401334.2022.2137169.

Wilson, Ana, Sean M. Ronnekleiv-Kelly, and Timothy M. Pawlik. 2017. "Regret in Surgical Decision Making: A Systematic Review of Patient and Physician Perspectives." *World Journal of Surgery* 41 (6): 1454–65. https://doi.org/10.1007/s00268-017-3895-9.

ORIGINAL ARTICLE

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

Charlene Johnson
is a licensed Doctor of Clinical Psychology working as a PTSD/SUD Psychologist for the Veterans Health Administration and is engaged in diversity training of students. She earned her doctoral degree at Indiana State University. This paper is based on her dissertation project.

Veanne N. Anderson
is a Professor in the Department of Psychology at Indiana State University. Her research focuses on stereotypes about and the psychological wellbeing of people with diverse gender and sexual identities.
✉ veanne.anderson@indstate.edu

Ryan Steiner
is a disability advocate and self-advocate with a focus on LGBTQ and autism, working to raise awareness about the challenges faced by individuals in these communities.

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 α = .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 α = .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 α = .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 α = .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 α = .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 α = .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 α = .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. [a]Partial 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 ***α = .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 ***α = .8***6-.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

	Trans Men			Nonbinary People		
Variables	**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, φ = .34. The two groups did not differ significantly in gender affirming surgeries, $\chi^2(1, N = 71) = .53$, p = .468, φ = .086; gender marker changes, $\chi^2(1, N = 74) = 5.62$, p = .018, φ = .28; and name change, $X^2(1, N = 72) = .30$, p = .585, φ = .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

	Gender-Affirming Surgeries			Gender Marker Changes			Name Change		
Variables	**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 (Hughto et al. 2020; Flynn and Bhambhani 2021). However, contrary to other findings (Hughto 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 heterogenous 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.

REFERENCES

Almazan, Anthony N., and Alex S. Keuroghlian. 2021. "Association Between Gender-Affirming Surgeries and Mental Health Outcomes." *JAMA Surgery* 156 (7): 611–618. https://doi.org/10.1001/jamasurg.2021.0952.

American Civil Liberties Union. 2024. "Mapping Attacks on LGBTQ Rights in U.S. State Legislatures in 2024." https://www.aclu.org/legislative-attacks-on-lgbtq-rights.

Ansara, Y. Gavriel, and Peter Hegarty. 2012. "Cisgenderism in Psychology: Pathologizing and Misgendering Children from 1999 to 2008." *Psychology & Sexuality* 3(2): 137–160. http://dx.doi.org/10.1080/19419899.2011.576696.

Ansara, Y. Gavriel, and Peter Hegarty, P. 2014. "Methodologies of Misgendering: Recommendations for Reducing Cisgenderism in Psychological Research." *Feminism & Psychology* 24 (2): 259–270. https://doi.org/10.1177/0959353514526217.

Baker, Kellan E., Lisa M. Wilson, Ritu Sharma, Vadim Dukanin, Kristen McArthur, and Karen A. Robinson. 2021. "Hormone Therapy, Mental Health, and Quality of Life Among Transgender People: A Systematic Review." *Journal of the Endocrine Society* 5 (4): 1–16. https://doi.org/10.1210/jendso/bvab011.

Balsam, Kimberly F., Blair Beadnell, and Yamile Molina. 2013. "The Daily Heterosexist Experiences Questionnaire: Measuring Minority Stress among Lesbian, Gay, Bisexual, and Transgender Adults." *Measurement and Evaluation in Counseling and Development* 46 (1): 3–25. http://dx.doi.org/ 10.1177/0748175612449743.

Balzarini, Rhonda N., Christoffer Dharma, Taylor Kohut, Bjarne M. Holmes, Lorne Campbell, Justin J. Lehmiller, and Jennifer J. Harman. 2019. "Demographic Comparison of American Individuals in Polyamorous and Monogamous Relationships." *The Journal of Sex Research* 56 (6): 6811–684. https://doi.org/10.1080/00224499.2018.1474333.

Barr, Sebastian M., Kate E. Snyder, Jill L. Adelson, and Stephanie L. Budge. 2022. "Postraumatic Stress in the Trans Community: The Roles of Anti-Transgender Bias, Non-Affirmation, and Internalized Transphobia." *Psychology of Sexual Orientation and Gender Diversity* 9 (4): 410–421. https://doi.org/10.1037/sgd0000500.

Bockting, Walter O., Michael H. Miner, Rebecca E. Swinburne Romine, Curtis Dolezal, Beatrice E. Robinson, B. R. Simon Rosser, and Eli Coleman. 2020. "The Transgender Identity Survey: A Measure of Internalized Transphobia." *LGBT Health* 7 (1): 15–27. https://doi.org/10.1089/lgbt.2018.0265.

Brooks, Virginia. R. 1981. *Minority Stress and Lesbian Women*. Lexington, MA: Lexington Books.

Cassidy, Kendal. 2020. "Wellbeing in Trans and Gender Diverse Individuals: An Investigation of Chosen Family Support." PhD diss., University of Nebraska.

Cook-Daniels, Loree. 2015. "Intimate Partner Violence in Transgender Couples: "Power and Control" in a Specific Cultural Context." *Partner Abuse* 6 (1):126–139. http://doi.org/10.1891/1946-6560.6.1.126.

Deiner, Ed, Robert A. Emmons, Randy J. Larson, and Sharon Griffin. 1985. "The Satisfaction with Life Scale." *Journal of Personality Assessment* 49 (1): 71–75. https://doi.org/10.1207/s15327752jpa4901_13.

Diamond, Lisa M., and Jenna Alley. 2022. "Rethinking Minority Stress: A Social Safety Perspective on the Health Effects of Stigma in Sexually-Diverse and Gender-Diverse Populations." *Neuroscience and Biobehavioral Reviews* 138: 104720. https://doi.org/10.1016/j.neubiorev.2022.104720.

DuBois, L. Zachary, Jae A. Puckett, Sarah F. Price, Kelsi Kuehn, Brenna Lash, Tian Walker, Natalie R. Holt, Allura L. Ralston, T. Zachary Huit, Makinna Miles et al. 2023. "The Impact of Sociopolitical Events on Transgender People in the US." *Bulletin of Applied Transgender Studies* 2 (1–2): 1–26. https://doi.org/ 10.57814/sdx3-7y41.

Du Bois, Steve N, Arryn A. Guy, Nicole Legate, and Ashley D. Kendall. 2021. "Examining Partnership-Health Associations Among Transgender Individuals Using Behavioral Risk Factor Surveillance System (BRFSS) Data." *Psychology of Sexual Orientation and Gender Diversity* 8 (4): 458–471. http://dx.doi.org/10.1037/sgd0000387.

Dyar, Christina, Brian A. Feinstein, Jasmine Stephens, Arielle R. Zimmerman, Michael E. Newcomb, and Sarah W. Whitton. 2020. "Nonmonosexual Stress and Dimensions of Health: Within-Group Variation by Sexual, Gender, and Racial/Ethnic Identities." *Psychology of Sexual Orientation and Gender Diversity* 7 (1): 12–25. https://doi.org/10.1037/sgd0000348.

Eisenberg, Marla E., Amy L. Gower, G. Nic Rider, Barbara J. McMorris, and Eli Coleman. 2019. "At the Intersection of Sexual Orientation and Gender Identity: Variations in Emotional Distress and Bullying Experience in a Large Population-Based Sample of U.S. Adolescents." *Journal of LGBT Youth* 16 (3): 235–254. https://doi.org/10.1080/19361653.2019.1567435.

Flynn, Maureen K., and Yash Bhambhani. 2021. "Internalized Transphobia, Nondisclosure of Gender Identity, and Life Satisfaction Among Transgender and Non-Binary Adults: The Moderating Roles of Psychological Flexibility and Inflexibility." *Journal of Contextual Behavioral Science* 20: 194–201. https://doi.org/10.1016/j.jcbs.2021.04.008.

Frost, David M., and Ilan H. Meyer. 2023. "Minority Stress Theory: Application, Critique, and Continued Relevance." *Current Opinion in Psychology* 51: Article 101579. https://doi.org/10.1016/j.copsyc.2023.101579.

Garro, Maria, Cinzia Novara, Gaetano Di Napoli, Cristiano Scandurra, Vincenzo Bochicchio, and Gioacchino Lavanco. 2022. "The Role of Internalized Transphobia, Loneliness, and Social Support in the Psychological Wellbeing of a Group of Italian Transgender and Gender Non-Conforming Youths." *Healthcare* 10: 2282.

https://doi.org/10.3390/healthcare10112282.
Giammattei, Shawn V. 2015. "Beyond the Binary: Trans-Negotiations in Couple and Family Therapy." *Family Process* 54 (3): 418–434. http://dx.doi.org/ 10.1111/famp.12167.
Glynn, Tiffany R., Kristi E. Gamarel, Christopher W. Kahler, Mariko Iwamoto, Don Operario, and Tooru Nemoto. 2016. "The Role of Gender Affirmation in Psychological Wellbeing Among Transgender Women." *Psychology and Sexual Orientation and Gender Diversity* 3 (3): 336–344. http://dx.doi.org/10.1037/sgd0000171.
Gorman, Kaitlyn R., Jillian C. Shipherd, Kathleen M. Collins, Hamish A. Gunn, Rachel O. Rubin, Brian A. Rood, and David W. Pantalone. 2022. "Coping, Resilience, and Social Support Among Transgender and Gender Diverse Individuals Experiencing Gender-Related Stress." *Psychology of Sexual Orientation and Gender Diversity* 9 (1): 37–48. http://dx.doi.org/10.1037/sgd0000455.
Green, Erica. L., Katie Benner, and Robert Pear. 2018. "'Transgender' Could be Defined Out of Existence Under Trump Administration." *New York Times,* October 21. https://www.nytimes.com/ 2018/10/21/us/politics/transgender-trump-administration-sex-definition.html.
Hendricks, Michael L., and Rylan J. Testa. 2012. "A Conceptual Framework for Clinical Work with Transgender and Gender Nonconforming Clients: An Adaptation of the Minority Stress Model." *Professional Psychology: Research and Practice* 43 (5): 460–467. http://dx.doi.org/ 10.1037/a0029597.
Hollister, Lisa A. 2023. "The Effects of Medical and Legal Transition on Gender Non-Affirmation in a Probability Sample of U.S. Transgender and Gender Non-Conforming Adults." Master's thesis, University of Colorado.
Horne, Sharon G., Mallaigh McGinley, Nedim Yel, and Meredith R. Maroney. 2022. "The Stench of Bathroom Bills and Anti-Transgender Legislation: Anxiety and Depression Among Transgender, Nonbinary, and Cisgender LGBQ People During a State Referendum." *Journal of Counseling Psychology* 69 (1): 1–13. https://doi.org/10.1037/cou0000558.
Hughto, Jaclyn M. W., Hamish A. Gunn, Brian A. Rood, and David W. Pantalone. 2020. "Social and Medical Gender Affirmation Experiences are Inversely Associated with Mental Health Problems in a U.S. Non-Probability Sample of Transgender Adults." *Archives of Sexual Behavior* 49 (7): 2635–2647. https://doi.org/10.1007/s10508-020-01655-5.
Hyde, Janet Shibley, Rebecca S. Bigler, Daphna Joel, Charlotte Chucky Tate, and Sari M. van Anders. 2019. "The Future of Sex and Gender in Psychology: Five Challenges to the Gender Binary." *American Psychologist* 74 (2): 171–193. https://dx.doi.org/10.1037/amp0000307.
Inderbinen, Marc, Kristin Schaefer, Andres Schneeberger, Jens Gaab, and David Garcia Nuñez. 2021. "Relationship of Internalized Transnegativity and Protective Factors with Depression, Anxiety, Non-Suicidal Self-Injury and Suicidal Tendency in Trans Populations: A Systematic Review." *Frontiers in Psychology* 12: 636513. https://dx.doi.org/10.3389/fpsyt.2021.636513.
Irwig, Michael S. 2017. "Testosterone Therapy for Transgender Men." *The Lancet: Diabetes & Endocrinology* 5 (4): 301–311. https://doi.org/10.1016/S2213-8587(16)00036-X.

Jäggi, Tiziana, Lena Jellestad, Salvatore Corbisiero, Dirk J. Schaefer, Josef Jenewein, Andres Schneeberger, Annette Kuhn, and David Garcia Nuñez. 2018. "Gender Minority Stress and Depressive Symptoms in Transitioned Swiss Transpersons." *BioMed Research International* 2018: 8639263. https://doi.org/10.1155/2018/8639263.

James, Sandy E., Jody L. Herman, Susan Rankin, Mara Keisling, Lisa Mottet, and Ma'ayan Anafi. 2016. *The Report of the 2015 U.S. Transgender Survey*. Washington, DC: National Center for Transgender Equality.

Johnson, Austin H. 2015. "Beyond Inclusion: Thinking toward a Transfeminist Methodology." In *At the Center: Feminism, Social Science and Knowledge*, edited by Vasilikie Demos and Marcia Texler Segal, 21–41. Cambridge MA: Emerald Books.

Johnson, Austin. H., and Baker A. Rogers. 2020. "'We're the Normal Ones Here': Community Involvement, Peer Support, and Transgender Mental Health." *Sociological Inquiry* 90 (2): 271–292. https://doi.org/10.1111/soin.12347.

Johnson, Kelly C., Allen J. LeBlanc, Curtis Dolezal, Anneliese A. Singh, and Walter O. Bockting. 2023. "Invalidation and Mental Health Among Nonbinary Individuals." *Psychology of Sexual Orientation and Gender Diversity.* Advance online publication. https://dx.doi.org/10.1037/sgd0000621.

Kade, Tristen. 2021. "'Hey, by the way, I'm Transgender': Transgender Disclosures as Coming Out Stories in Social Contexts Among Trans Men." *Socius* 7: 1–12. https://doi.org/10.1177/23780231211039389.

Kia, Hannah, Kinnon Ross MacKinnon, Alex Abramovich, and Sarah Bonato. 2021. "Peer Support as a Protective Factor Against Suicide in Trans Populations: A Scoping Review." *Social Science & Medicine* 279: 114026. https://doi.org/10.1016/j.socscimed.2021.114026.

Kline, Kai, and Ashley K. Randall. 2021. The Moderating Effect of Internalized Transphobia on the Association Between Gender Congruence and Sexual Satisfaction for Transgender Men." *Journal of LGBTQ Issues in Counseling* 15 (1): 93–109. https://doi.org/10.1080/15538605.2021.1868378.

Kroenke, Kurt, Robert L. Spitzer, and Janet B. W. Williams. 2001. "The PHQ-9: Validity of a Brief Depression Severity Measure." *Journal of General Internal Medicine* 16 (9): 606–613. http://dx.doi.org/10.1046/j.1525-1497.2001.016009606.x.

Lane, Megan, Jennifer F. Waljee, and Daphna Stroumsa. 2022. "Treatment Preferences and Gender Affirmation of Nonbinary and Transgender People in a National Probability Sample." *Obstetrics & Gynecology* 140 (1): 77–81. https://doi.org/10.1097/AOG.0000000000004802.

Lee, Hyemin, Kevin K. Tomita, Janice M. Habarth, Don Operario, Horim Yi, Sungsub Choo, and Seung-Sup Kim. 2020. "Internalized Transphobia and Mental Health Among Transgender Adults: A Nationwide Cross-Sectional Survey in South Korea." *International Journal of Transgender Health* 21 (2): 182–193. https://doi.org/10.1080/26895269.2020.1745113.

Levin, Nina Jackson, Shanna K. Kattari, Emily K. Piellusch, and Erica Watson. 2020. "'We Just Take Care of Each Other': Navigating 'Chosen Family' in the Context of Health, Illness, and the Mutual Provision of Care Amongst Queer and Transgender Young Adults." *International Journal of Environmental Research and Public*

Health 17: 7346. https://doi.org/10.3390/ijerph17197346.
Levitt, Heidi M., and Maria R. Ippolito. 2014. "Being Transgender: Navigating Minority Stressors and Developing Authentic Self-Presentation." *Psychology of Women Quarterly* 38 (1): 46–64. https://doi.org/10.1177/0361684313501644.
Livingston, Nicholas A., Annesa Flentje, James Brennan, Ethan H. Mereish, Oakleigh Reed, and Bryan N. Cochran. 2020. "Real-Time Associations Between Discrimination and Anxious and Depressed Mood Among Sexual and Gender Minorities: The Moderating Effects of Lifetime Victimization and Identity Concealment." *Psychology of Sexual Orientation and Gender Diversity* 7 (2): 132–141. http://dx.doi.org/10.1037/sgd0000371.
Lykens, James E., Allen J. LeBlanc, and Walter O. Bockting. 2018. "Healthcare Experiences Among Young Adults Who Identify as Genderqueer or Nonbinary." *LGBT Health* 5 (3): 191–196. https://doi.org/10.1089/lgbt.2017.0215.
Malpas, Jean. 2006. "From Otherness to Alliance: Transgender Couples in Therapy." *Journal of GLBT Family Studies* 2(3/4): 183–206. http://dx.doi.org/10.1300/j461v02n03_10.
Malta, Monica, Sara LeGrand, Jack Turban, Tonia Poteat, and Kathryn Whetten. 2020. "Gender-Congruent Government Identification is Crucial for Gender Affirmation." *Lancet Public Health* 5 (4): e178–e179. https://doi.org/10.1016/S2468-2667(20)30054-2.
Marshall, Ellen, Cris Glazebrook, Sally Robbins-Cherry, Serge Nicholson, Nat Thorne, and Jon Arcelus. 2020. "The Quality and Satisfaction of Romantic Relationships in Transgender People: A Systematic Review of the Literature." *International Journal of Transgenderism* 21 (4): 373–390. https://doi.org/10.1080/26895269.2020.1765446.
Martin, Ashley E., and Michael L. Slepian. 2021. "The Primacy of Gender: Gendered Cognition Underlies the Big Two Dimensions of Social Cognition." *Perspectives on Psychological Science* 16 (6): 1143–1158. https://doi.org/10.1177/1745691620904961.
McKay, Timothy R., and Ryan J. Watson. 2020. "Gender Expansive Youth Disclosure and Mental Health: Clinical Implications of Gender Identity Disclosure." *Psychology of Sexual Orientation and Gender Diversity* 7 (1): 66–75. https://dx.doi.org/10.1037/sgd0000354.
Meyer, Ilan.H. 2003. "Prejudice, Social Stress, and Mental Health in Lesbian, Gay, and Bisexual Populations: Conceptual Issues and Research Evidence." *Psychological Bulletin* 129 (5): 674–697. http://dx.doi.org/ 10.1037/0033-2909129.5.674.
Milton, David C., and Douglas Knutson. 2023. "Family of Origin, Not Chosen Family, Predicts Psychological Health in a LGBTQ+ Sample." *Psychology of Sexual Orientation and Gender Diversity* 10 (2): 269–278. https://doi.org/10.1037/sgd0000531.
Moors, Amy C. 2023. "Five Misconceptions About Consensually Nonmonogamous Relationships." *Current Directions in Psychological Science* 32 (5): 355–361. https://doi.org/10.1177/09637214231166853.
Moors, Amy C., Amanda N. Gesselman, and Justin R. Garcia. 2021. "Desire, Familiarity, and Engagement in Polyamory: Results From a National Sample of Single Adults in the United States." *Frontiers in Psychology* 12: 811. https://doi.org/10.3389/fpsyg.2021.619640.

Morgenroth, Thekla, Marie Gustafsson Sendén, Anna Lindqvist, Emma A. Renström, Michelle Ryan, M. K., and Thomas A. Morton. 2021. "Defending the Sex/Gender Binary: The Role of Gender Identification and Need for Closure." *Social Psychological and Personality Science* 12 (5): 731–740. https://doi.org/10.1177/1948550620937188.

Parker, Kim, Juliana Menasce Horowitz, and Anna Brown. 2022. "Americans' Complex Views on Gender Identity and Transgender Issues." *Pew Research Center.* https //www.pewresearch.org/social-trends/2022/06/28/americans-complex-views-on-gender-identity-and-transgender-issues/.

Peitzmeier, Sarah M., Jaclyn M. W. Hughto, Jennifer Potter, Madeline B. Deutsch, and Sari L. Reisner. 2019. "Development of a Novel Tool to Assess Intimate Partner Violence Against Transgender Individuals." *Journal of Interpersonal Violence* 34 (11): 2376–2397. http://dx.doi.org/10.1177/0886260519827660.

Pinna, Federica, Pasquale Paribello, Giulia Somaini, Alice Corona, Antonio Ventriglio, Carolina Corrias, Ilaria Frau et al.. 2022. "Mental Health in Transgender Individuals: A Systematic Review." *International Review of Psychiatry* 34 (3–4): 292–359. https://doi.org/10.1080/09540261.2022.2093629.

Poquiz, Jonathan L., Claire A. Coyne, Robert Garofalo, and Diane Chen. 2021. "Comparison of Gender Minority Stress and Resilience Among Transmasculine, Transfeminine, and Nonbinary Adolescents and Young Adults." *Journal of Adolescent Health* 68 (3): 615–618. https://doi.org/10.1016/j.jadohealth.2020.06.014.

Puckett, Jae A., Peter Cleary, Kinton Rossman, Brian Mustanski, and Michael E. Newcomb. 2018. "Barriers to Gender-Affirming Care for Transgender and Gender Nonconforming Individuals." *Sexuality Research and Social Policy* 15. (1): 48–59. https://doi.org/10.1007/s13178-017-0295-8.

Puckett, Jae A., Samantha Tornillo, Brian Mustanski, and Michael E. Newcomb. 2022. "Gender Variations, Generational Effects, and Mental Health of Transgender People in Relation to Timing and Status of Gender Identity Milestones." *Psychology of Sexual Orientation and Gender Identity* 9 (2): 165–178. https://doi.org/10.1037/sgd0000391.

Pulice-Farrow, Lex, Alma Bartnik, Louis Lindley, Corey E. Flanders, and Kirsten A. Gonzalez. 2023. "Experiences of Community Connection and Belonging for Sexual Minority Trans Individuals." *Psychology of Sexual Orientation and Gender Diversity*. Advance online publication. https://dx.doi.org/10.1037/sgd0000629.

Pulice-Farrow, Lex, Tabria D. Brown, and M. Paz Galupo. 2017. "Transgender Microaggressions in the Context of Romantic Relationships." *Psychology of Sexual Orientation and Gender Identity* 4 (3): 362–373. http://dx.doi.org/10.1037/sgd0000238.

Ralston, Allura L., Natalie R. Holt, Arthur R. Andrews III, T. Zachary Huit, Jae A. Puckett, Nathan Woodruff, Richard Mocarski, and Debra A. Hope. 2022. "Mental Health and Marginalization Stress in Transgender and Gender Diverse Adults: Differences Between Urban and Non-Urban Experiences." *Psychology of Sexual Orientation and Gender Diversity*. Advance online publication. http://dx.doi.org/10.1037/sgd0000595.

Riggle, Ellen D. B., and Jonathan J. Mohr. 2015. "A Proposed Multi-Factor Measure of Positive Identity for Transgender Identified Individuals." *Psychology of Sexual Orientation and Gender Diversity* 2 (1): 78–85. http://dx.doi.org/10/1037/

sgd0000082.
Rogers, Michaela M. 2021. "Exploring the Domestic Abuse Narratives of Trans and Nonbinary People and the Role of Cisgenderism in Identity Abuse, Misgendering, and Pathologizing." *Violence Against Women* 27 (12–13): 2187–2207. https://doi.org/10.1177/077801220971368.
Rood, Brian A., Meredith R. Maroney, Jae A. Puckett, Ariel K. Berman, Sari L. Reisner, and David W. Pantalone. 2017. "Identity Concealment in Transgender Adults: A Qualitative Assessment of Minority Stress and Gender Affirmation." *American Journal of Orthopsychiatry* 87 (6): 704–713. http://dx.doi.org/ 101037/ort0000303.
Rood, Brian A., Sari L. Reisner, Francisco I. Surace, Jae A. Puckett, Meredith R. Maroney, and David W. Pantalone. 2016. "Expecting Rejection: Understanding the Minority Stress Experiences of Transgender and Gender-Nonconforming Individuals." *Transgender Health* 1 (1): 151–164. https://doi.org/10.1089/trgh.2016.0012.
Scandurra, Cristiano, Vincenzo Bochicchio, Anna Lisa Amodeo, Concetta Esposito, Paolo Valerio, Nelson Mauro Maldonato, Dario Bacchini, and Roberto Vitelli. 2018. "Internalized Transphobia, Resilience, and Mental Health: Applying the Psychological Mediation Framework to Italian Transgender Individuals." *International Journal of Environmental Research and Public Health* 15 (3): 508–527. http://dx.doi:10.3390/ijerph15030508.
Scandurra, Cristiano, Agostino Carbone, Roberto Baiocco, Selene Mezzalira, Nelson Mauro Maldonato, and Vincenzo Bochicchio. 2021. "Gender Identity Milestones, Minority Stress and Mental Health in Three Generational Cohorts of Italian Binary and Nonbinary Transgender People." *International Journal of Environmental Research and Public Health* 18 (17): 9057. https://doi.org/10.3390/ijerph18179057.
Scheim, Aayden I., Amaya G. Perez-Brumer, and Greta R. Bauer. 2020. "Gender-Concordant Identity Documents and Mental Health among Transgender Adults in the USA: A Cross-Sectional Study." *Lancet Public Health* 5 (4): e196–e203. https://doi.org/10.1016/S2468-2667(20)30032-3.
Spitzer, Robert L., Kurt Kroenke, Janet B. W. Williams, and Bernd Löwe. 2006. "A Brief Measure for Assessing Generalized Anxiety Disorder: The GAD-7." *Archives of Internal Medicine* 166 (10): 1092–1097. http://dx.doi.org/10.1001/archinte.166.10.1092.
St. Amand, Colt, Carla Sharp, Jared Michonski, Julia C. Babcock, and Kara Fitzgerald. 2013. "Romantic Relationships of Female-to-Male Trans Men: A Descriptive Study." *International Journal of Transgenderism* 14 (2): 75–85. https://doi.org/10.1080/15532739.2013.791651.
Taber, Jamie L., Christopher B. Stults, Hannah Song, and Walter Kaczetow. 2023. "The Role of Internalized Transphobia and Negative Expectations in the Relationship Between Identity-Specific Intimate Partner Violence and Mental Health Outcomes in Transgender and Gender Nonconforming Young Adults." *Psychology of Sexual Orientation and Gender Diversity.* Advance online publication. https://dx.doi.org/10.1037/sgd0000641.
Tan, Kyle K. H., Sonja J. Ellis, Johanna M. Schmidt, Jack L. Byrne, and Jaimie F. Veale. 2020. "Mental Health Inequities Among Transgender People in Aotearoa

New Zealand: Findings from the Counting Ourselves Survey." *International Journal of Environmental Research and Public Health* 17 (8): 862. https://doi.org/10.3390/ijerph17082862.

Tan, Kyle K. H., Gareth J. Treharne, Sonja J. Ellis, Johanna M. Schmidt, and Jaimie F. Veale. 2020. "Gender Minority Stress: A Critical Review." *Journal of Homosexuality* 67 (10): 1471–1489. https://doi.org/10.1080/00918369.2019.1591789.

Tatum, Alexander K., Jory Catalpa, Nova J. Bradford, Alex Kovic, and Dianne R. Berg. 2020. "Examining Identity Development and Transition Differences Among Binary Transgender and Genderqueer Nonbinary (GQNB) Individuals." *Psychology of Sexual Orientation and Gender Diversity* 7 (4): 379–385. https://dx.doi.org/10.1037/sgd0000377.

Testa, Rylan J., Janice Habarth, Jayme Peta, Kimberly Balsam, K, and Walter Bockting. 2015. "Development of the Gender Minority Stress and Resilience Measure." *Psychology of Sexual Orientation and Gender Diversity* 2 (1): 65–77. http://dx.doi.org/10.1037/sgd0000081.

Testa, Rylan J., Matthew S. Michaels, Whitney Bliss, Megan L. Rogers, Kimberly F. Balsam, and Thomas Joiner. 2017. "Suicidal Ideation in Transgender People: Gender Minority Stress and Interpersonal Theory Factors." *Journal of Abnormal Psychology* 126 (1): 125–136. http://dx.doi.org/10.1037/abn0000234.

The Trevor Project. 2023. "2023 U.S. National Survey on the Mental Health of LGBTQ Young People." http://web.archive.org/web/20230514072435/https://www.thetrevorproject.org/ survey-2023/.

Tomita, Kevin K., Rylan J. Testa, and Kimberly F. Balsam. 2019. "Gender-Affirming Medical Interventions and Mental Health in Transgender Adults." *Psychology of Sexual Orientation and Gender Diversity* 6 (2): 182–193. https://doi.org/10.1037/sgd0000316.

Turban, Jack L., Dana King, Jeremi M. Carswell, and Alex S. Keuroghlian. 2020. "Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation." *Pediatrics* 145 (2): e20191725. https://doi.org/10.1542/peds.2019-1725.

van Anders, Sari M., Zach C. Schudson, Will J. Beischel, and Sara B. Chadwick. 2023. "Feminist and Queer Science: Principles for Research with Gender, Sex, and Sexuality in Psychology and Beyond." *Psychology of Sexual Orientation and Gender Diversity*. Advance online publication. https://dx.doi.org/10.1037/sgd0000646.

Veale, Jamie F., Kyle K. H. Tan, and Jack L. Byrne. 2022. "Gender Identity Change Efforts Faced by Trans and Nonbinary People in New Zealand: Associations with Demographics, Family Rejection, Internalized Transphobia, and Mental Health." *Psychology of Sexual Orientation and Gender Diversity* 9 (4): 478–487. https://doi.org/10.1037/sgd0000537.

ORIGINAL ARTICLE

Trans Birth Parents' Experiences of Domestic Violence: Conditional Affirmation, Cisgenderist Coercion, and the Transformative Potential of Perinatal Care

Ruth Pearce
is a Lecturer in Community Development at the University of Glasgow. Her work explores inequality, power, and transformative struggle from a trans feminist perspective. She is author of *Understanding Trans Health* (Policy Press, 2018), co-editor of *TERF Wars* (Sage, 2020), and co-editor of the *Community Development Journal*.
✉ Ruth.Pearce@glasgow.ac.uk

Carla Pfeffer
is a Professor in the Department of Sociology at Michigan State University. Her research is at the intersection of critical inquiry into contemporary families, genders, health, sexualities, and bodies considered marginal. She is the author of *Queering Families* (Oxford University Press, 2016).

Damien W. Riggs
is a Professor in Psychology at Flinders University and an Australian Research Council Future Fellow. He is the author of over 200 publications on gender, family, and mental health, including (with Shoshana Rosenberg, Heather Fraser, and Nik Taylor) *Queer Entanglements: Gender, Sexuality and Animal Companionship* (Cambridge University Press, 2021).

Francis Ray White
is a Senior Lecturer in Social Science at the University of Westminster. Their research, writing and teaching is in the area of gender studies, particularly around questions of queer, trans, and fat embodiment.

Sally Hines
is a Professor in the Department of Sociological Studies at the University of Sheffield. Her research falls across the interdisciplinary fields of sociology, gender studies, social policy, law, politics, health studies, and science and technology studies. She is the author of *Is Gender Fluid?* (Thames and Hudson, 2018).

Transgender people face disproportionately high rates of violence, including domestic violence. Like cisgender survivors, trans survivors typically report a pattern of coercion and control on the part of abusers. Drawing on the findings of an international qualitative study with trans parents who have conceived and carried their own children (i.e. trans birth parents), this article describes power and control tactics experienced by survivors, and how these may depart from the "public story" of domestic violence. The article reports on two thematic contexts of coercion and control that are particularly relevant for this population. First, conditional affirmation is a form of identity-related abuse that can be utilised by abusers to gain and maintain access to vulnerable individuals who may otherwise feel they have no other access to gender affirmation in their lives. Secondly, abusers may use pregnancy as a site of cisgenderist coercion, in which trans birth parents are deprived of autonomy through being socially and interpersonally feminized and ascribed into womanhood in the context of pregnancy. We then discuss how perinatal care can function as a site of heightened risk or mitigation for the impact of these forms of violence. The article concludes with recommendations for practitioners in healthcare, education, and domestic violence services, emphasising the importance of gender affirmation, trauma-informed services, and training around what domestic violence looks like for trans people.

KEYWORDS transgender, nonbinary, pregnancy, domestic violence, identity-related abuse
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Transgender people face disproportionate rates of gendered violence and abuse. They are at heightened risk of experiencing forms of domestic violence, including intimate partner violence (Peitzmeier et al. 2020), dating violence (Obradovic 2021), and childhood abuse (Thoma et al. 2021). However, the specific needs and experiences of trans birth parents – that is, men, transmasculine, and nonbinary people who have conceived and carried their own children – with regards to domestic violence have received little attention to date. This article presents data and analysis from an international study of the experiences of trans birth parents, with important lessons for researchers, practitioners, and educators working in perinatal services, in domestic violence services, in schools and colleges, and/or with trans people more broadly.

In this article, we use the standalone "trans" in the broad, political sense popularised by theorists and community members such as Leslie Feinberg (1999).[1] We therefore understand trans not (simply) as an identity category, nor as a biomedical marker, but rather as a way to refer to a diverse group of people with a shared interest in collective liberation. The participants in our research variously described themselves as (for example) men, trans men, transmasculine, nonbinary, genderqueer, agender,

1 "Transgender"—which is often used interchangeably with the standalone "trans," but has subtly different socio-political connotations (Pearce et al. 2019)—is used in the abstract and at the beginning of the article to support searchability through the internet and in academic databases.

and/or greygender; what they shared was that their lived experience of sex/gender differed from the sex they were coercively assigned at birth. This in turn provides a basis for other shared experiences: of gender joy and self-determination (shuster and Westbrook 2022), but also specific forms of discrimination and violence, both in public and within the home.

Of particular relevance to this article are trans peoples' shared experiences of transphobia and cisgenderism. Whereas transphobia consists of prejudiced attitudes and actions towards trans people, cisgenderism is the wider social ideology that works to invalidate or pathologise self-designated genders (Ansara and Hegarty 2012). For example, the common assumption that only women can conceive, carry, and give birth to a child is cisgenderist. This results in cisnormative systems, in which cis norms are "built into institutional practices, protocols, and other patterns of action" (Besse et al. 2020, 527). The consequence of this assumption is that trans bodies are often unintelligible within contexts such as fertility services, midwifery, or obstetrics, with potentially severe consequences for the safety and wellbeing of trans birth parents and their children (Riggs et al. 2021).

Our use of the term "domestic violence" is similarly intended to capture patterns of social behaviour. Following Liz Kelly and Nicole Westmorland (2016), we find it unhelpful to conceptualise domestic violence in terms of individual incidents, such as a specific physical assault. Rather, domestic violence is best understood as everyday, repetitive courses of conduct on the part of the abuser, characterised primarily by coercive control and the exercise of power (Stark 2007). Like cisgenderism, domestic violence carries profound consequences for the safety and wellbeing of survivors.

Understanding transphobia, cisgenderism, and domestic violence as part of wider patterns of social behaviour, rather than isolated incidents, is vital in accounting for trans birth parents' specific experiences of physical violence and coercive control from partners, family members, dates, and donors. We therefore argue that experiences of domestic violence among trans birth parents inevitably occur against a backdrop of societal transphobia and cisgenderism, potentially within the context of perinatal care as well as within the domestic sphere. This requires an expanded understanding of domestic violence, one which goes beyond the normative "public story."

We next review the literature on this public story of domestic violence, and its consequences for trans victims and survivors. We then explore literature on domestic violence within trans populations, showing that domestic violence is disproportionately experienced within trans populations, with specific forms of coercion and control including identity-related abuse (Guadalupe-Diaz and Anthony 2017) and experiential abuse (Donovan and Barnes 2020). After this we introduce the methodology used for our research, before providing a broad overview of experiences reported by the 10 research participants who provided narratives relating to their experiences of domestic violence. We report on two key themes present in these narratives which are important for understanding the specific experiences of these trans birth parents: conditional affirmation, a subtle control tactic through which abusers gain and maintain access to vulnerable individuals; and cisgenderist forms of reproductive coercion. Finally, we discuss how the context of perinatal care may exacerbate or mitigate the impact of domestic violence, before concluding with recommendations for practitioners and educators.

DOMESTIC VIOLENCE BEYOND THE "PUBLIC STORY"

Catherine Donovan and Rebecca Barnes argue that certain strands of feminist research and activism have contributed to the emergence of an influential "public story" about domestic violence. This public story "presents [domestic violence and abuse] as a problem of heterosexual men for heterosexual women, a problem of physical violence and a problem of a particular presentation of gender: the 'big' strong man being physically violent to the small 'weak' woman" (Donovan and Barnes 2020, 561). Importantly, while this story is rooted in reality, it presents only a partial truth.

For example, "violence" is often associated with the use of physical force. However, the term also refers to the intentional use of power or threatened physical force "against oneself, another person, or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation" (World Health Organization 2014, 84). Studies on intimate relationships have demonstrated the immense harm that can be inflicted through the everyday coercive micromanagement of partners and children (Stark 2007), financial control (Postmus et al. 2020), sexual abuse (Maniglio 2009) and emotional abuse (Iwaniec et al. 2006). Such behaviours are often gendered, with decades of research demonstrating that women are more likely to be subject to intimate partner violence, and men are more likely to commit it (Kelly and Westmarland 2016). Moreover, feminist scholars typically insist that "coercively controlling behaviours [over time] constitute a substantively different kind of violence and abuse than a one-off incident situationally motivated to win an argument or indicate frustration" (Donovan and Barnes 2021, 243). Xavier Guadalupe-Diaz and Amanda Koontz Anthony (2017, 1) argue that this is because such abuse "can be understood as interactional control through which abusers direct or manipulate the victim's identity work and sense of self."

Consequently, domestic violence has been theorised as "a pattern of behaviours involving power and control, based in and reproducing gender inequality" (Kelly and Westmarland 2016, 116). Lori L. Heise (1998) argues for an "ecological" approach to understanding this phenomenon, in which personal, situational, and sociocultural factors all play a part in shaping individual experiences of domestic violence. An ecological approach can help us understand how high-level social phenomena such as rigid gender roles and male entitlement under patriarchy may be enacted through social relations, for example through the likelihood of lower socioeconomic status for women, and male dominance within the family.

The public story of domestic violence emerges (and is contested) as these analyses are debated by feminist scholars and activists, and mediated by journalists, politicians, and policymakers. For example, Kelly and Nicole Westmarland critique UK Government, Office for National Statistics (ONS), and media measures of "domestic violence and abuse." They observe that gendered inequalities are acknowledged but also downplayed in prevalence data, which counts single incidents such as "a single push, slap, or demeaning comment" as equivalent to repeated patterns of violence; by contrast, analyses which factor in "frequency, injury, and fear [reveal] much more gender asymmetry in victimization" (Kelly and Westmarland 2016, 114–115). Kate Seymour (2017) similarly argues that Australia's 2010-2022 *National Plan to Reduce Violence Against Women and Children* is unhelpful in its primary focus on physical acts of violence. However, she also criticises the *National Plan* for its failure to account for LGBTI experienc-

es of domestic violence.[2] Donovan and Barnes (2021, 246) call for increased attention to male as well as LGBT experiences of domestic violence, noting that their point "is not to challenge the extent of violence against women; it is to emphasise that the analysis does not evidence that *only* women are victimised and severely injured […] but rather that they constitute the biggest proportion (and numbers) of those victimized." They further observe that the UK's 2018 ONS statistics indicate that bi women are twice as likely to report experiencing partner abuse when compared to heterosexual women, reflecting wider observations around how sexual marginalisation increases the likelihood of victimisation for people of all genders (Donovan and Barnes 2021; Seymour 2017).

Patterns of coercive violence may also manifest differently for LGBTIQ+ people as compared to cis-heterosexual victim/survivors. Forms of "identity-related abuse" are widely reported, which involves abusers "discrediting, belittling, and devaluing a partner's already-stigmatised LGBTQ identity" (Scheer and Baams 2019, 8053). Catherine Donovan (2018, 2) describes one form of identity-related abuse as "experiential abuse", in which "an abusive partner has been out for longer than the victim/survivor and insists that their behaviour is "what it's like" being LGB and/or T." Guadalupe-Diaz and Anthony (2017) observe that abusers in relationships with trans people may work to discredit or manipulate the identity of their partners, through focusing on their partner's insecurities or seeking to target or regulate their partner's transition.

As a result, many people do not necessarily recognise their experiences as domestic violence "because they do not see themselves in the public story" (Donovan and Barnes 2020, 561). For instance, in a survey of 60 Scottish trans people, Amy Roch and colleagues found that while 80% of respondents identified having experienced abusive behaviour from a partner or ex-partner, "only 60% of respondents recognised the behaviour as domestic abuse" (Roch et al. 2010, 5). Alternatively, victims/survivors may not be recognised as such by others due to factors such as gender modality (Ashley 2022), sexuality, or racialisation. For example, Donovan and Barnes (2020) describe how a mixed-ethnicity cis lesbian who participated in their research was arrested by police after being assaulted in public by her abusive partner, a more stereotypically feminine white woman.

To understand trans people's experiences of domestic violence, therefore, we must learn from the insights of queer and feminist research on the topic, while looking beyond the public story. Systemic forms of oppression regarding gender and sexuality are key to understanding the risks and dynamics of domestic violence facing trans people. However, such violence is not limited to the abuse of physical force, and normative assumptions around what constitutes a typical victim or survivor cannot possibly account for the diversity or complexity of lived experience.

2 Our preferred acronym for sexual and gender minorities in this article is LGBTIQ+ (lesbian, gay, bi, trans, intersex, and queer, etc). However, where cited authors use other acronyms, we reflect this, given they may be referring to somewhat different populations.

DOMESTIC VIOLENCE IN TRANS POPULATIONS

Heise's (1998) ecological approach, which emphasises contextual and systemic elements in understanding risk factors for domestic violence against women, is also helpful for understanding the risks to which trans people of all genders are subject. In a deeply transphobic and cisgenderist world, trans people experience systemic sociopolitical and economic marginalisation and disempowerment. Trans women face the double burden of intersecting misogyny and transphobia, plus the specific forms of non-consensual sexualisation and dehumanisation known as transmisogyny (Serano 2007). Nonbinary individuals living in societies with a binary sex distinction experience particular challenges due to the lack of cultural intelligibility for their gender (Vincent 2020). While some trans men and nonbinary individuals may have access to forms of male privilege, for example through increased pay or respect in the workplace, their trans status renders this privilege provisional; it may be challenged if their trans history is known (Schilt 2010). These experiences are compounded for trans people who experience intersecting forms of oppression, such as racism and ableism (Gamarel et al. 2022; Vincent 2020). These experiences of marginalisation and disempowerment provide a context in which trans people of all genders are disproportionately likely to experience domestic violence when compared to cis people, and also commonly encounter specific patterns of coercive control that reflect the forms of intersecting inequality to which they are subject.

Prevalence of domestic violence among trans people

Sarah Peitzmeier and colleagues conducted an international systematic review and meta-analysis of intimate partner violence experienced by trans people. Across 85 articles and 74 datasets, they found trans people of all genders are 1.7 times more likely than cis people to experience any kind of intimate partner violence, and more than twice as likely to experience physical or sexual violence from an intimate partner; these disparities persist when comparing trans people (of all genders) specifically to cis women (Peitzmeier et al. 2020). In a secondary analysis of national data from the US 2015 Transgender Survey, Keith A. King and colleagues (2022) found that 48.3% of trans people experienced intimate partner violence in their lifetime. In the UK, Chaka Bachmann and Becca Gooch (2017) found that 28% of trans respondents reported abuse from a partner in the previous year.

The likelihood and extremity of domestic violence is heightened when forms of intersecting inequality are taken into account. For example, Leigh A. Bukowski and colleagues (2019) found that 44.7% of Black trans women reported experiencing physical assault from an intimate partner in the previous year, from a sample of 493 women across six US cities. Similarly in the US, trans people of Native American, Alaskan Native American and Middle Eastern heritage are significantly more likely to experience psychological forms of intimate partner violence than white trans people (King et al. 2022). Other factors linked to the highest lifetime risk of intimate partner violence include lower incomes, substance use, being part of a religious or spiritual community, and engaging in sex work (King et al. 2022).

Amy Obradovic observes that both trans populations and young people are particularly at risk of partner violence, suggesting that "gender minority youth may present as doubly vulnerable, indicating an uncomfortable oversight within the current […]

literature" (Obradovic 2021, 10). Obradovic uses the term "dating violence" to capture processes of sexual, psychological, and physical abuse in the context of young people's dating and courtship. Her systematic review found that young trans and gender non-conforming people experienced "significantly greater odds of psychological and particularly sexual victimisation relative to their cisgender (including sexual-minority) peers" (Obradovic 2021, 7). Overall, dating violence prevalence rates were 35.4% for trans girls, 25.7% for trans boys, and 23.9% for young nonbinary people, with sexual and especially psychological abuse being more common than physical abuse.

Young trans people also experience an elevated risk of domestic violence from parents, caregivers, and other family members, often due to perceived deviation from sex/gender norms. Brian Thoma and colleagues' (2021) US study of 1836 trans and cis adolescents noted that trans adolescents had higher odds of reporting psychological, physical, and sexual abuse than cis adolescents. In a systemic review, Valerie Tobin and Kathleen Delaney found that "[a]ll four studies that investigated whether or not CGNC [childhood gender nonconformity] was associated with child abuse found it to be so. Two studies found that the higher the CGNC, the more abuse the child suffered" (Tobin and Delaney 2019, 580). This indicates that children who exhibit gender nonconformity – including disclosing they are trans or queer – are more likely to then be subjected to abuse *because* of others' discomfort with their nonconformity.

Trans-focused risk and control factors

Cisgenderism and transphobia therefore place trans people at risk of focused forms of power and control tactics by abusers. US trans anti-violence group FORGE (2013), list a range of abusive tactics relating to (1) threats of outing or disclosure, (2) weaponizing LGBT community attitudes, (3) gender stereotyping and transphobia, (4) using or undermining a person's identity in order to excuse abuse, (5) violating boundaries, and (6) restricting access to medical treatment or self-expression. How these trans-focused power and control tactics may play out in practice is explored by a growing number of researchers. For example, Jackson Schultz (2020, 308) observes:

> In addition to common tactics such as gaslighting and manipulation, tactics abusers use specifically against trans men include: threatening to publicly "out" stealth trans men; undermining our identities by refusing to use the correct name and pronouns; telling us that "real men" enjoy rough sex, do not cry, or would not report abuse; denying access to transition-related treatment, support spaces, or information; purposefully touching parts of our bodies that cause dysphoria or using offensive terms for our body parts.

Similarly, Loree Cook-Daniels (2015, 129) notes that a trans person's self-doubt about their own gender "is easily exploited by intimate partners, who can undermine a person's gender identity by claiming they are 'not doing it right' or 'aren't really [the gender they say they are].'" Abusers telling partners that they are not a real man or woman was the most commonly reported form of intimate partner violence in the 2015 US Transgender Survey (King et al. 2022). In Scotland, Roch and colleagues (2010, 12) found that 73% of respondents experienced forms of abusive behaviour from partners or ex-partners "which specifically aimed to oppress or invalidate the transgender person's gender identity, undermine their ability to transition, or to influence their decision about

coming out to others."

Guadalupe-Diaz and Anthony's (2017) concept of "discrediting identity work" is useful for explaining these trans-focused forms of domestic violence. They describe identity work as the activities people engage in to create, present, and sustain socially acceptable identities which reflect their self-conceptualisation. For trans people, gendered identity work is both vital and precarious in a trans-antagonistic world (Guadalupe-Diaz 2019). Guadalupe-Diaz and Anthony (2017) identify two means by which trans people's identity work may be discredited within relationships, therefore increasingly their vulnerability and reliance on their abuser. Firstly, "altercasting" involves defining a social situation in ways that define or otherwise limit the role or identity of another, for example through claiming their partner is not being a "real man" or "real woman" unless they act in particular ways. Secondly, abusers may target "sign vehicles"—that is, props for signifying an individual's identity—for example through seeking to control how a trans partner dresses or what medication they take.

Trans people can be particularly vulnerable to domestic violence if isolated from supportive communities due to transphobia and cisgenderism (Guadalupe-Diaz 2019). Trans people may therefore experience "severe dependency" on their abusers (Guadalupe-Diaz and Anthony 2017, 2), especially if they appear to be initially supportive (Guadalupe-Diaz 2019). This reflects known risk factors for domestic violence among cis women (Heise 1998). Brian Peter Tesch and Debra A. Bekerian (2015, 400) report that a service provider claimed that for some trans women, "the abuse might actually help to affirm their status as a 'real woman.'" The service provider further speculated that trans women who stay with abusers who affirm their status'" in this way do so because of how their gender is denied in other contexts. Xavier Guadalupe-Diaz and Jana Jasinski (2016) observe that trans people face challenges in navigating "genderist" (i.e. cisnormative) resources when seeking help. Abusers may therefore "invoke the fear of provider discrimination by attempting to convince us that, because we are trans, our reports of abuse will not be taken seriously by clinicians, doctors, or police" (Schulz 2020, 308). These fears are frequently justified, with abusers turning systemic transphobia to their advantage. For example, in the context of custody battles, attorneys across numerous jurisdictions have argued that a survivor's trans status means that they are not fit to parent (Greenberg 2012; Rogers 2013).

Importantly, forms of discrediting identity work and isolation may also be used against trans people by partners who are themselves trans (FORGE 2013), in a similar manner to abuse tactics within LGB relationships (Donovan and Barnes 2020). For instance, in Guadalupe-Diaz's (2019) qualitative study of trans survivors, six of the abusers were trans. This emphasises the importance of identifying ecological risk factors for domestic violence, rather than simply the sex/gender or gender modality of the abuser. These may include factors such as patriarchal binary gender norms and socioeconomic precarity (Heise 1998), plus intercommunity inequalities that give rise to phenomena such as experiential abuse within LGBTIQ+ populations more widely (Donovan and Barnes 2020).

Interpersonal and institutional affirmation contributes to trans people's resilience in the face of aforementioned risks. Affirmation involves recognition of a trans person's self-knowledge, thereby reinforcing that person's own account of their life, identity, and experience of sex/gender (Horton 2022). As Schultz (2020, 209) notes,

"[f]or many trans survivors, the ability to access spaces of empathy and innate understanding is a useful tool in recovery." It is therefore a necessary element of appropriate services for trans survivors of domestic violence (Kurdyla et al. 2021; Riggs et al. 2016).

Risks experienced by trans birth parents

We are not aware of any published research to date that looks substantially at trans parents' experiences of domestic violence, especially for trans birth parents. However, related literatures indicate the likelihood of heightened vulnerability immediately before and during pregnancy, as well as during the postpartum period, due to wider ecological factors. Trans birth parents across a range of national contexts face "significant challenges during pregnancy and birth […] which are informed by institutionalized cisnormativity" (Besse et al. 2020, 518). These can include experiences of exclusion, isolation, and loneliness (Charter et al. 2018), lack of awareness and knowledge among healthcare providers (Light et al. 2014), mistreatment and microaggressions (Falck et al. 2021), and an absence of legal recognition for their fatherhood or parenthood (Love 2022). Together, these factors put both trans parents and their children at significant risk.

For example, Daphna Stroumsa and colleagues (2019) report on a case study in which a heavily pregnant man's unborn baby died while he was in a hospital seeking help; medical staff had not initially recognised that it was possible for him to be pregnant. Trevor MacDonald and colleagues (2021) observe that a research participant was reported to social services by a midwife simply because he was a pregnant man. In an LGBT Foundation (2022) study of 121 trans birth parents in England, 30% of respondents did not access any kind of support from National Health Service (NHS) or private midwives during their pregnancy or pregnancies (compared to less than 2.1% of cis mothers). Discomfort with perinatal services (for example, fear of misgendering and prejudiced treatment) was a major risk factor for respondents giving birth without medical support. Notably, a higher proportion of trans people of colour in the LGBT Foundation study did not access support: 46%, compared to 28% of white trans birth parents. This shows how trans people of colour are particularly vulnerable at the intersection of racism and transphobia, paralleling the experiences of cis women of colour in reproductive health (Valdez and Deomampo 2019).

The experiences of cis parents further demonstrate that family planning, pregnancy, and the postpartum period can be specific sites of heightened risk for domestic violence (Hedin 2000). Of particular relevance to our own findings are forms of reproductive coercion: that is, behaviours that interfere with a person's autonomous decision-making with regards to reproductive health (Grace and Anderson 2016). For people of all genders, this involves a partner exerting power and control over their reproductive choices and outcomes, such as through pressure and/or coercion to have sex for the purpose of conception, or the prevention and/or sabotage of birth control methods (Park et al. 2016). Two participants in Guadalupe-Diaz's (2019) study describe how potential pregnancy was used against them as a form of identity-related abuse by cis men; in one instance an abuser threatened to make his partner pregnant, and in the other he tried to prevent his partner from undergoing genital surgery so they could conceive.

RESEARCH METHODS

The Trans Pregnancy Project was an international study of the experiences and healthcare needs of trans people with regards to pregnancy and childbirth. The research took place across four Minority World jurisdictions: Australia, Canada, the United States, and the European Union, including the pre-Brexit United Kingdom (see Pfeffer et al. 2023 and Riggs et al. 2021 for a detailed discussion of methods, sampling, and ethical approval). The participant narratives that inform this article are drawn from 52 semi-structured interviews undertaken between 2018 and 2021, with men, transmasculine, and/or nonbinary people who experienced pregnancy. Interviews were undertaken by the first author, Ruth Pearce (in EU countries), the second author, Carla Pfeffer (in North America), and a research associate of the third author, Damien W. Riggs (in Australia). We interviewed participants in urban and rural settings from a range of socio-economic backgrounds; however, the sample was disproportionately white. We sought to achieve racial diversity in the research sample and utilised enhanced recruitment incentives for North American participants of colour. Effective recruitment was undermined by the limitations of the all-white research teams' social networks (a primary means of research recruitment), disproportionate impacts of COVID-19 on communities of colour during the latter years of the recruitment period, and failure to effectively engage the project's community advisory board (see Riggs et al. 2023 for a critical account).

While the interviews included questions about trans birth parents' experiences of sex and relationships, research participants were *not* asked to disclose experiences of domestic violence. Indeed, this was also not a topic we considered addressing when designing the interview schedule. However, 12 participants voluntarily disclosed that they had experienced domestic violence, 10 of whom provided more detailed narratives. This information provided the basis for the analysis present here.

All participants were informed verbally and in writing that they had full autonomy over what they chose to share. They did not have to answer any of the questions asked or provide any kind of detailed response if they did not want to, could withdraw from the interview at any time, could withdraw retroactively from the study, and could request amendments to the interview transcript. In discussing forms of risk and vulnerability associated with gestational parenthood among trans people, we aim to honour the trust these individuals placed in us as researchers, providing new insights into how domestic violence may be experienced specifically by trans birth parents.

The sub-sample of 10 individuals discussed in this article is smaller than the 52 interviewed for the wider project. Further, because we did not directly inquire about the experience of domestic violence in our interviews, it is possible that the nearly 20 percent of participants who discussed these experiences is a considerable underestimation of those actually experiencing domestic violence in the context of their experience as trans birth parents. It nevertheless offers an important opportunity to identify some of the potential social dynamics and risk factors relating to domestic violence among trans birth parents.

There is no consensus among methodologists regarding the minimum number of qualitative interviews required to draw conclusions from an empirical sample (Baker and Edwards 2017). Some have sought to identify the number of interviews required to achieve "saturation" in terms of codes, themes, and/or theories that might be iden-

tified within a sample (Hagaman and Wutich 2017); this, in theory, might enable some replicability and/or generalizability of findings. However, as Virginia Braun and Victoria Clarke (2021) observe, such requirements presuppose that meaning (and by extension, themes) exist "in" data prior to any process of analysis. Our position, following Braun and Clarke (2021) is that analytic themes are identified actively and reflexively by the researchers through their engagement with the data. This task does not necessarily call for a specific number of participants, but rather requires analyses that dive deep into individual experiences and contextualise them within a wider social field. Moreover, as Jacqueline Low argues, "there are always new theoretical insights to be made as long as data continues to be collected and analysed" (Low 2019, 131).

In this article we do not make any generalisable claims regarding the prevalence of given forms of violence, as we are reporting on a qualitative sample which does not necessarily reflect the wider population of trans birth parents (especially given, for example, the underrepresentation of trans people of colour). Rather, our findings show *how* domestic violence *can* be experienced in specific ways by trans men, trans/masculine and nonbinary people experiencing pregnancy and childbirth and identify phenomena that have not previously been analysed in this context. This is important given the current dearth of empirical research on this topic, and we hope researchers and practitioners will find it a useful starting point for future work.

The first author, Ruth Pearce, conducted the primary thematic analysis for this article, coding material from interview transcripts using the qualitative data analysis software Nvivo. The initial coding tree was based upon the FORGE (2013) categories of trans-specific power and control tactics. Ruth also coded for specific forms of physical and sexual violence, the relationship between the research participant and their abuser, and the response of relevant practitioners where described (e.g. birth workers, therapists, physicians, social workers). This approach enabled us to contextualise the reported experiences of trans birth parents in terms of what is already known about domestic violence, both among trans people and within the wider trans population, and identify experiences which are largely unaccounted for in existing literature.

We identified two central themes in participant narratives that have not explicitly been discussed in previous work: conditional affirmation, which we describe as a form of identity-based emotional abuse; and pregnancy as a site of cisgenderist coercion. These findings expand upon existing accounts of domestic violence while demonstrating ways in which coercion and control may be enacted specifically against trans birth parents.

PARTICIPANTS' EXPERIENCES OF VIOLENCE

We now provide a brief introduction to the experiences of the 10 trans birth parents who provided narratives of domestic violence. We also outline an example of how individual experiences of violence fitted into wider patterns of coercive and controlling behaviour from abusers. Pseudonyms are used for all participants quoted, to help protect their privacy; we also provide some demographic details when introducing them to offer a little more context for their stories.

All 10 participants reported experiencing psychological abuse, reflecting existing findings on the commonality of this form of violence among trans people (Guada-

lupe-Diaz 2019; King et al. 2022). Six individuals described being subjected to identity-related abuse through dehumanising or discriminatory language from partners and/or carers, which included (for example), misgendering, dismissal of their sexual and/or gender identity, and non-consensual fetishization of their sexual and/or gender identity. Two participants described partners controlling their finances. Three participants faced custody battles for their children from abusive ex-partners and/or after having their children removed by social services due to discrimination connected to their trans and/or survivor status, reflecting wider legal trends in multiple countries (Greenberg 2012; Rogers 2013).

Four participants described the use of physical force against themselves and/or their children from partners and/or carers. Two of these individuals disclosed experiences of rape at the hands of long-term partners and/or parents. A further two participants described experiencing statutory rape through casual sex with considerably older men as minors.

A majority of participants named their abusers as cis men: this included intimate partners, fathers/stepfathers, and a sperm donor. However, one participant described violence committed by a trans man partner, another by a cis woman partner, and several participants described psychological and/or physical abuse enacted by mothers or grandmothers during childhood or early adulthood as well as by male partners later in life. This reflects what is known about domestic violence more widely. Individuals subject to violence in childhood experience greater risk in adulthood; while abusers are disproportionately men, they are not exclusively so; and LGBTIQ+ people may perpetrate as well as experience abuse (Donovan and Barnes 2021; Guadalupe-Diaz 2019). Therefore, while gender inequality within a relationship can be an important individual factor in abuse, the wider ecological context of disempowerment and risk must also be acknowledged (Heise 1998).

The story of Rubin, a white genderqueer research participant living "below poverty" in the US, illustrates the importance of an ecological approach, to account for the way in which multiple forms of transphobic violence form a pattern of abuse within the context of cisgenderist norms. After Rubin came off testosterone to conceive, his partner – a bisexual cis man – wrongly assumed that he was planning to detransition: "[He] thought I was going to transition to be a woman again. I think that's what he wanted because he didn't actually feel comfortable being seen as a gay guy."[3] Subsequently, Rubin's partner started putting significant pressure on him to actually change his gender, which would eventually cause Rubin to temporarily detransition.

Against Rubin's explicit wishes, his partner discouraged affirmation of Rubin's gender by birth workers and by his own family, and encouraged others to read him as a woman, for example through purchasing breast prostheses for Rubin to wear. He also refused to contribute financially to the family, despite Rubin (who was working a low-wage job) experiencing malnourishment during and after the pregnancy. He began to physically abuse Rubin, with Rubin describing how "there was one argument in which he pushed me down after my [child] was born […] he would use his strength a lot to

3 It is common for prospective trans birth parents who use testosterone to pause hormone therapy before attempting to conceive (Pfeffer et al. 2023).

show me kind of that he could throw me around." Rubin eventually left his partner and took out a restraining order after discovering he had been physically violent towards their six-year-old child. A lengthy custody battle followed, in which Rubin's trans status was used against him.

Rubin's story demonstrates trans-focused forms of discrediting identity work, including altercasting through projecting a female identity onto him, and controlling this through props (Guadalupe-Diaz and Anthony 2017). His narrative reflects but also complicates elements of the public story of domestic violence (Donovan and Barnes 2020); misgendering and pressure to detransition sit alongside financial and physical abuse within a pattern of coercion and control. Importantly, Rubin's narrative also highlights how pregnancy can provide a specific context for domestic violence. He was subject to cisgenderist assumptions about the nature of pregnancy as essentially tied to womanhood and feminized social and reproductive labour, coupled with rejection of his gender as a man. This meant he was especially vulnerable to gender-based violence from his partner and his partner's family. Acknowledging these complexities is vital in accounting for the experiences of domestic violence among trans birth parents.

CONDITIONAL AFFIRMATION

The theme we describe as "conditional affirmation" demonstrates how coercive and contingent forms of gender-affirming behaviour may constitute emotional abuse, as part of a pattern of violence. This expands on Guadalupe-Diaz and Anthony's (2017) account of identity abuse, Donovan and Barnes' (2020) work on abuse of experiential power, and FORGE's (2013) typology of trans-specific domestic violence. It also speaks to Tesch and Bekerian's (2015) claim that some trans women may rationalise their experience of domestic violence as a form of affirmation within a wider context of denial and deprivation. We posit that trans people who experience little in the way of gender affirmation elsewhere in their lives – especially young trans people – are particularly at risk of conditional affirmation. Moreover, the risks and/or impact of this may be intensified through pregnancy or actions that lead to conception.

This can be seen in the example of Charlie, a white, working-class, masculine-leaning person living in the UK. As a teenager, Charlie did not feel safe being openly trans with his family or in school. Indeed, his fears of a negative response were realised when he attempted to come out as bisexual to immediate family. He therefore built a network of friends outside of school who offered some level of gender affirmation.

> Charlie: So I won't be able to transition in my family's eyes, but at least I want my friends to know who I am.
>
> Ruth: Yeah, so did they change the name or pronouns they used for you at the time?
>
> Charlie: Yes, they even came up with a nickname they could use around family, around the friends that didn't know. And they used very much gender-neutral pronouns.

Many of these individuals were a lot older than Charlie; for example, he explains that

one of them "would have been late 20s." Within this group, Charlie began having regular unprotected sex, and became pregnant for the first time aged 13. He reflected: "Even though they were, they supported me, they were a lot older than me and they shouldn't have done what they did."

Similarly, Matthew, a white, working-class, transmasculine person living in the UK, reported having sex with older men as a minor. Chris, a mixed-heritage, working-class, trans man living in Germany, described marrying a "much older" man as an out trans teenager, with whom they conceived a child. More generally, research from North America indicates that trans youth with the ability to conceive are more likely to experience a teenage pregnancy than cis peers, with physical and sexual abuse identified as a risk factor (Charlton et al. 2021). In addition to disrupting the public story of domestic violence, the experiences of these young people disrupt emergent narratives of trans pregnancy and childbirth, in which much media coverage and research has focused on adult men in a monogamous relationship, who strongly desire a child but may struggle to conceive (Pearce and White 2019).

These experiences can be understood as a form of identity-related abuse, in which abusers exploit an intimate or dating partners' contextual isolation, as well as their desire for recognition and partnership, to ensure that their partner is indebted to them and to control their behaviour (Guadalupe-Diaz and Anthony 2017; Guadalupe-Diaz 2019). They can also be understood as a form of experiential abuse, in which a more experienced partner in a queer relationship takes advantage of the discrepancy between their access to community knowledge and support. Furthermore, these participants' experiences reflect long-standing observations regarding the impact of economic inequality as a risk factor for domestic violence (Heise 1998), even as the dynamics of youthful queer relationships may differ from the public story of abuse (Donovan and Barnes 2020).

However, we argue it is important to name conditional affirmation as a specific problem, and one that can either lead to unintended pregnancy or put people at higher risk during the perinatal period. This particular form of identity abuse occurs in the context of trans people's frequent social isolation, especially as young trans people face increasing systemic hostility in countries such as the UK and US (Horton 2023; DuBois et al. 2023). It is addressed occasionally within trans art and culture,[4] but not explicitly within current academic literature. Stories such as Charlie's clearly show how young people can be placed at heightened risk of both violence and unplanned teenage pregnancy due to an absence of unconditional affirmation for their gendered experience from institutions, family, and friends. Our observations provide further qualitative context for existing quantitative findings that associate increased childhood gender nonconformity with increased experiences of abuse (Tobin and Delaney 2019). Trans people with no other support available may seek recognition from individuals who offer a form of gender affirmation in the context of sexual and emotional abuse.

The exploitation of trans people through forms of conditional gender affirmation therefore demonstrates the importance of holistic support from institutions such

4 For example, underscores' (2023) song "Johnny johnny johnny" is written from the perspective of a trans girl who is groomed by a paedophile; she describes how he takes advantage of her desire for affirmation.

as schools, as well as within families. For birth parents, traumatic experiences can inform their experiences of conception and pregnancy, and, as we shall show, provide context for later vulnerability during labour and birth.

PREGNANCY AS CISGENDERIST COERCION

The second theme we identified involved weaponization of gendering by abusive partners, as a cisgenderist form of reproductive coercion. In Western societies, reproductive desire is often seen to reify binary sex/gender norms; pregnancy is therefore normatively positioned as a hyperfeminine activity that, more than anything else, comes to define womanhood (Pfeffer et al. 2023). The gendering of presumed motherhood is critiqued by postcolonial feminist scholars such as Oyèrónkẹ́ Oyěwùmí, who observes that Western notions of binary sex/gender are just one way in which we might attach meaning "to the events and processes associated with human reproduction and attendant social reproduction" (Oyěwùmí 2016, 8). Michelle Walks (2017) describes the feminisation of pregnancy and birth as a "cultural fetish," reinforced by social factors such as the stereotypically-hyperfeminized design of most pregnancy clothing, and heightened heteronormativity in everyday social interactions. Consequently, participants reported forms of abusive, cisnormative gendering which encompass—but also differ substantially from—the kinds of reproductive coercion experienced by cis people (Park et al. 2016). Specifically, participants described a loss of reproductive autonomy through being coerced into femininization or ascribed womanhood through their pregnancy.

Every one of the 52 trans birth parents interviewed for the Trans Pregnancy Project reported grappling with how their pregnancy was frequently coded *by others* as a significantly "feminine" cultural signifier. This was especially a problem in public, where the supposed impossibility of the pregnant masculine and/or trans body either rendered participants invisible (through being positioned either as not-pregnant or as cis mothers) or hypervisible (as a "pregnant man"). It is in this context that several participants described how their pregnancy was (mis)gendered by abusers, as part of a pattern of coercion and control. This invariably involved gender ascription of prospective trans parents as "really" women. In this way, private and domestic spaces also became sites of coercive gendering.

Rubin described how: "I detransitioned during that time of pregnancy. And that has to do a lot with the abusive situation that I was in also, and got forced into and pushed all the way back into female." Similar pressures were described by participants such as Chris. They came out as a boy prior to marrying a far older man in their late adolescence. After their husband expressed a desire for a child, Chris stopped taking testosterone and became pregnant during their final year of school. They explained that "because of my pregnancy, it was more hard or I think impossible for [the husband] to see me as a man anymore," demonstrating the conditional nature of his affirmation of Chris' gender. This was reinforced by members of their husband's family, who told Chris that their clothes "look like trash bags" when they began to wear non-feminine baggy attire (such as large hoodies) during their pregnancy. In this way, Chris' pregnancy was used an excuse for discrediting their identity as a man (Guadalupe-Diaz and Anthony 2017). Matters came to a head in the hospital while Chris was

giving birth. Their husband repeatedly spoke over them about their needs, called them a "mother," and misgendered them in front of medical staff. Following this extremely stressful experience, Chris divorced their husband. However, they reflected that prior to these experiences, "I just ignored some signs for a very long time, I think."

While Chris moved through the world as male prior to their pregnancy, other participants described how coerced parenthood caused them to delay a desired social and/or physical transition. For example, Rich, a mixed-heritage man living in Australia, outlined how: "My partner at the time was quite abusive and coerced me into going off birth control so we could have a pregnancy. So that's kind of how it went down. So it was planned, but not particularly consensual." Rich explained that his pregnancy, and subsequently, the new baby, kept him "locked in" to this abusive relationship. He reflected on how his transition might "have fast forwarded a couple of years if I hadn't have been pregnant." Moddy, a white, working-class agender person living in the UK, similarly explained:

> I only actually fell pregnant, got pregnant, the next three times because my ex fucked around with my child contraception and the dates in my calendars and stuff. He could see that [Moddy's first two children] were growing up and getting to that stage of independence where he didn't need me. Giving me two more children was a way of keeping me.

Moddy only felt they could come out to others as agender after ending their relationship with this partner.

In many ways, stories such as Rich's and Moddy's reflect the kinds of narrative present in cis parents' experiences of reproductive coercion (Park et al. 2016). However, through the (cis)gendering of their pregnancy, they also share something important with participants such as Rubin and Chris: they are not only manipulated into staying within a relationship, but also actively prevented from expression their gender authentically.

Pregnancy, gender, and presumed motherhood are deeply implicated in sexist *and* cisnormative systems of social control and regulation; abusive partners may exploit these systems. Our findings build on accounts of reproductive coercion among cis people (Park et al. 2016) to show how the feminization of pregnancy, in particular, may be used against trans people as a cisgenderist form of identity abuse (Guadalupe-Diaz and Anthony 2017). In this way, prospective trans parents can experience pressure to detransition, delay transition, or not transition within the private as well as the public sphere, while simultaneously being coerced to remain in a violent relationship.

CONSEQUENCES FOR PERINATAL CARE

Experiences of conditional affirmation or cisgenderist coercion during or prior to pregnancy can have substantial consequences for perinatal care. Several participants explained that an absence of sensitivity from birth workers compounded harms they experienced in former and/or ongoing domestic abuse. Conversely, other participants described how tailored care can ensure a safer and more positive experience of pregnancy and birth. From an ecological perspective, we demonstrate that perinatal care can offer both a context of additional risk and possible harm mitigation for trans survivors.

Little research has been undertaken on trans people's experiences of traumatic pregnancy and birth (Greenfield and Darwin 2021). However, accounts such as Chris' story of misgendering in a hospital shows how trans birth parents' experiences of abuse can be highly significant for their experience of perinatal care. We therefore found that the availability of gender-affirming *and* trauma-informed care from birth workers (such as midwives, obstetricians, gynaecologists, and doulas) is vital, especially given the high prevalence of domestic violence among trans people (Peitzmeier et al. 2020).

Compounding harm in perinatal care

The experiences of participants in this research show how important it is for birth workers to listen to what prospective parents say about their gender, rather than what their partners say. Participants described how, following experiences of conditional affirmation and/or gendered cisgenderist coercion, the violence they had received was inadvertently compounded by birth workers. For example, on arrival at the hospital to give birth, Chris explained their gender to the midwife, who initially saw them "as a man." However, with the influence of Chris' husband, she began to misgender Chris, thereby reinforcing the husband's cisgenderist coercion:

> We were—those three persons in the room; my husband, me, and her. And she just talked to him and said, "She has to lay down," and "She has to put her leg up" [...] Because she could have said, "You, please lay down," or "Could you please put your legs up?" But she just talked to my husband and used "she."

Rubin reported a similar experience receiving medical check-ups during his pregnancy:

> [The midwives] were mostly straightforward and—not too awkward, except with [Rubin's partner]'s weird interjections that started making me wonder what was going on and why people were treating me in a way I didn't understand. So—I felt like the people that I chose would have been fine if I had had a supportive partner who was clearly on the same page with me and had my back.

While Rubin states that he might have been treated better if he had a supportive partner, his account also indicates that birth workers sometimes took his abuser's "weird interjections" more seriously than Rubin's description of his own desires and needs. This undermined the treatment he received, leading to a traumatic birth experience that Rubin described as "like rape."

These experiences highlight the importance of consent and communication *with the birth parent* throughout the perinatal period. They further demonstrate the risks of medical transphobia and importance of birth workers being aware of trans birth parents' heightened risks of experiencing domestic violence. Due to the discursive impact of cisgenderism (Ansara and Hegarty 2012), as well as the public story of domestic violence (Donovan and Barnes 2020), it is possible that the birth workers in these stories simply did not recognise that they were complicit in the abuse of participants such as Chris or Rubin.

Mitigating harm in perinatal care

By contrast, several participants highlighted examples of trauma-informed perinatal care which significantly improved their experiences of pregnancy and childbirth. For example, Emma, a white, upper-middle-class, greygender person living in the UK, explained how supported they felt by the specialist midwife team provided by their local NHS trust:

> They have a specialist midwife team […] that specifically looks after people who – essentially, vulnerable situations. So they may refer you to them if you're under 19, victim of domestic violence, or have complex mental health, or any difficult needs. Which is actually, given the system, the complexity of the system, is incredibly useful.

Emma, who was pregnant at the time of interview, highlighted their worries around birth planning and birth preferences, including "the gendering of language." While they were concerned about the limits of what the specialist midwife team might be able to achieve, they clearly valued the provision of a service that explicitly acknowledged those who might have specific needs due to having experienced domestic violence.

Joseph, a white, middle-class, nonbinary and transmasculine person living in the UK, had a very positive experience of perinatal care, despite past experiences that put his health at risk during pregnancy and labour. During his interview, he described being subject to domestic violence during his childhood and young adulthood. In particular, he reflected on experiences of conditional affirmation in his 20s, when he was homeless, mentally ill, and "literally nobody [else] in my life […] was able to affirm my gender."

> So I had nowhere to stay […] I wasn't able to work, I'd completely – there was nothing left of me. And there's this one person who called me "he." And so I ended up staying at her house. We had a sexual relationship […] I wasn't allowed to say no. And that started with sex, and ended up with [being made to] hold hands on the subway.

Joseph further speculated his former partner "liked the idea of being nicely straight […] But she actually wanted someone who was very soft," being attracted to his normatively youthful appearance prior to taking testosterone as a white, transmasculine person. As Joseph explained, "In that trans guy way, I looked very, very young. So even though I was in my 20s, I looked 15." When Joseph did begin to take testosterone, "she resented that, and it caused a lot of issues." Hence, while Joseph's partner offered a limited form of affirmation through gendering him correctly, she ultimately denied him agency over his own life and body.

In connection with these past experiences, Joseph found it difficult to be touched by midwives or doctors, and experienced dissociative seizures. After he conceived with a new partner, it was very important to him to experience consent-oriented and person-centred care throughout the perinatal period. While he did experience medical transphobia during this time, he benefited from the support of a dedicated home birth team, with the same midwives working with him through pregnancy and birth, providing trauma-informed *and* gender-affirming treatment. In particular, Joseph described an extremely positive experience of birth:

> So giving birth is really the only time in my life that I can think of, since

> I've been an adult, possibly ever, where I felt truly looked after. Truly vulnerable, but also safe. […] The love and support I got, and the understanding, and just the fact that consent was such a big part of my birthing experience.

Joseph acknowledged that this level of care arose in part from his ability to advocate for himself:

> I was claiming my own pregnancy. And some of that is because I like to research things. I felt I had to research it because I'm trans. And I felt very vulnerable to just go down that river rapids because, for me, what isn't a sharp rock for other people was gonna puncture my boat.

To an extent, Joseph's self-advocacy reflects aspects of his positionality. While we are cautious about drawing substantial conclusions from a small qualitative sample, it is notable that every participant who described violence they experienced being compounded in a perinatal setting also described themselves as working class, and Chris was also racialised as non-white. By contrast, participants who reported positive experiences were white and middle class.

However, participants such as Emma and Joseph also benefited from midwives taking the initiative in providing trauma-informed care. For example, Joseph's midwives offered (but did not insist on) one-to-one antenatal classes, and worked to ensure that colleagues were adequately informed and prepared to support him. In this way, actively accounting in advance for Joseph's gender and past experience of domestic violence better ensured that birth would be a safe and positive experience for him.

CONCLUSION AND RECOMMENDATIONS

Trans people are not just disproportionately likely to experience domestic violence; they are also at risk of identity-related and experiential abuse, including conditional affirmation and cisgenderist coercion. Our qualitative findings in this article expand on this knowledge through showing how pregnancy and birth are particular sites of gendered vulnerability for trans people, even as their experiences depart from the public story of domestic violence (Donovan and Barnes 2020).

Our findings demonstrate the vital importance of active trans inclusion and affirmation in a range of healthcare and education settings, including midwifery, gynecology, obstetrics, abortion care, mental health care, domestic violence services, schools, and colleges. It is important that trans people are expected in these spaces and know they can receive trans-inclusive and trauma-informed support. Affirming an individual's stated name, gender, and pronouns ensures that they receive a basic level of respect, and will help practitioners avoid revisiting trauma upon them. Ideally, this involves structural measures (e.g. reducing barriers to a change of sex/gender marker) as well as improved interpersonal care (Peitzmeier et al. 2020). A wealth of guidance on affirmative practice is already available from sources such as Brighton and Sussex Hospitals NHS Trust Gender Inclusion Midwives (Green and Riddington 2021).

The proactive availability of trauma-informed, trans-inclusive practice is vital in perinatal care. Practitioners should explain what support is available, and support trans service users to communicate their needs and boundaries, such as around being touched (LGBT Foundation 2022). Professional and peer-led community educa-

tion around what domestic violence looks like in trans communities is also necessary (Peitzmeier et al. 2020). This is relevant to schools and colleges as well as domestic violence services, especially to inform the implementation of trans-sensitive prevention and intervention strategies (Obradovic 2021).

Further research and policy work is urgently needed. A key limitation of this work is the underrepresentation of trans people of colour, and inability of our data to more fully account for the complex intersections of racism and transphobia. Given what we do know about the compounding violence racialised trans people face in both the context of domestic abuse (Bukowski et al. 2019; King et al. 2022) and perinatal care (LGBT Foundation 2022), it is important for future work to better involve trans people of colour as leaders and collaborators as well as participants, to more holistically address the impact of interlocking forms of oppression.

Our final observation is that while trans people are especially vulnerable to abuse, trans communities hold a huge amount of knowledge and tools for both resilience and resistance (Schulz 2020). In the face of enormous barriers and lived trauma, the participants in this research were highly thoughtful in articulating their needs and outlining proposed solutions. It is time for their words to be taken seriously in the fight against domestic violence.

REFERENCES

Ansara, Y. Gavriel, and Peter Hegarty. 2012. "Cisgenderism in Psychology: Pathologising and Misgendering Children from 1999 to 2008." *Psychology & Sexuality* 3(2): 137–160.

Ashley, Florence. 2022. "'Trans' Is My Gender Modality: A Modest Terminological Proposal." In *Trans Bodies, Trans Selves,* edited by Laura Erickson-Schroth. New York: Oxford University Press.

Bachmann, Chaka L., and Becca Gooch. 2017. *LGBT in Britain: Trans Report*. London: YouGov and Stonewall. https://www.stonewall.org.uk/system/files/lgbt_in_britain_-_trans_report_final.pdf.

Baker, Sarah Elsie, and Rosalind Edwards. 2017. *How Many Qualitative Interviews Is Enough? Expert Voices and Early Career Reflections on Sampling and Cases in Qualitative Research*. Southampton: National Centre for Research Methods. https://eprints.ncrm.ac.uk/id/eprint/2273/4/how_many_interviews.pdf.

Besse, Margaret, Nik M. Lampe, and Emily S. Mann. 2020. "Focus: Sex & Reproduction: Experiences with Achieving Pregnancy and Giving Birth Among Transgender Men: A Narrative Literature Review." *The Yale Journal of Biology and Medicine* 93 (4): 517–528.

Braun, Virginia, and Victoria Clarke. 2021. "To Saturate or Not to Saturate? Questioning Data Saturation as a Useful Concept for Thematic Analysis and Sample-Size Rationales." *Qualitative Research in Sport, Exercise and Health* 13 (2): 201–216.

Bukowski, Leigh A., Melvin C. Hampton, Cesar G. Escobar-Viera, Jordan M. Sang, Cristian J. Chandler, Emmett Henderson, Stephanie L. Creasy, and Ronald D. Stall. 2019. "Intimate Partner Violence and Depression among Black Transgender Women in the USA: The Potential Suppressive Effect of Perceived Social Support." *Journal of Urban Health* 96: 760–771.

Charlton, Brittany M., Colleen A. Reynolds, Ariella R. Tabaac, Eli G. Godwin, Lauren M. Porsch, Madina Agénor, Frances W. Grimstad, and Sabra L. Katz-Wise. 2020. "Unintended and Teen Pregnancy Experiences of Trans Masculine People Living in the United States." *International Journal of Transgender Health* 22 (1–2): 65–76.

Charter, Rosie, Jane M. Ussher, Janette Perz, and Kerry Robinson. 2018. "The Transgender Parent: Experiences and Constructions of Pregnancy and Parenthood for Transgender Men in Australia." *International Journal of Transgender Health* 19 (1): 64–77.

Cook-Daniels, Loree. 2015. "Intimate Partner Violence in Transgender Couples: 'Power and Control' in a Specific Cultural Context." *Partner Abuse* 6 (1): 126–139.

Donovan, Catharine. 2018. "Written Evidence Submitted by Professor Catherine Donovan (DVA0060)." London: House of Commons Home Affairs Committee. https://committees.parliament.uk/writtenevidence/92702/pdf/.

Donovan, Catherine, and Rebecca Barnes. 2020. "Help-Seeking Among Lesbian, Gay, Bisexual and/or Transgender Victims/Survivors of Domestic Violence and Abuse: The Impacts of Cisgendered Heteronormativity and Invisibility." *Journal of Sociology* 56 (4): 554–570.

Donovan, Catherine, and Rebecca Barnes. 2021. "Re-Tangling the Concept of Coercive Control: A View From the Margins and a Response to Walby and Towers (2018)." *Criminology & Criminal Justice* 21 (2): 242–257.

DuBois, L. Zachary, Jae A. Puckett, Sarah F. Price, Kelsi Kuehn, Brenna Lash, Tian Walker, Natalie R. Holt, Allura L. Ralston, T. Zachary Huit, Makinna Miles, Sage Volk, A. Capannola, Clover Tipton, Debra A. Hope, Richard Mocarski, and Robert-Paul Juster. 2023. "The Impact of Sociopolitical Events on Transgender People in the US." *Bulletin of Applied Transgender Studies* 2 (1–2): 1–26.

Falck, Felicitas, Louise Frisén, Cecilia Dhejne, and Gabriela Armuand. 2021. "Undergoing Pregnancy and Childbirth as Trans Masculine in Sweden: Experiencing and Dealing with Structural Discrimination, Gender Norms and Microaggressions in Antenatal Care, Delivery and Gender Clinics." *International Journal of Transgender Health* 22 (1–2): 42–53.

Feinberg, Leslie. 1999. *Trans Liberation: Beyond Pink or Blue*. Boston: Beacon Press.

FORGE (2013). *Trans-Specific Power and Control Tactics*. Milwaukee: FORGE. https://forge-forward.org/wp-content/uploads/2020/08/power-control-tactics-categories_FINAL.pdf.

Gamarel, Kristi E., Laura Jadwin-Cakmak, Wesley M. King, Ashley Lacombe-Duncan, Racquelle Trammell, Lilianna A. Reyes, Cierra Burks, Bré Rivera, Emily Arnold, and Gary W. Harper. 2022. "Stigma Experienced by Transgender Women of Color in Their Dating and Romantic Relationships: Implications for Gender-based Violence Prevention Programs." *Journal of Interpersonal Violence* 37 (9–10): NP8161–NP8189.

Grace, Karen Trister, and Jocelyn C. Anderson. 2018. "Reproductive Coercion: A Systematic Review." *Trauma, Violence, & Abuse* 19 (4): 371–390.

Green, Helen, and Ash Riddington. 2021. *Gender Inclusive Language in Perinatal Services*. Brighton: Brighton and Sussex University Hospitals NHS Trust. https://web.archive.org/web/20210211081227/https://www.bsuh.nhs.uk/maternity/our-ser-

vices/specialist-support/gender-inclusion/.
Greenberg, Kae. 2012. "Still Hidden in the Closet: Trans Women and Domestic Violence." *Berkeley Journal of Gender, Law & Justice* 27 (2): 198251.
Greenfield, Mari, and Zoe Darwin. 2021. "Trans and Nonbinary Pregnancy, Traumatic Birth and Perinatal Mental Health: A Scoping Review." *International Journal of Transgender Health* 22 (1–2): 203–216.
Guadalupe-Diaz, Xavier L. 2019. *Transgressed: Intimate Partner Violence in Transgender Lives.* New York: New York University Press.
Guadalupe-Diaz, Xavier L., and Amanda Koontz Anthony. 2017. "Discrediting Identity Work: Understandings of Intimate Partner Violence by Transgender Survivors." *Deviant Behavior* 38 (1): 1–16.
Guadalupe-Diaz, Xavier L., and Jana Jasinski. 2017. "'I Wasn't a Priority, I Wasn't a Victim': Challenges in Help Seeking for Transgender Survivors of Intimate Partner Violence." *Violence Against Women* 23 (6): 772–792.
Hagaman, A. K., and Wutich, A. 2017. "How Many Interviews Are Enough to Identify Metathemes in Multisited and Cross-cultural Research? Another Perspective on Guest, Bunce, and Johnson's (2006) Landmark Study." *Field Methods* 29 (1): 23–41.
Hedin, Lena Widding. 2000. "Postpartum, Also a Risk Period for Domestic Violence." *European Journal of Obstetrics and Gynecology* 89 (1): 41–45.
Heise, Lori L. 1998. "Violence Against Women: An Integrated, Ecological Framework." *Violence Against Women* 4 (3): 262–290.
Horton, Cal. 2022. "'Of Course, I'm Intimidated by Them. They Could Take My Human Rights Away': Trans Children's Experiences with UK Gender Clinics." *Bulletin of Applied Transgender Studies* 1 (1–2): 47–70.
Horton, Cal. 2023. "Depathologising Diversity: Trans Children and Families' Experiences of Pathologisation in the UK." *Children & Society* 37: 753–770.
Iwaniec, Dorota, Emma Larkin, and Siobhán Higgins. 2006. "Research Review: Risk and resilience in cases of emotional abuse." *Child & Family Social Work* 11 (1): 73–82.
Kelly, Liz, and Nicole Westmorland. 2016. "Naming and Defining 'Domestic Violence': Lessons from Research with Violent Men" *Feminist Review* 112 (1): 113–127.
King, Keith A., R. Andrew Yockey, and Rebecca A. Vidourek. 2022. "Transgender Individuals and Psychological Intimate Partner Violence: a National Study." *Journal of Family Violence* 37: 289–300.
Kurdyla, Victoria, Adam M. Messinger, and Milka Ramirez. 2021. "Transgender Intimate Partner Violence and Help-Seeking Patterns." *Journal of Interpersonal Violence* 36 (19–20): NP11046–NP11069.
LGBT Foundation. 2022. *Trans and Nonbinary Experiences of Maternity Services*. Manchester: LGBT Foundation. https://dxfy8lrzbpywr.cloudfront.net/Files/97ecdaea-833d-4ea5-a891-c59f0ea429fb/ITEMS%2520report%2520final.pdf.
Light, Alexis D., Juno Obedin-Maliver, Jae M. Sevelius, and Jennifer L. Kerns. 2014. "Transgender Men Who Experienced Pregnancy After Female-to-Male Gender Transitioning." *Obstetrics & Gynecology* 124 (6): 1120–1127.
Love, Gillian. 2022. "Trans Pregnancy in a Repronormative World." In *Towards Gender Equality in Law: An Analysis of State Failures from a Global Perspective*, edited

by Gizem Guney, David Davies, and Po-Han Lee, 35–58. London: Palgrave Macmillan.
Low, J. 2019. "A Pragmatic Definition of the Concept of Theoretical Saturation." *Sociological Focus* 52 (2): 131–139.
MacDonald, Trevor Kirczenow, Michelle Walks, MaryLynne Biener, and Alanna Kibbe. 2021. "Disrupting the norms: Reproduction, gender identity, gender dysphoria, and intersectionality." *International Journal of Transgender Health* 22 (1–2): 18–29.
Maniglio, Roberto. 2009. "The Impact of Child Sexual Abuse on Health: A Systematic Review of Reviews." *Clinical Psychology Review* 29 (7): 647–657.
Obradovic, Amy. 2021. "Que(e)r(y)ing Gender-Based Violence: Inquiry Into the Gender-Based Assaults of Trans-Identifying People." PhD thesis, Canterbury Christ Church University.
Oyěwùmí, Oyèrónkẹ́. 2016. *What Gender Is Motherhood? Changing Yoruba Ideals of Power, Procreation, and Identity in the Age of Modernity*. Basingstoke: Palgrave Macmillan.
Park, Jeanna, Sherry K. Nordstrom, Kathleen M. Weber, and Tracy Irwin. 2016. "Reproductive Coercion: Uncloaking an Imbalance of Social Power." *American Journal of Obstetrics and Gynecology* 2014 (1): 74–78.
Pearce, Ruth, Deborah Lynn Steinberg, and Igi Moon. 2019. "The Emergence of 'Trans.'" *Sexualities* 22 (1–2): 3–12.
Pearce, Ruth, and Francis Ray White. 2019. "Beyond the Pregnant Man: Representing Trans Pregnancy in *A Deal with the Universe*." *Feminist Media Studies* 19 (5): 764–767.
Peitzmeier, Sarah M., Mannat Malik, Shanna K. Kattari, Elliot Marrow, Rob Stephenson, Madina Agénor, and Sari L. Reisner. 2020. "Intimate Partner Violence in Transgender Populations: Systematic Review and Meta-Analysis of Prevalence and Correlates." *American Journal of Public Health* 110 (9): e1–e14.
Pfeffer, Carla A., Sally Hines, Ruth Pearce, Damien W. Riggs, Elisabetta Ruspini, and Francis R. White. 2023. "Medical Uncertainty and Reproduction of the 'Normal': Decision-Making Around Testosterone Therapy in Transgender Pregnancy." *SSM - Qualitative Research in Health* 4: 100297.
Postmus, Judy L., Gretchen L. Hoge, Jan Breckenridge, Nicola Sharp-Jeffs, and Donna Chung. 2020. "Economic Abuse as an Invisible Form of Domestic Violence: A Multicountry Review." *Trauma, Violence, & Abuse* 21 (2): 261–283.
Riggs, Damien W., Ruth Pearce, Sally Hines, Carla A. Pfeffer, and Francis Ray White. 2023. "Whiteness in Research on Men, Trans/Masculine and Nonbinary People and Reproduction: Two Parallel Stories." In *The Routledge International Handbook of New Critical Race and Whiteness Studies*, edited by Rikke Andreassen, Catrin Lundström, Suvi Keskinen, and Shirley Anne Tate. New York: Routledge.
Riggs, Damien W., Carla A. Pfeffer, Ruth Pearce, Sally Hines, and Francis Ray White. 2021. "Men, Trans/Masculine, and Nonbinary People Negotiating Conception: Normative Resistance and Inventive Pragmatism." *International Journal of Transgender Health* 22 (1–2): 6–17.
Riggs, Damien W., Heather Fraser, Nik Taylor, Tania Signal and Catherine Donovan. 2016. "Domestic Violence Service Providers' Capacity for Supporting Transgender Women: Findings From an Australian Workshop." *British Journal of Social Work* 46: 2374–2392.

Roch, Amy, James Morton, and Graham Ritchie. 2010. *Out of Sight, Out of Mind? Transgender People's Experiences of Abuse*. Edinburgh: LGBT Youth Scotland and Equality Network.
Rogers, Michaela. 2013. "'Transforming Practice': Understanding Trans People's Experience of Domestic Abuse and Social Care Agencies." PhD thesis, University of Sheffield.
Scheer, Jillian R., and Laura Baams. 2021. "Help-Seeking Patterns Among LGBTQ Young Adults Exposed to Intimate Partner Violence Victimization." *Journal of Interpersonal Violence* 36 (17–18): 8050–8069.
Schilt, Kristen. 2010. *Just One of the Guys? Transgender Men and the Persistence of Gender Inequality*. Chicago: University of Chicago Press.
Schulz, Jackson W. 2020. "Supporting Transmasculine Survivors of Sexual Assault and Intimate Partner Violence: Reflections from Peer Support Facilitation." *Sociological Inquiry* 90 (2): 293–315.
Serano, Julia. 2007. *Whipping Girl: A Transsexual Woman on Sexism and the Scapegoating of Femininity*. Emery, CA: Seal Press.
Seymour, Kate. 2017. "(In)Visibility and recognition: Australian policy responses to 'domestic violence.'" *Sexualities* 22 (5–6): 751–766.
shuster, stef m. and Laurel Westbrook. 2022. "Reducing the Joy Deficit in Sociology: A Study of Transgender Joy." *Social Problems*: spac034.
Stark, Evan. 2007. *Coercive Control: Men's Entrapment of Women in Everyday Life*. Oxford: New York University Press.
Stroumsa, Daphna, Elizabeth FS Roberts, Hadrian Kinnear, and Lisa H. Harris. 2019. "The Power and Limits of Classification: A 32-Year-Old Man with Abdominal Pain." *The New England Journal of Medicine* 380: 1885–1888.
Tesch, Brian Peter, and Debra A. Bekerian. 2015. "Hidden in the Margins: A Qualitative Examination of What Professionals in the Domestic Violence Field Know About Transgender Domestic Violence." *Journal of Gay & Lesbian Social Services* 27 (4): 391–411.
Thoma, Brian C., Taylor L. Rezeppa, Sophia Choukas-Bradley, Rachel H. Salk, and Michael P. Marshal. 2021. "Disparities in Childhood Abuse Between Transgender and Cisgender Adolescents." *Pediatrics* 148 (2): e2020016907. https://doi.org/10.1542/peds.2020-016907.
Tobin, Valerie, and Kathleen R. Delaney. 2019. "Child Abuse Victimization Among Transgender and Gender Nonconforming People: A Systematic Review." *Perspectives in Psychiatric Care* 55 (4): 576–583.
underscores. 2023. "Johnny johnny johnny." In *Wallsocket*. Corporate Rockmusic.
Valdez, Natali, and Daisy Deomampo. 2019. "Centering Race and Racism in Reproduction." *Medical Anthropology* 38 (7): 551–559.
Vincent, Ben. (2020). *Nonbinary Genders: Navigating Communities, Identities, and Healthcare*. Bristol: Policy Press.
Walks, Michelle. 2017. "The Gender of Pregnancy." In *Global Currents in Gender and Feminism: Canadian and International Perspectives*, edited by Glenda Tibe Bonifacio, 181–194. Bingley: Emerald.
World Health Organization. 2014. *Global Status Report on Violence Prevention 2014*. Geneva: World Health Organization. https://www.who.int/publications/i/item/9789241564793.

ORIGINAL ARTICLE

"It's Not the 'Being Trans,' It's Everything Around That": Trans Community Perspectives for Suicide Prevention

Anne V. Kirby
is an Associate Professor at the University of Utah. Her professional background is in occupational therapy, and she holds an academic position in the Department of Occupational and Recreational Therapies, as well as an adjunct appointment in the Department of Psychiatry and at the Huntsman Mental Health Institute.
✉ avkirby@gmail.com

Emily Krebs
is an Assistant Professor in the Department of Communication and Media Studies at Fordham University and was a doctoral student at the University of Utah at the time this study was conducted.

Laurel Hiatt
is a doctoral student at the University of Utah in the Department of Genetics. Their research focuses on genetics also on transgender health.

Anna Docherty
is an Associate Professor in the Department of Psychiatry and the Huntsman Mental Health Institute at the University of Utah. She is a quantitative geneticist and psychologist, examining genetic risk and resilience in the context of severe outcomes including psychosis and suicide.

Nicole L. Mihalopoulos
is an adolescent medicine physician and Associate Professor at the University of Utah. She has special interest in obesity and heart disease risk factors, menstrual management, eating disorders, and transgender healthcare.

Brooks R. Keeshin
is a child and adult psychiatrist with appointments at the University of Utah and Intermountain Healthcare in Utah, USA, as well as at the Department of Public Health and Caring Science, Child Health and Parenting (CHAP), Uppsala University, Uppsala, Sweden. He specializes in childhood trauma.

Elese Peifer
is an occupational therapist, and was a master's student at the University of Utah at the time this study was conducted.

Marlee Craker
is an occupational therapist, and was a master's student at the University of Utah at the time this study was conducted.

Michael Staley
is a suicide researcher at the Office of the Medical Examiner in the Utah Department of Health and Human Services. He aims to better understand the risk and protective factors related to suicide in the state, including among the LGBTQIA+ population.

Amanda V. Bakian
is an Associate Professor in the Department of Psychiatry and the Huntsman Mental Health Institute at the University of Utah. She conducts epidemiological research to investigate environmental risks of suicide.

Hilary Coon
is a Professor in the Department of Psychiatry and the Huntsman Mental Health Institute at the University of Utah. Her research focuses on risk factors for suicide, including genetic, phenotypic, and environmental risks.

Trans people are at significantly elevated risk of suicide death, suicide attempts, and suicidal ideation than their cisgender peers. Suicide prevention efforts are needed that address the most important issues to the trans community. In this qualitative study conducted in the United States in 2021, we aimed to broadly explore trans community member perspectives on suicidality and suicide prevention needs. We conducted four virtual focus groups—including one exclusively for trans people of color. We also solicited additional online responses to the same focus group questions. A total of 56 trans individuals with a history of suicidality participated. We utilized reflexive thematic analysis to develop themes to inform suicide prevention efforts for the trans community. The themes were multicontextual, representing needs across healthcare, legal and political arenas, workplaces, community groups, and interpersonal relationships. The central organizing theme identified as crucial for suicide prevention was "Having (Real) Rights and Respect." Supporting themes were "Being in Control of Our Own Bodies," "Being Safe as Ourselves," and "Feeling Support and Acceptance," which also included a subtheme of "Embracing Diversity within the Trans Community." We provide suggestions and directions for suicide prevention, which build on these themes.

KEYWORDS trans, transgender, suicide prevention, qualitative, healthcare
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Suicide death, suicidal actions, and suicidal thoughts are critical public health concerns throughout the US and globally (SAMHSA 2021; WHO 2021). One segment of the population consistently identified with heightened risk of suicidality is LGBTQIA+ individuals (The Trevor Project 2022), with strikingly high indication of suicide risk among trans individuals (Herman et al. 2019; Marshall et al. 2016; McNeil et al. 2017). Trans people are individuals whose gender identity does not correspond with the sex they were assigned at birth and can include a wide variety of binary and nonbinary gender identities. According to Herman and colleagues (2022), 1.6 million people in the US, or an estimated 0.6% of the population over the age of 12, identify as trans. Trans people may decide to transition in one or more ways if they have the opportunity and safety to do so. For example, trans individuals may seek social transition (e.g., altering their name, pronouns, appearance), legal transition (e.g., legal name change, gender marker change), and/or medical transition (e.g., gender-affirming healthcare such as hormone therapy, surgeries) to affirm self and identity (Coleman et al. 2022). While disclosure of trans identity (i.e., coming out) is important for many trans people, coming out and undergoing transition can also be accompanied by experiences of discrimination, stigma, loss of social networks, and violence (James et al. 2016).

Overwhelming evidence demonstrates significantly elevated risk of suicidality among trans people (Herman et al. 2019; Kidd et al. 2023; Marshall et al. 2016; McNeil et al. 2017). A US national study of high school youth found that trans students were at six-fold greater risk for a suicide attempt than their cisgender peers (Johns et al. 2019). Meanwhile, estimates suggest an 18-fold higher rate of past-year suicide attempts among trans adults in the 2015 US Transgender Survey compared to the US general population (Herman et al. 2019). In the more recent 2022 US Transgender Survey, 44% of trans adults reported recent suicidal ideation and 7% reported a recent suicide attempt (Kidd et al. 2023).

Our study builds on a body of existing evidence about risk and protective factors among trans people. Notable risk factors for suicidality among trans people often center around discrimination and rejection (Hunt et al. 2020; McNeil et al. 2017). Further, recent studies have included both trans and sexual minority participants in in-depth qualitative explorations. Clark and colleagues' (2022) work included eight trans and nonbinary participants in a study of sexual and gender minority people who had near-fatal suicide attempts and found that aspects of identity invalidation, structural stigma, and normalization of suicide contributed to participants' experiences of acquiring the capability for suicide. Kaniuka and colleagues' (2024) study on sexual and gender minority suicide risk and protection, which included 13 trans and gender nonconforming participants, described how precipitating vulnerabilities and stressors led to feelings of being hopeless and trapped. Together, these studies lend credence to the relevance of minority stress theory (Brooks 1981; Hendricks and Testa 2012; Rich et al. 2020) in explaining the heightened risk of suicidality in the trans community. Minority stress is characterized by stress resulting from stigmatized social status, and in the case of trans people, resulting from transphobia and gender non-affirmation (Hendricks and Testa 2012).

Further, consistent with minority stress theory, other quantitative and qualitative studies with trans participants have also identified some protective factors for suicidality, namely social support, transitioning, and resilience (McCann et al. 2021;

McNeil et al. 2017; Moody et al. 2015). The qualitative study of written responses to open-ended online questions from 133 trans adults—with and without histories of suicidality—in Canada conducted by Moody and colleagues (2015) identified protective experiences for trans individuals such as self-acceptance, coping skills, and individual reasons for living. Thus, the existing literature suggests that individual, social, and structural factors are relevant for understanding suicide risk and prevention in the trans community.

Despite knowledge about social and structural factors related to suicide risk, suicide prevention efforts often view suicide as a mental health problem related to psychiatric illness and internalizing psychological factors (Bryan 2022; Franklin et al. 2017). This psychocentric (Rimke and Brock 2012) lens contributes to an emphasis on crisis lines, screening tools, and mental health treatments as commonly relied-on suicide prevention efforts. The tendency to view trans suicide risk through a solely mental illness lens may be even more likely given the medicalization of trans identities wherein being trans is associated with a disorder within the *Diagnostic and Statistical Manual*. Accordingly, the potential influences of systems, environments, and social structures on suicide risk in the trans community (White Hughto et al. 2015) are often ignored or de-emphasized as pathways for suicide prevention.

While mental health treatments are indeed one important resource for people experiencing suicidality, the dominance of these prevention strategies have not had the desired population-level impact on preventing suicides or reducing suicidality (Bryan 2022) and the research base for specific mental health prevention strategies is relatively limited (Platt and Niederkrotenthaler 2020). Two reviews and meta-analyses have found that, across multiple studies, single-level, and even single-encounter, mental health interventions had an impact on reducing suicide completion and attempts among prior attempters (Doupnik et al. 2020; Hofstra et al. 2020). However, despite developments in the mental health space, we continue to see a gradual rise in risk of suicide death in the United States (CDC 2021). Therefore, there is a compelling need to also look outside of mental health services for additional suicide prevention opportunities. Two reviews have pointed to the potential promise of multi-level suicide prevention interventions, which take into account multiple aspects of community, social life, and healthcare (Hofstra et al. 2020; Platt and Niederkrotenthaler 2020).

In the current study, we aimed to build on the strengths of the existing literature and theoretical developments related to trans suicide risk and prevention to gather a comprehensive understanding of avenues for trans suicide prevention. We desired to take a community-oriented approach to understand how the trans community thinks about their risk of suicide and what they see as the community's suicide prevention needs. We approached the study with research questions about risk and protective factors related to suicidality for trans individuals and suicide prevention needs, and during the analytic process (detailed later) focused in on prevention needs specifically while relying on the interconnected discussions of risk and prevention to frame the findings and implications.

METHODS

We used a qualitative, inductive approach to develop a comprehensive and community-driven understanding of suicide prevention needs from the perspectives of trans individuals who have experienced suicidality. Because of our desire to be community-driven, we selected focus group methodology as our main approach to center discussions among community members (Flick 2006). We wanted to inform recommendations for policy and practice, with particular emphasis in our interpretation on implications for healthcare settings. The study was approved by the University of Utah Institutional Review Board.

Recruitment

We initially set out to conduct three focus groups of trans community members who have experienced suicidality in Utah. We recruited participants by disseminating digital fliers to LGBTQIA+ and trans community organizations and healthcare services throughout the state. To be eligible, individuals needed to identify as trans, report a history of experiencing suicidal thoughts or behaviors, be 18 years of age or older, and reside in the state. We purposefully did not place boundaries on the criteria to be considered trans for inclusion in this study. Rather, in line with the philosophical positioning of the study, we included any individuals who consider themselves to be trans. Similarly, we did not place specific bounds on what qualified as meaningful suicidality and considered eligible any individual who reported lifetime or past year suicidal thoughts or behaviors (question wording: "*Do you have a history of experiencing suicidal thoughts or behaviors (includes serious thoughts about ending your life and/or suicide attempts)?*").

Although we took steps to recruit a racially and ethnically diverse participant pool, we received very few responses from trans individuals who identified as members of minoritized racial or ethnic groups. We expected this may be related to relatively limited racial and ethnic diversity in Utah. To address this gap, we planned a fourth focus group exclusively for trans people of color and broadened recruitment to people living anywhere in the US However, notably, six of the seven enrolled participants in this fourth group also resided in Utah (the seventh resided in Texas).

During recruitment, the team shared an IRB-approved consent cover letter and invited questions in advance of the focus group. Then, prior to the start of the focus group, the facilitator reviewed the document verbally and visually (using the screen-sharing feature on Zoom) and allowed additional time for questions prior to each participant providing verbal consent. Online participants reviewed a consent cover letter and had the opportunity to reach out to the study team with questions.

Data collection

We collected data for this study between June and October 2021.

Screening and descriptive data questionnaire

During recruitment, we invited interested individuals to complete an online form in REDCap (Research Electronic Data Capture) to determine if they were eligible for the study and to provide descriptive data. We used the gathered descriptive data to facilitate maximum variation sampling (Patton 2002; Schreier 2018). Specifically, we aimed

to invite a diverse panel for each focus group with variability in ages, gender identities, transition experiences, recency of suicidality, and backgrounds. Our descriptive questionnaire is detailed in Supplement A.

Focus groups

Focus group methodology was selected as the primary approach in this study to align with our goal to understand community-level perspectives and needs. Focus groups allow for group discussion and conversation as a source of knowledge, in addition to individual contributions (Flick 2006). We followed guidelines outlined in Flick (2006) and the accumulated knowledge and experience of the facilitation team. We conducted four focus groups virtually over Zoom (Zoom Video Communications, Inc., San Jose, CA) with 7–9 participants per group. Experienced staff from our university's NIH-funded Clinical and Translational Science Awards Program led recruitment, coordinated with participants, facilitated the focus group sessions, and took notes throughout the session. One investigator from the research team was present throughout each session to provide an overview of the research and answer any participant questions about the study.

During recruitment and at focus groups, we provided participants with a list of available suicide and mental health crisis resources (e.g., TransLifeline, The Trevor Project, National Suicide Prevention Lifeline). A clinical psychologist was present for each session to provide additional mental health resources or crisis support to participants, if needed or desired.

We recognize the frequent problem of fraudulent research participants in online studies (Pullen Sansfaçon et al. 2024; Ridge et al. 2023) and took steps to prevent fraudulent data. We first reviewed the screening and descriptive questionnaire findings for suspicious responses. Further, a study investigator was present for each focus group, and contributed to assessing the legitimacy of participants. We excluded two potential participants who we determined to be fraudulent before starting one focus group. Participants offered meaningful, unique, consistent, and relevant contributions to the discussion, and the study team is confident they were not fraudulent. Participants were not expressly required to have their cameras on for the focus group, but all participants chose to.

The questions guiding the focus group sessions are listed in Table 1, including the alternative wording for the fourth group. Questions were developed, refined, and finalized by our research team, which included mental health professionals, trans healthcare providers, suicide and mental health researchers, and graduate students. Our team approached this study with a desire to support the autonomy and self-determination of the trans community, and to honor their perspectives as paramount for understanding their suicide risk and prevention needs. One member of our research team is also trans and evaluated the questions from their perspective, considering how they and their fellow community members may respond. The questions probed about community-level risk for suicide and also about personal protective and stress factors related to their broader mental health to gather a blend of positive and negative personal and community-level considerations for both suicide prevention and broader mental health needs among trans individuals with a history of suicidality. Participants received the questions in advance so they could consider their answers outside the

Table 1. Questions asked to participants [including additions made for the focus group for trans people of color]

Question Number	Question Wording
1	From your perspective, what do you think are reasons that trans people [—and BIPOC trans people in particular—] may be at risk for mental health problems and suicide?
2	What have been protective factors in your own life (what has helped your mental health)? What have been stress factors (what has hurt your mental health)?
3	Thinking broadly about things related to society, local communities, and health-care, what ideas do you have about suicide prevention for the [BIPOC] trans community?

Note. We also asked participants about their priorities for research related to suicide risks and prevention; however, the responses to that question were not included in this analysis. BIPOC: Black, Indigenous, and people of color. We used the term BIPOC for recruitment and framing questions in this group because that was a commonly used term in our community at the time of the study. However, we have altered the terminology in this manuscript since this language is less common at the time of submission.

group setting. Study team members transcribed the audio-recorded Zoom sessions and downloaded the chat transcripts. After each focus group, participants received a written summary of the discussion, and were invited to make any additions or clarifications via email, as a form of member checking (Schwandt 2007). One participant provided a response, adding further clarity to a point they had made. Participants were also invited to send private chat messages to the facilitation team at any point during the focus groups, which one participant chose to do to disagree with another participant. Focus group participants each received a $75 gift card.

Online submissions

Because community member interest in the study exceeded our focus group capacity, we further extended the study to the remaining eligible individuals who had completed the screening and descriptive data questionnaire. After initial screening, we sent 40 eligible individuals email invitations to answer the questions from Table 1 through an online submission in REDCap. Twenty-two participants completed an online submission and received a $20 gift card.

Participants

Study participants included 34 focus group participants and 22 online respondents (total $N = 56$). Participants self-described their gender identities and expressions in a variety of ways (see Table 2). They also answered a close-ended question about their gender, with 46.4% identifying primarily as man/male/masc, 28.6% as primarily woman/female/femme, and 25.0% as primarily nonbinary. No participants selected the fourth response option to decline to be categorized. Participants ranged in age from 18 to 67 years ($M = 30.3$, $SD = 12.2$). Nine (16.1%) participants identified as a member of one or more minoritized racial or ethnic groups. See Table 3 for complete participant descriptive information.

In open-ended questions, we asked participants to briefly describe the ways they had transitioned, as well as any ways they plan to transition in the future. Par-

Table 2. Participants' self-described genders

Participant Number	Open-ended Self-description
1	Trans masc/non-binary
2	Transgender male
3	Female
4	Trans man
5	Female
6	Non-binary/masc
7	Maleish
8	Transmasculine/Non-binary
9	Non binary, agender, genderfluid
10	Female
11	Transmasc nonbinary
12	Man
13	Male
14	Transmasc non-binary
15	Non binary
16	Female
17	Male
18	I am an AFAB (Assigned Female at Birth) transmasculine individual. I mostly present as male but do experiment with my presentation often
19	Trans male
20	Genderqueer, non-binary
21	MTF
22	Trans femme
23	Transgender woman
24	Female
25	Straight male
26	Trans man
27	Transgender Male
28	[N]on-binary transmasculine genderfluid
29	Trans-masc non-binary
30	Nonbinary/Agender, trans masculine
31	Non binary/agender/trans
32	I'm a non-binary trans man.
33	Transgender Agender
34	Transgender woman (MTF)
35	Agender

Participant Number	Open-ended Self-description
36	Male
37	Trans man
38	Transwoman
39	Transmasculine
40	Female
41	Non-binary/Agender
42	Transgender man
43	Nonbinary
44	Transgender woman
45	Post Op MtF
46	I am trans feminine.
47	Man, Trans-man
48	Ftm
49	Transfeminine
50	Transgender Man
51	Non binary/trans
52	Transgender woman
53	Transgender male
54	Non binary
55	Female (mtf)
56	Non-binary/transmasc

ticipants provided wide ranging responses, some having transitioned in only one way (e.g., socially, with their name and/or pronouns) and some in several ways (e.g., socially; medically, through treatments and/or procedures; and/or legally, through name and/or gender marker changes). Most participants had several plans or hopes to transition further in the future, while fewer (16.1%) expressed that they had no future plans (e.g., responding with: "Happy now"; "I am there now. Complete."; and "pretty much done").

A majority (60.7%) of participants had experienced suicidality in the last year and the remaining (39.3%) had experienced it in the past but not the last year. Participants also reported diagnosed mental health conditions, with many experiencing depression (94.6%), anxiety (82.1%), and post-traumatic stress disorder (53.6%). The majority also reported currently receiving mental healthcare including therapy or counseling (67.9%) and medication (57.1%).

We asked about other social factors that can influence access to mental health and gender-affirming transition services (e.g., income, employment status, geography; James et al. 2016). Participants reported a range of annual household income brackets, with over 30% reporting below the poverty line. More than half (57.1%) of par-

ticipants reported being currently employed, 17.9% reported being unemployed and looking for work, and 23.2% reported being unemployed but not looking (e.g., student, engaged in unpaid caregiving). Most participants indicated that they lived in a suburban or urban location.

Data analysis

We conducted an experiential qualitative analysis (Braun and Clarke 2022) focused on centering the experiences and meaning that participants ascribed to their experiences (e.g., essentialist or realist framework). We set out to follow Braun and Clarke's phases for reflexive thematic analysis. Through the process, we used an open, exploratory, and iterative approach to identify themes representing patterns of "shared meaning organised around a central concept" (Braun and Clarke 2022, 77).

While Braun and Clarke (2002) do not recommend engaging in evaluations of saturation when using reflexive thematic analysis, our approach aimed to gather a broad view that incorporated diverse community perspectives. We used the focus group data as our primary analytic focus for inductive analyses and then followed-up with analysis of the online survey data looking for confirming and disconfirming evidence. The online survey results were highly consistent with the focus group findings and offered support for the transferability (Schwandt 2007) of the study findings outside of the focus group context.

The four-person core analytic team read and re-read the text data, and met regularly to discuss key concepts, preliminary codes, and developing themes that represented important patterns and concepts in the data focused on suicide risks, protective factors, and ideas for prevention. Through this process, we also identified the salience of contexts within which the participants' experiences of suicidality and suicide prevention occurred. Engaging in an iterative process, we developed several different ways of conceptualizing the data; we returned to the data each time we refined the patterns and concepts to evaluate their fit with the data. We also engaged the larger research team throughout the process to review preliminary results, ask questions, and provide feedback to improve the process (e.g., internal auditing; Lincoln and Guba 1985). In the finalized analysis, we focused on themes of suicide prevention using an interpretative analysis of the data (Braun and Clarke 2022).

We used Dedoose (Version 9.0.18) analytic software and Microsoft Excel worksheets during the process to help organize data extracts. We present verbatim quotes in this report to enhance trustworthiness and transparency in the process and to center the voices of participants. We labeled each quote with a randomly assigned participant number following a letter indicating the focus group (A/B/C, or D for the people of color group; and ending with a "c" if originating from the Zoom chat) or online submission (O). Gender identities used in-text are verbatim as provided by the participant, and their included race or ethnicity came from a categorical descriptive question. Quotes are unedited, except where brackets (to clarify) or ellipses (to abbreviate) are used.

Throughout the process, we engaged in several steps to promote trustworthiness of the qualitative research process and methodological rigor (Lincoln and Guba 1985; Schwandt 2007). First, credibility was supported by sending focus group summaries to participants after the sessions (i.e., member checking) and engaging a trans team

Table 3. Participant descriptive information (N = 56)

Variable	**n (%) / *M* (*SD*)**
Categorized gender[a]	
Non-binary	14 (25.0%)
Woman/Female/Femme	16 (28.6%)
Man/Male/Masc	26 (46.4%)
Decline to be categorized	0 (0%)
Age (years)	30.3 (12.24), range 18–67
Race and ethnicity[b]	
Asian	4 (7.1%)
Black or African American	0 (0%)
Hispanic or Latinx	5 (8.9%)
Middle Eastern or Northern African	0 (0%)
Native American or Alaska Native	2 (3.6%)
Pacific Islander or Native Hawaiian	1 (1.8%)
White	52 (92.9%)
More than one Race or Ethnicity	3 (5.4%)
Suicidality experiences	
In the past year	34 (60.7%)
Previously, but not in the past year	22 (39.3%)
Current mental health treatment[b]	
Therapy/counseling	38 (67.9%)
Medication	32 (57.1%)
Total annual household income	
Less than $10,000	8 (14.3%)
$10,000-24,999	9 (16.1%)
$25,000-39,999	11 (19.6%)
$40,000-49,999	6 (10.7%)
$50,000-74,999	12 (21.4%)
$75,000 or more	9 (16.1%)
Missing	1 (1.8%)
Employment status	
Not employed for pay and looking for work	10 (17.9%)
Not employed for pay and not looking (student, volunteering, engaged in unpaid caregiving, etc.)	13 (23.2%)
Employed for pay (includes self-employment, full-time, part-time)	32 (57.1%)
Missing	1 (1.8%)

Note. [a]See Table 2 for each participant's self-described gender, [b]responses are not mutually exclusive, so percentages do not total 100.

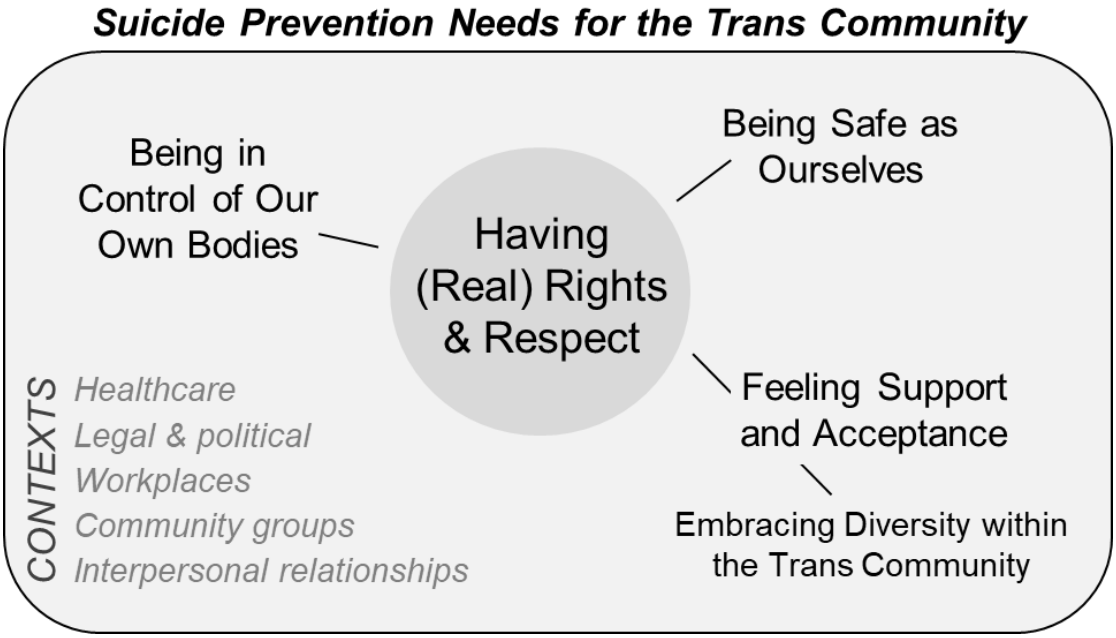

Figure 1. Visual map of results

member throughout the research process. Transferability was supported by examining similarities and differences within and between focus groups as well as between the focus groups and the online survey data. Dependability was supported by documenting each step of the research process, using previously established and successful approaches, and engaging in internal auditing by experienced qualitative researchers and team members with diverse expertise. Finally, confirmability was supported by engaging a multi-person analytic team, internal auditing of the analysis and findings, and providing verbatim quotes throughout the manuscript with transparency about the source of the data (which focus group or online survey).

We also approached the study mindful of representational ethics and the politics of our analysis (Braun and Clarke 2022). We aimed to uphold representational ethics through first ensuring that participants knew the purpose of our study and the lens through which we approach this work by having an investigator deliver an introduction at each focus group. We also encouraged them to respond openly and honestly to our questions, also providing options to do so privately if they preferred (via chat or email) as well as in response to the summary sent to them after the focus group. Finally, we were mindful throughout the analytic process and in disseminating the findings that we do our best to honor the participants' perspectives and avoid inadvertent harm to the community through our representations.

RESULTS

The analysis process produced one central organizing theme, three themes, and one subtheme. We also identified important contexts for suicide prevention that are rel-

evant across the themes. As one white transgender woman[1] articulated, "It's not the 'being trans,' it's everything around that" (A08). The discussed contexts for suicide prevention included healthcare, legal and political arenas, workplaces, community groups (e.g., religious communities, LGBT+ community groups), and interpersonal relationships (e.g., families, friendships). See Figure 1 for a visual map of the results.

Having (Real) Rights and Respect

The central organizing theme we identified focuses on the need for rights and respect in order to reduce risk of suicide for the trans community. Participants spoke about the importance of civil rights, institutional protections, stigma- and discrimination-free access to healthcare and other survival needs, as well as respect from individuals and society. The inclusion of "(Real)" in the theme name highlights participants' assertions that rights and respect must be more than in name only; they need to be fully carried out to have an impact on suicide prevention.

Regarding their civil rights, participants emphasized the impact of the significant negative legislative attention that has been on the trans community in their state and across the United States. A white transgender woman described that the recent attention on anti-trans legislation[2] felt like the trans community had become the latest "queer punching bag" (B06). She directly connected this to her suicidality, stating, "it can feel really hard to feel proud of yourself and feel like a real person when you've become this political talking point and there are these debates about whether or not you exist, what you deserve" (B06). This link between rights, respect, and suicidality was emphasized by a white trans masc/nonbinary participant stating that discriminatory policies made them feel "like I am not worth the air I breathe or other resources I consume because I am a joke to society" (B01).

The ability to have names and gender markers legally changed was seen as another important right that can support suicide prevention for trans community. One white transmasc nonbinary participant explained about the mental health impact of their name change, "I was, just recently was able to get my name legally changed and it's been incredible to be able to have" (B03). However, it was clear that legal rights do not automatically address discrimination and stigma. One biracial (Asian and white) non binary/agender/trans participant reported, "I don't want to change my gender marker. I do not want people to know that I am legally nonbinary to further persecute me" (D01), emphasizing that the everyday realities of discrimination still exist even with legal rights.

Participants also spoke about the need for employment rights in workplaces and yet how even current protections are rarely enacted. A biracial (Asian and white) non binary/agender/trans participant described, "no matter what actual policies exist in a workplace, none of it is actually protecting trans people in the workplace" (D01). Employment discrimination can result in trans people's "Struggle to have or find a job at all or one that accepts/acknowledges your identity" (D03), as described by a bira-

1 Gender descriptors accompanying each quote are in each participant's own words based on a fill-in survey item; race and ethnicity descriptors are based on a categorical survey item.

2 Participants were primarily referring to the rhetoric around numerous bathroom bills and youth sports-related bills being proposed at the time of the study in 2021.

cial (Asian and white) non-binary transmasculine genderfluid participant. One white nonbinary/agender trans masculine participant described frequently having to change jobs due to discrimination and the negative influence of that on their mental health:

> I also lost my job because of being trans last year and have had— I had the same job for 7 years and [now] I've had 4 in one year because I just can't—I keep running into people—I can't get a basic amount of respect. (A01)

Ensuring the basic right to healthcare for trans community members is another critical avenue for suicide prevention. Several participants described their restricted ability to receive healthcare, related to stigma and discrimination. For example, one white man explained:

> The lack of access to healthcare that is not transition related. Even just being able to get support for other things like my ADHD—which has nothing to do with me being trans—but the fact that I'm trans makes it harder to receive care for that. (C03)

Another participant (in a different focus group), a white transgender man, explained this common phenomenon of healthcare discrimination: "some people call it the 'trans broken arm syndrome' where all your symptoms are kind of lumped into your transness and attributed to the transness" (A02) making it more difficult for trans people to receive standard care. Meanwhile, a white transgender woman reported a reverse of this issue, where her trans identity was not taken seriously because of her autism diagnosis: "I have faced problems just being Autistic and they'll try to say that my gender dysphoria is a special interest thing, which it's not" (C06). This ableist framing contributed to invalidation, inadequate healthcare, and suicidality.

Overall, the central organizing theme 'Having (Real) Rights and Respect' reflects the emphasis from participants that suicide prevention needs to be viewed systemically and supported through enacted policies, rather than viewed as an individual problem for trans people to address with strength and resilience. One white nonbinary/agender trans masculine participant explained the importance of systems:

> Putting all of the pressure on the system—not on us—to do better. Because a lot of the times when we're in these conversations, I feel like I'm back in women's self-defense classes again… where you're being told how not to be hate-crimed instead of talking to the people doing the hate crime… it shouldn't be on us to do that. It should be based on… the system. (A01)

Being in Control of Our Own Bodies

Bodily validation, connection, and autonomy were described by participants as critical for suicide prevention. Participants were in agreement that having access to medical transition options was critical to their mental health. Participants described the psychological benefits of "physical transition. I can't stress that enough" (O19; white man trans-man). When asked what has been protective in their own life, one white transmasc nonbinary participant described, "having my surgeries: top surgery and my hysterectomy. Those have both helped a lot" (B03). A white male in the same focus group reflected, "being able to medically transition somewhat and going through the process of starting HRT [Hormone Replacement Therapy] has been super affirming" (B02).

Feeling a lack of control over his physical development, one white man trans-man wrote, "Female puberty was one of the worst things of my life. My body was betraying me and there was nothing I could do" (O19). Such experiences of gender dysphoria, while not experienced by all participants, were described by many as contributing to suicidality when not validated or supported through gender affirming care.

Systemic barriers to receiving gender affirming care, described by participants as "gatekeeping," were frequently pointed to as worsening suicidality. In many cases other people (e.g., parents, therapists, policy) hold the power to decide whether or not trans people—especially when they are younger than 18 years—can access gender affirming healthcare. One white female participant described her personal experience with others deciding when and how she could medically transition:

> Being told by my family and healthcare providers that if I wanted to receive trans related healthcare I would need to wait until I was 18… [I] left my home and paid for it on my own, needlessly putting it off for years. (O10)

Another participant, a white transmasc nonbinary individual, provided an example of how, paradoxically, their suicidality was used as a reason they were denied gender affirming surgery:

> When I went to have top surgery, the surgeon that I had chosen cancelled my surgery a week before I was supposed to have it because they decided I was at risk for suicidality. Which was interesting because it wasn't like [delaying the surgery] helped with depression. Like, it was kinda the opposite of what I would think would help. (B03)

Finally, the financial barriers to accessing gender affirming care were also emphasized by participants as ways that lack of control over their own bodies contributed to suicidality. A white non binary/trans participant explained:

> I'm not currently validated in my bodily experience, my transitioning experience, because transitioning is incredibly expensive and as a college student, I don't have that kind of money. So, I think—'cause when you're in a body that you know was not yours, it feels very disheartening and not validating. And when you feel like you're in the wrong body, obviously, you're going to experience suicidality. (C02)

Thus, for participants, having bodily autonomy was not just about the legal availability of gender affirming care, but also its access and affordability.

Being Safe as Ourselves

The physical and emotional safety of participants was a common thread described by participants as essential for suicide prevention. Physical violence, homelessness, poverty, and emotional abuse were patterns of threats to safety experienced by participants.

Physical violence, abuse, hate crimes, and threats were extremely traumatic experiences contributing to suicidality. A white transgender man described, "I'm a trans man and I've been raped and sexually ass[a]ulted" (A04c). A white trans masc/non-binary participant explained how physical assaults seemed intended to change their identity: "[I] had, like, the queer beaten out of me, but you know, it doesn't go. And so, you know, it kept popping back up and every time, physically beaten out of me,

but it doesn't go" (B01). A Latinx and multi-racial (Native American and white) trans femme participant stated, "I cannot tell you the amount of times—it's white women—pull guns at me" (D02). She also shared how she sees society justify violence against the trans community:

> When people shot at me, the first thing I thought of was, if we die right now, all these people and the way they react to other shootings, they're gonna be like "ah well they failed out of this class" or "well, they weren't that good of an employee because they were late"… people justify violence against us. (D02)

Safe housing and financial safety were described as critical suicide prevention needs. A white transgender man explained the connection: "My parents kicked me out and I was homeless and there was a lot of bad shit on the streets, a lot of bad shit happened for a long time…I had multiple suicide attempts and a lot of self-harm" (A02). Others described how these risks can prevent trans individuals from living as their true self. For example, a white transgender woman (MTF) explained:

> For a lot of people, being trans is literally a threat to your livelihood. I'm still in a situation where, although I'm out with most friends and family, most of my day-to-day life at work I'm still not out and I can't really come out for the foreseeable future. And so, coming out would present a direct threat to eating, paying rent, stuff like that. (A08)

Participants also frequently discussed the impacts of emotional abuse such as bullying, harassment, gaslighting, micro- and macro-aggressions, and misgendering on their suicidality. For example, participants shared transphobic statements made to them, such as a white trans male, "Being told that I must not have morals because I'm trans" (O15), and a white transgender man reporting, "My Mom says I'm a trans man because I have 'daddy issues'" (A04c). These attitudes from important people in their lives contributed to participants' diminished self-worth and led to suicidality.

A common domain of discussion related to emotional violence was religious culture. The salience to participants may be due to the predominance of religion in Utah but was also discussed as connected to early experiences of suicidality by participants raised elsewhere. Participants described the experiences of rejection, being told that they were sinful, "religious shame and threats" (O09; white trans man), experiencing conversion therapy, and the influence that conservative religions can have on harmful policies and offensive societal/personal opinions about the trans community.

Participants also described how many dehumanizing and traumatic experiences resulted in emotional distress manifested as anxiety, PTSD, and substance use, which then further decreased their safety and exacerbated their suicidality. For example, a biracial (Asian and white) non binary/agender/trans participant stated, "When you can't bring your full self into a room, you are constantly having to protect those parts of yourself, and it just really puts you on high alert. It gives you a lot of anxiety" (D01). Another, who is a Latinx and multi-racial (Native American and white) trans femme, stated:

> Having been a victim of different hate crimes, both for race and being queer, it's just hard to feel safe. So not having that many places where I could really take off that high alert definitely affected my anxiety, because it's just like a survival mechanism to always be on such high alert. (D02)

The prior quote also reflects participants' perspectives on the importance of considering intersectionality within the trans community for suicide prevention.

Feeling Support and Acceptance

Participants shared about the many benefits of social support and acceptance for suicide prevention, and conversely about the pain and negative impacts on suicidality when social support lacked or diminished. In particular, participants described the value of having a social network of other trans people. For example, participants shared: "Honestly, being around other trans people of color, or trans people in general, and watching them transition has helped my mental health" (D01; biracial (Asian and white) non binary/agender/trans), and "Online communities probably saved my life" (A08c; white transgender woman (MTF)). While support and acceptance from cisgender individuals was often harder to come by, it was also supportive of suicide prevention for participants. For example, a white transgender woman shared, "One of the most positive things has just been being treated like just a normal person" (B06). Another participant, a Latinx and Native American nonbinary individual, shared xir appreciation for xir family's growth and acceptance over time: "As many growing pains and heart aches I've had with my family, I have to say, they've come around a lot, especially the last few years, with understanding who I was" (D06). These experiences made it easier for participants to feel loved and part of a social fabric, lessening suicidality.

Better education about the trans community—as a mode of increasing awareness, acceptance, and social support—was underscored as a critical need for suicide prevention. Participants shared about the relief they experience when people in their lives demonstrate knowledge and acceptance about gender, trans experiences, and respectful language. One white transmasculine/non-binary participant shared: "I think education is one of the key ways to reduce Suicide risk in the trans community. Many people are discriminatory or prejudiced simply because they are uneducated or misinformed regarding the trans community" (O07). However, participants also discussed how much pressure there is on them to educate others about transness. For example, a white non-binary trans man described how they experience "marginalization fatigue" from repeatedly being "that person who educates others…[which] puts your own mental health into jeopardy because you're constantly having to defend yourself" (C01).

Embracing diversity within the trans community

Discussions of support and acceptance among participants highlighted a need for better inclusion, representation, and wider acceptance of the myriad of identities in the community. Embracing diversity in trans communities (related to aspects such as gender identity, transition decisions, sexual orientation, race and ethnicity, country of origin, appearance, disability) can more comprehensively support broad suicide prevention and community wellbeing. Multiple layers of exclusion were described by participants as current barriers, even within the LGBTQIA+ and trans communities. A white female participant said,

> Even in the LGBT+ community, [being trans] is still really divisive… you still have people who don't even think that trans people should be in the queer community. And then, within even in the trans community, you have, you know, like trans medicalists who are going to be saying, "you

> need X amount of dysphoria to be trans," or "you need surgeries to be trans," and all of this stuff. (B05)

A Latinx transmasc non-binary participant shared about the importance of diverse representation to contribute to better awareness and broader acceptance of the whole community:

> I also think one of the biggest things is lack of visibility. All of the trans representation that we have is very cis-passing, very binary narratives and I don't see a lot of people of color, I don't see a lot of Black people, I don't see a lot of fat people, I don't see a lot of neurodivergence. I don't see me anywhere I go, which is my point. (A03)

Further, participants in the fourth focus group described how the trans community can be exclusionary to people of color. For example, a biracial (Asian and white) non binary/agender/trans participant explained how white trans people in their life claimed ownership over trans identities, which they attributed to cultural differences and power differences. They said, "Something that really affected my mental health was white queer people telling me that there was no way that I could be trans" (D01) and referred to it as having their gender "colonized." They continued:

> That hurt me. Looking up to whiteness, and seeing how I didn't feel represented in it, in its queer transness, prevented me from coming out for so long, prevented me from changing my pronouns, prevented me from starting hormones. I had to fight myself and my internalized racism every fucking step of the way that I chose to step into my queer brown transness. (D01)

Some participants of color also described challenges with feeling on the borders of their communities, and having conflicting experiences related to multiple identities and their intersections. The following quote offers an example of the liminality experienced.

> Being biracial and being nonbinary has left me in this kind of weird in-between space, where I'm not quite trans enough for the trans community in some spaces. I'm not quite white enough or Asian enough in other communities. So that's kind of a feeling of disconnect from certain communities, and something I'm trying to continuously reach out for support. (D07; biracial (Asian and white) transgender male)

Speaking specifically about seeking out mental healthcare for people who have intersectional trans identities, a Latinx agender participant explained, "because we deal with that intersectionality, the mental health resources we go to will either be someone who doesn't understand your struggles as a trans person, or one that doesn't understand your struggles as a person of color" (D04).

DISCUSSION

This study characterized suicide prevention needs directly from the perspectives of trans people with a history of suicidality. Using data collected from focus groups and an open-ended online questionnaire, we identified key themes that can support trans suicide prevention. Although all participants had at least one diagnosed mental health condition, their perspectives about suicide risk and prevention did not center on these

conditions nor on mental healthcare access (although it was mentioned as a community need). Instead, participants emphasized a need for rights and respect to be at the center of suicide prevention efforts for the diverse trans community. They focused attention on the need for social, cultural, and systemic changes over conventional individual-focused suicide prevention approaches, such as efforts to enhance a patient's resilience and coping skills (one of the protective factors identified by Moody et al. 2015). These findings are important to consider in the context of White Hughto et al.'s (2016) work applying a socioecological model to understanding transgender stigma. Similarly, we find here that suicide prevention needs identified by the trans community are related to structural, interpersonal, and individual level needs. Based on our findings, addressing trans stigma at each of these levels, as suggested by White Hughto and colleagues (2016), would be supportive of suicide prevention.

In Table 4, we outline recommendations to support suicide prevention within the healthcare context, a critical context discussed by participants. The recommendations are based on the suggestions and narratives from participants, organized and presented through the lens of the interpretive thematic structure of the results. Healthcare was one of the most heavily discussed contexts in this study. Healthcare settings are crucial, lifesaving spaces where all people should feel safe and cared for. However, participants described frequently experiencing both mistreatment and cultural incompetence in healthcare, as well as limited power and constrained self-determination. Their embodied knowledge of their own needs was often not respected by providers, which contributed to suicidality for participants.

Bodily autonomy was an important theme identified in this study, and typically requires healthcare support. Prior research supports the linkage between gender affirming medical care and lower risk of suicidality (Almazan and Keuroghlian 2021; Baker et al. 2021; Fontanari et al. 2020; Herman et al. 2019; Jackson 2023). These findings suggest that increasing access to bodily autonomy through information and access to gender affirming care options is an important component of suicide prevention.

Participants also explained how their identity and needs as a trans person could intersect with other healthcare needs, often finding that providers were not adequately prepared to provide needed care which limited their rights to healthcare and contributed to suicidality. This occurred in several ways, by (a) focusing only on trans-related needs and/or assuming all their needs were related to trans identity (e.g., trans broken arm syndrome; Wall et al. 2023), (b) dismissing trans needs due to other factors such as age or disability (which has been described previously, e.g., Shapira and Granek 2019), or (c) lack of education or preparedness to address the comprehensive healthcare needs of the full diversity of the trans community. Providers should be trained to have a nuanced understanding of binary and nonbinary trans healthcare needs, as well as how to provide individualized and bias-free care for all trans people to ensure their comprehensive healthcare needs are met. There are growing efforts to incorporate trans education into healthcare, with evidence of efficacy for improving provider attitudes and knowledge (Dubin et al. 2018). Based on our study, we believe that these improved provider attitudes and knowledges will likely serve as a protective factor for patient suicidality. Future studies should look at this link between provider education and trans patient suicide risk directly.

It is also critical to consider the many social determinants of health that can im-

Table 4. What healthcare providers can do to support suicide prevention for the trans community: Suggestions based on participant perspectives, organized by study theme

Theme	Suggestion
Having (Real) Rights and Respect	· Support trans people's legal rights to accessible and appropriate healthcare (including general health, gender affirming care, and mental health services) free of discrimination and stigma. This support could take the form of legal testimony, published statements, or signed letters of support for trans rights legislation. · Prioritize respect for trans people in all interactions. · Consider the current state of trans rights within and beyond healthcare settings; advocate for equity and representation across all contexts (e.g., workplace, education, legal, community).
Being in Control of Our Own Bodies	· Insist that trans individuals lead decision making about their gender affirming care, with clear and transparent information from healthcare providers. · Recognize that gender affirming care is currently not financially accessible to many people in the trans community, take steps to decrease financial barriers (e.g., working with a wide range of insurance providers, offering additional funding options for uninsured patients, sharing opportunities for external grants and other financial resources for patients), and advocate for systemic change around informed consent. · Reject implications that mental health conditions or other disabilities (e.g., autism) thwart individuals' abilities to make informed decisions about their transition journeys. · Engage in educated advocacy (e.g., based on reading work by trans people or listening to trans people's testimonies) alongside the trans community to reduce gatekeeping and increase patient's rights where current policies or procedures do not support bodily autonomy.
Being Safe as Ourselves	· Provide trauma-informed healthcare at all levels of care, recognizing that trans people have often experienced high levels of emotional abuse and physical violence. · Consider the social determinants that may be affecting the health of trans patients, which could include discrimination, safety concerns, familial instability, housing instability, employment disruptions, and financial stress. · Acknowledge that trans people likely have had negative healthcare experiences in the past and work to create a safe and respectful healthcare experience, inclusive of paperwork, administrative phone calls, patient-provider interactions, the clinical environment, and documentation. This includes allowing people to self-identify their gender and pronouns instead of selecting from predetermined options, and taking steps to prevent misgendering across healthcare interactions.

Feeling Support and Acceptance	· Seek out comprehensive and up-to-date education about the trans community. Healthcare education programs and employers should integrate high quality, community-informed training. · Consider concrete ways to signal your commitment to trans patients (e.g., on websites, in office/clinic/units, wearing trans pride flag pins, lanyards, etc.). · Be prepared to provide information for trans-affirming community organizations, support groups, and other resources if warranted or desired by patients. Also consider if family members or other supporters need education or resources to effectively support trans patients. Healthcare systems may need to work to create new trans-affirming resources if they are unavailable in the community.
Embracing Diversity within the Trans Community	· Recognize that trans people are diverse across many aspects of identity including culture, race, gender identity and expression, age, sexual orientation, appearance, body size, and disability status. Trans people have various countries of origin, interests, career paths, educational histories, family structures, religious/spiritual preferences, and life choices. Avoid stereotypical and culturally limited perspectives about the trans community and seek out expansive education and representation. Recognize that not all trans people identify in the gender binary, and not all trans people choose medical transition. · Support trans people who seek to medically transition in ways that do not align with traditional comprehensive, binary paths (e.g., seeking top surgery without taking hormones, taking hormones temporarily but not permanently, seeking non-flat top surgery).

pact trans community members and their risk of suicidality. Basic survival and safety needs are the most fundamental forms of suicide prevention (Britton et al. 2014) and participants described often not having access to the resources needed to survive and live safely. Existing research demonstrates that trans people are three times more likely to be unemployed than the national average and over two times as likely to live below the poverty line (James et al. 2016). One-in-10 trans individuals report being physically attacked, and those attacks are correlated with elevated risk of suicide attempt (James et al. 2016). The constant fear of physical violence and emotional abuse described by participants are known to be chronic minority stressors associated with suicidality (Green et al. 2022; Pellicane and Ciesla 2022). Healthcare providers need to consider the impact of social determinants of health and ways to address them to support the health of trans patients (see Andermann 2016, for a framework for addressing SDOH for health professionals), as well as to acknowledge the potential traumas that trans individuals are more likely to experience by adopting trauma-informed care practices (Guelbert 2023; Levenson et al. 2023).

The healthcare sector is strongly linked with policy, as healthcare can be restricted or mandated by policies. According to participants, supportive and inclusive policies (e.g., national, state, local, institutional) hold potential to be helpful for suicide prevention—but only when they are truly enacted. Participants referenced a

wide range of laws and policies from HR discrimination policies in employment settings, school policies for both students and teachers, bathroom bills, name and gender marker change policies and laws, and laws restricting access to gender affirming care for minors. There was a clear indication of a need for policies that are inclusive of trans people and allow for their self-determination and ability to participate in all aspects of life and community. Other available evidence supports this finding, with Perez-Brumer and colleagues (2015) reporting fewer trans suicide attempts in places with lower state-level structural discrimination. While the development and enactment of new supportive and inclusive policies are clearly warranted, the most pressing need appears to be stopping the wave of negative, restrictive, and discriminatory policies targeting trans people that have been discussed, proposed, and codified in recent years. When we gathered the data for this study in 2021, the number of anti-trans bills had more than doubled proposals from any prior year (Branigin and Kirkpatrick 2022). Participants described how the increased and highly negative political rhetoric around these bills contributed to their suicidality. Since then, we have seen even more legislation that further marginalizes trans people proposed and codified (American Civil Liberties Union 2023). Well educated healthcare providers may be well positioned to advocate alongside the trans community for rights to bodily autonomy, healthcare access, and other trans needs, as appropriate in their community and workplace.

The need for support and acceptance across multiple contexts was highlighted by participants in this study as necessary for suicide prevention, which is consistent with prior qualitative studies (e.g., Clark et al. 2022; Kaniuka et al. 2024; Moody et al. 2015). Further, Diamond and Alley (2022) emphasized how social safety is critical for health and wellness, and often under threat for sexual and gender minority populations. Prior research shows that social protection from suicidality can begin in adolescence; young trans people who feel supported in social transition (e.g., using their chosen name and pronouns) are significantly less likely to report suicidality (Russell et al. 2018; The Trevor Project 2020). Family support can be especially critical for mental wellbeing among trans youth (Durwood et al. 2021), while the lack of family support is associated with homelessness (Siebel et al. 2018) and suicidality (The Trevor Project 2020). Participants discussed the importance of having social support from individuals and communities, and prior research supports the connection between interpersonal/community rejection and suicidality (James et al. 2016). They also emphasized the importance of people in participants' lives being educated about the trans community. There is a clear need for efforts to improve family and social support, which can be informed by the best practice clinical strategies outlined by Malpas and colleagues (2022) such as using multiple modes of support, offering psychoeducation, and emphasizing the meaningful impact of family acceptance.

Participants talked about suicide risk and prevention in the context of formal community organizations and institutions. For example, participants described experiences of rejection in religious communities as well as conversion therapy efforts which are known to be linked to increased suicidality (Campbell et al. 2022; James et al. 2016; Turban et al. 2020). However, studies such as Moody and colleagues (2015) have also pointed to religion and spirituality as protective factors for suicide for trans people. More surprisingly, some participants also described exclusion from LGBTQIA+ communities, and even trans-specific communities. Exclusion experiences were

linked to participants' multiple and intersecting identities: as trans (vs. lesbian, gay, or bisexual), nonbinary (vs. identifying within the gender binary), and/or people of color (vs. white). Prior research has demonstrated unique forms of marginalization related to intersectionality in the LGBTQIA+ community and associated mental health consequences (Kulick et al. 2017). Furthermore, having multiple marginalized identities (including racial minority and disability) is associated with increased risk of suicidality among trans adults (Cramer et al. 2022). Whereas supportive communities and positive representation play a protective and affirming role for trans mental health. Specifically, Sherman and colleagues (2020) found that actively participating in the trans community (e.g., in-person, online, or through engagement with positive media representations) was associated with better mental health and reduced distress. Participants in this study also suggested a causal link from engaging in an online community to reduced distress related to suicidality. Together, these findings highlight the need for positive and affirming communities inclusive of the full diversity of the trans community. Community advocates are already doing this work (Horak 2019)—and participants spoke about their own attempts to advocate in their communities—but broader awareness and recognition of these problems within the community may help advance these efforts.

Strengths and limitations

The primary strength of this study was our focus on the perspectives of the trans community, honoring embodied knowledge and community priorities. This is further reflected by our use of open-ended questions and an inductive analytic process to understand community priorities for suicide prevention. Because of the nature of the study and our focus on recruiting trans people who experienced suicidality, we cannot draw conclusions about protective factors that may support trans people to never experience suicidality in the first place (as explored by Moody et al. 2015). However, we were able to gather data about what has been both helpful and harmful for participants using a broad lens, which supported our development of interpretive themes for suicide prevention. Further, recruiting participants from a politically and religiously conservative state allowed us to explore the experiences and needs of trans community members in a place where trans rights are under social and political siege. We do not know if the results would differ if we had also enrolled participants from politically moderate or liberal states. Additional research is needed to test how restrictive public policy at the state level does or does not contribute to rates of suicidality among trans people.

Focus groups and online data collection each have their own strengths and limitations. Specifically, focus groups allow for group discussion and community engagement, but may risk social pressure and privacy concerns. Whereas online data collection can lack depth of understanding because of the inability to ask follow-up questions and does not incorporate community discussion, but may create more opportunity for candid responses. We hope that by utilizing both in this study, we maximize the benefits of each. Notably, the results across focus groups and between the focus groups and online responses were highly similar.

We aimed to recruit a diverse group of trans community members within Utah. We accomplished this aim on several fronts including having participants representing a wide range of ages, gender identities, income levels, and mental health needs.

However, we experienced some difficulties recruiting participants from a broad range of racial and ethnic backgrounds. Throughout our recruitment and data collection process, it was apparent that trans people of color often feel on the outskirts of trans spaces (this also supported by existing research, e.g., de Vries 2012; James et al. 2016; Ussher et al. 2022). Once we advertised a focus group exclusively for trans people of color, we had an increased response. We suggest that future efforts to gather community input should consider offering spaces specifically for trans people of color—they may feel safer, more welcomed, and more confident they will be heard.

Although participants in this study provided valuable insights about needed directions for suicide prevention, our approach was not designed to identify the specific mechanisms through which recommendations could be accomplished. Future research and community efforts can build on the recommendations provided herein to identify and address key mechanisms of change. Lastly, we did not ask details about participants' histories of suicidality, beyond whether their experiences were in the past year or further in their history. Given the advancement of ideation-to-action frameworks of suicide (e.g., Bayliss et al. 2022), knowing more about the types and timing of suicidal thoughts and actions may have allowed for more nuanced implications about suicide prevention. This could be explored in future research.

CONCLUSION

This study examined perspectives on trans community suicide prevention needs from trans people with a history of suicidality. We identified rights and respect as central suicide prevention needs along with bodily autonomy, safety, and social support and inclusion of the full diversity of the trans community. The findings underscore the need for future research and suicide prevention that focuses on social and systemic change efforts to support suicide prevention strategies that extend beyond mental healthcare.

REFERENCES

Almazan, Anthony N, and Alex S. Keuroghlian. 2021. "Association between Gender-Affirming Surgeries and Mental Health Outcomes." *JAMA Surgery* 156 (7): 611–618. https://doi.org/10.1001/jamasurg.2021.0952.

American Civil Liberties Union. 2023. "Mapping Attacks on LGBTQ Rights in US State Legislatures." *American Civil Liberties Union*. https://www.aclu.org/legislative-attacks-on-lgbtq-rights.

Andermann, Anne. 2016. "Taking Action on the Social Determinants of Health in Clinical Practice: A Framework for Health Professionals." *Canadian Medical Association Journal* 188 (17–18): E474–E483. https://doi.org/10.1503/cmaj.160177.

Baker, Kellan E, Lisa M. Wilson, Ritu Sharma, Vadim Dukhanin, Kristen McArthur, and Karen A. Robinson. 2021. "Hormone Therapy, Mental Health, and Quality of Life among Transgender People: A Systematic Review." *Journal of the Endocrine Society* 5 (4): bvab011. https://doi.org/10.1210/jendso/bvab011.

Bayliss, Luke T, Steven Christensen, Andrea Lamont-Mills, and Carol du Plessis. 2022. "Suicide Capability within the Ideation-to-Action Framework: A Systematic Scoping Review." *PLOS One* 17 (10): e0276070. https://doi.org/10.1371/

journal.pone.0276070.
Branigin, Anne, and N Kirkpatrick. 2022. "Anti-Trans Laws are on the Rise. Here's a Look at Where — and What Kind." *The Washington Post*, October 14. https://www.washingtonpost.com/lifestyle/2022/10/14/anti-trans-bills/.
Braun, Virginia, and Victoria Clarke. 2022. *Thematic Analysis: A Practical Guide*. Thousand Oaks, CA: SAGE.
Britton, Peter C, Kimberly A. Van Orden, Jameson K. Hirsch, and Geoffrey C. Williams. 2014. "Basic Psychological Needs, Suicidal Ideation, and Risk for Suicidal Behavior in Young Adults." *Suicide & Life-threatening Behavior* 44 (4): 362–371. https://doi.org/10.1111/sltb.12074.
Brooks, Virginia R. 1981. *Minority Stress and Lesbian Women*. Lexington, MA: Lexington Books.
Bryan, Craig J. 2021. *Rethinking Suicide: Why Prevention Fails, and How We Can Do better*. New York: Oxford University Press.
Campbell, Travis, and Yana van der Meulen Rodgers. 2023. "Conversion Therapy, Suicidality, and Running Away: An Analysis of Transgender Youth in the US" *Journal of Health Economics* 89: 102750. https://doi.org/10.1016/j.jhealeco.2023.102750.
Clark, Kristy A, Travis Salway, Erin M. McConocha, and John E. Pachankis. 2022. "How Do Sexual and Gender Minority People Acquire the Capability for Suicide? Voices from Survivors of Near-Fatal Suicide Attempts." *SSM - Qualitative Research in Health* 2: 100044. https://doi.org/10.1016/j.ssmqr.2022.100044.
Cramer, Robert J, Andrea R. Kaniuka, Farida N. Yada, Franck Diaz-Garelli, Ryan M. Hill, Jessamyn Bowling, James M. Macchia, and Raymond P. Tucker. 2022. "An Analysis of Suicidal Thoughts and Behaviors among Transgender and Gender Diverse Adults." *Social Psychiatry and Psychiatric Epidemiology* 57: 195–205. https://doi.org/10.1007/s00127-021-02115-8.
de Vries, Kylan M. 2012. "Intersectional Identities and Conceptions of the Self: The Experience of Transgender People." *Symbolic Interaction* 35 (1): 49-67. https://doi.org/10.1002/symb.2.
Diamond, Lisa M, and Jenna Alley. 2022. "Rethinking Minority Stress: A Social Safety Perspective on the Health Effects of Stigma in Sexually-Diverse and Gender-Diverse Populations." *Neuroscience and Biobehavioral Reviews* 138: 104720. https://doi.org/10.1016/j.neubiorev.2022.104720.
Doupnik, Stephanie K, Brittany Rudd, Timothy Schmutte, Diana Worsley, Cadence F. Bowden, Erin McCarthy, Elliott Eggan, Jeffrey A. Bridge, and Steven C. 2020. "Association of Suicide Prevention Interventions with Subsequent Suicide Attempts, Linkage to Follow-up Care, and Depression Symptoms for Acute Care Settings: A Systematic Review and Meta-Analysis." *JAMA Psychiatry* 77 (10): 1021–1030. https://doi.org/10.1001/jamapsychiatry.2020.1586.
Dubin, Samuel N, Ian T. Nolan, Carl G. Streed Jr., Richard E. Greene, Asa E. Radix, and Shane D. Morrison. 2018. "Transgender Health Care: Improving Medical Students' and Residents' Training and Awareness." *Advances in Medical Education and Practice* 9: 377–391. https://doi.org/10.2147/AMEP.S147183.
Durwood, Lily, Leila Eisner, Kaitlyn Fladeboe, Chonghui (Gabriella) Ji, Samantha Barney, Katie A. McLaughlin, and Kristina R. Olson, K.R. 2021. "Social Support

and Internalizing Psychopathology in Transgender Youth." *Journal of Youth and Adolescence* 50 (5): 841–854. https://doi.org/10.1007/s10964-020-01391-y.
Flick, Uwe. 2006. *An Introduction to Qualitative Research*. Thousand Oaks, CA: SAGE.
Fontanari, Anna Martha V, Felipe Vilanova, Maiko A. Schneider, Itala Chinazzo, Bianca M. Soll, Karine Schwarz, Maria Ines R. Lobato, and Angelo B. Costa. 2020. "Gender Affirmation is Associated with Transgender and Gender Nonbinary Youth Mental Health Improvement." *LGBT Health* 7 (5): 237–247. http://doi.org/10.1089/lgbt.2019.0046.
Franklin, Joseph C, Jessica D. Ribeiro, Kathryn R. Fox, Kate H. Bentley, Evan M. Kleiman, Xieyining Huang, Katherine M. Musacchio, Adam C. Jaroszewski, Bernard P. Chang, and Matthew K. Nock. 2017. "Risk Factors for Suicidal Thoughts and Behaviors: A Meta-Analysis of 50 Years of Research." *Psychological Bulletin* 143 (2): 187–232. https://doi.org/10.1037/bul0000084.
Green, Amy E, Myeshia N. Price, and Sam H. Dorison. 2022. "Cumulative Minority Stress and Suicide Risk among LGBTQ Youth." *American Journal of Community Psychology* 69 (1–2): 157–168. https://doi.org/10.1002/ajcp.12553.
Guelbert, Cristopher S. 2023. "Providing Trauma-Informed Care to Patients Who Identify as LGBTQAI." *Nursing* 53 (4): 45–48. https://doi.org/10.1097/01.NURSE.0000920440.68593.aa.
Hendricks, Michael L, and Rylan J. Testa. 2012. "A Conceptual Framework for Clinical Work with Transgender and Gender Nonconforming Clients: An Adaptation of the Minority Stress Model." *Professional Psychology: Research and Practice* 43 (5), 460–467. https://doi.org/10.1037/a0029597.
Hofstra, Emma, Chijs van Nieuwenhuizen, Marjan Bakker, Dilana Özgül, Iman Elfeddali, Sjakko J. de Jong, Christina M. van der Feltz-Cornelis. 2020. "Effectiveness of Suicide Prevention Interventions: A Systematic Review and Meta-Analysis." *General Hospital Psychiatry* 63: 127–140. https://doi.org/10.1016/j.genhosppsych.2019.04.011.
Horak, Molly. 2019. "The Role of the Transgender Community in the LGBT+ Rights Movement." *Lawyer's Committee for Civil Rights Under Law.* https://www.lawyerscommittee.org/the-role-of-the-transgender-community-in-the-lgbt-rights-movement/.
Hunt, Quintin A, Quinlyn J. Morrow, and Jennifer K. McGuire. 2020. "Experiences of Suicide in Transgender Youth: A Qualitative, Community-Based Study." *Archives of Suicide Research* 24 (Suppl 2): S340–S355. https://doi.org/10.1080/13811118.2019.1610677.
Jackson, Daniel. 2023. "Suicide-Related Outcomes Following Gender-Affirming Treatment: A Review." *Cureus* 15 (3): e36425. https://doi.org/10.7759/cureus.36425.
James, Sandy E, Jody L. Herman, Susan Rankin, Mara Keisling, Lisa Mottet, and Ma'ayan Anafi. 2016. *The Report of the 2015 US Transgender Survey*. Washington, DC: National Center for Transgender Equality.
Johns, Michelle M, Richard Lowry, Jack Andrzejewski, Lisa C. Barrios, Zewditu Demissie, Timothy McManus, Catherine N. Rasberry, Leah Robin, and J. Michael Underwood. 2019. "Transgender Identity and Experiences of Violence Victimization, Substance Use, Suicide Risk, and Sexual Risk Behaviors among

High School Students — 19 States and Large Urban School Districts 2017." *Morbidity and Mortality Weekly Report* 68: 67–71. http://dx.doi.org/10.15585/mmwr.mm6803a3.

Kaniuka, Andréa R, Eleanor M. Nanney, Ryan Robertson, Rhoen Hoff, Mac Smith, Jessamyn Bowling, Erin D. Basinger, Alicia A. Dahl, Robert J. Cramer. 2024. "A Grounded Theory of Sexual and Gender Minority Suicide Risk: The Sexual and Gender Minority Suicide Risk and Protection Model." *Psychology of Sexual Orientation and Gender Diversity.* Advance online. https://dx.doi.org/10.1037/sgd0000699.

Kidd, Jeremy D, Nicky A. Tettamanti, Roma Kaczmarkiewicz, Thomas E. Corbeil, Jordan D. Dworkin, Kasey B. Jackman, Tonda L. Hughes, Walter O. Bockting, and Ilan H. Meyer. 2023. "Prevalence of Substance Use and Mental Health Problems among Transgender and Cisgender US Adults: Results from a National Probability Sample." *Psychiatry Research* 326: 115339. https://doi.org/10.1016/j.psychres.2023.115339.

Kulick, Alex, Laura J. Wernick, Michael R. Woodford, and Kristen Renn. 2017. "Heterosexism, Depression, and Campus Engagement among LGBTQ College Students: Intersectional Differences and Opportunities for Healing." *Journal of Homosexuality* 64 (8): 1125–1141. https://doi.org/10.1080/00918369.2016.1242333.

Levenson, Jill S, Shelley L. Craig, and Ashley Austin. 2023. "Trauma-Informed and Affirmative Mental Health Practices with LGBTQ+ Clients." *Psychological Services* 20 (Suppl 1): 134–144. https://doi.org/10.1037/ser0000540.

Lincoln, Yvonna S, and Egon G. Guba. 1985. *Naturalistic inquiry.* SAGE Publications.

Malpas, Jean, Michael J. Pellicane, and Elizabeth Glaeser. 2022. "Family-Based Interventions with Transgender and Gender Expansive Youth: Systematic Review and Best Practice Recommendations." *Transgender Health* 7 (1): 7–29. https://doi.org/10.1089/trgh.2020.0165.

Marshall, Ellen, Laurence Claes, Walter Pierre Bouman, Gemma L. Witcomb, and Jon Arcelus. 2016. "Non-Suicidal Self-Injury and Suicidality in Trans People: A Systematic Review of the Literature." *International Review of Psychiatry* 28 (1): 58–69. https://doi.org/10.3109/09540261.2015.1073143.

McCann, Edward, Gráinne Donohue, and Michael Brown. 2021. "Experiences and Perceptions of Trans and Gender Non-binary People Regarding Their Psychosocial Support Needs: A Systematic Review of the Qualitative Research Evidence." *International Journal of Environmental Research and Public Health* 18 (7): 3403. https://doi.org/10.3390/ijerph18073403.

McNeil, Jay, Sonja J. Ellis, and Fiona J R Eccles. 2017. "Suicide in Trans Populations: A Systematic Review of Prevalence and Correlates." *Psychology of Sexual Orientation and Gender Diversity* 4 (3): 341–353. https://doi.org/10.1037/sgd0000235.

Moody, Chérie, Nate Fuks, Sandra Peláez, and Nathan Grant Smith. 2015. "'Without This, I Would For Sure Already Be Dead': A Qualitative Inquiry Regarding Suicide Protective Factors among Trans Adults." *Psychology of Sexual Orientation and Gender Diversity* 2 (3): 266–280. https://doi.org/10.1037/sgd0000130.

Patton, Michael Quinn. 2002. *Qualitative Research & Evaluation Methods.* 3rd ed. California: Sage Publications, Inc.

Pellicane, Michael J, and Jeffrey A. Ciesla. 2022. "Associations between Minority

Stress, Depression, and Suicidal Ideation and Attempts in Transgender and Gender Diverse (TGD) Individuals: Systematic Review and Meta-Analysis." *Clinical Psychology Review* 91: 102113. https://doi.org/10.1016/j.cpr.2021.102113.

Perez-Brumer, Amaya, Mark L. Hatzenbuehler, Catherine E. Oldenburg, and Walter Bockting. 2015. "Individual- and Structural-Level Risk Factors for Suicide Attempts among Transgender Adults." *Behavioral Medicine* 41 (3): 164–171. https://doi.org/10.1080/08964289.2015.1028322.

Platt, Stephen, and Thomas Niederkrotenthaler. 2020. "Suicide Prevention Programs: Evidence Base and Best Practice." *Crisis: The Journal of Crisis Intervention and Suicide Prevention* 41 (Suppl 1): S99–S124. https://doi.org/10.1027/0227-5910/a000671.

Pullen Sansfaçon, Annie, Elio Gravel, and Morgane A. Gelly. 2024. "Dealing with Scam in Online Qualitative Research: Strategies and Ethical Considerations." *International Journal of Qualitative Methods* 23. https://doi.org/10.1177/16094069231224610.

Rich, Ashleigh J, Travis Salway, Ayden Scheim, and Tonia Poteat. 2020. "Sexual Minority Stress Theory: Remembering and Honoring the Work of Virginia Brooks." *LGBT Health*, 7 (3): 123-168. https://doi.org/10.1089/lgbt.2019.0223.

Ridge, Damien, Laurna Bullock, Hilary Causer, Tamsin Fisher, Samantha Hider, Tom Kingstone, Lauren Gray, Ruth Riley, Nina Smyth, Victoria Silverwood, Johanna Spiers, and Jane Southam. 2023. "'Imposter Participants' in Online Qualitative Research, a New and Increasing Threat to Data Integrity?" *Health Expectations* 26 (3): 941–944. https://doi.org/10.1111/hex.13724.

Rimke, Heide and Debra Brock. 2012. "The Culture of Therapy: Psychocentrism in Everyday Life." In *Power and Everyday Practices*, edited by Deborah Brock, Aryn Martin, Rebecca Raby and Mark Thomas, 182–202. Toronto: University of Toronto Press.

Russell, Stephen T, Amanda M. Pollitt, Gu Li, and Arnold H. Grossman. 2018. "Chosen Name Use Is Linked to Reduced Depressive Symptoms, Suicidal Ideation, and Suicidal Behavior among Transgender Youth." *The Journal of Adolescent Health* 63 (4): 503–505. https://doi.org/10.1016/j.jadohealth.2018.02.003.

Schreier, M. 2018. "Sampling and Generalization." In *The SAGE Handbook of Qualitative Data Collection*, edited by Uwe Flick, 84–98. Thousand Oaks, CA: SAGE.

Schwandt, Thomas A. 2007. *The SAGE Dictionary of Qualitative Inquiry.* Thousand Oaks, CA: SAGE.

Shapira, Shahar, and Leeat Granek. 2019. "Negotiating Psychiatric Cisgenderism-Ableism in the Transgender- Autism Nexus." *Feminism & Psychology* 29 (4): 494–513. https://doi.org/10.1177/0959353519850843.

Sherman, Athena D.F., Kristen D. Clark, Kelley Robinson, Tara Noorani, and Tonia Poteat. 2020. "Trans* Community Connection, Health, and Wellbeing: A Systematic Review." *LGBT Health* 7 (1): 1–14. https://doi.org/10.1089/lgbt.2019.0014.

Siebel, Bruna L, Bruno de Brito Silva, Anna M.V. Fontanari, Ramiro F. Catelan, Ana M. Bercht, Juliana L. Stucky, Diogo A. DeSousa, Elder Cerqueira-Santos, Henrique C. Nardi, Silvia H. Koller, and Angelo B. Costa. 2018. "The Impact of the Parental Support on Risk Factors in the Process of Gender Affirmation of Transgender and Gender Diverse People." *Frontiers in Psychology* 9: 399. https://

doi.org/10.3389/fpsyg.2018.00399.
Substance Abuse and Mental Health Services Administration (SAMHSA). 2021. "Key Substance Use and Mental Health Indicators in the United States: Results from the 2020 National Survey on Drug Use and Health." (HHS Publication No. PEP21-07-01-003, NSDUH Series H-56). *Center for Behavioral Health Statistics and Quality, SAMHSA*. https://www.samhsa.gov/data.
The Trevor Project. 2022. "2022 National Survey on LGBTQ Youth Mental Health." *The Trevor Project*. https://www.thetrevorproject.org/survey-2022.
Turban, Jack L, Noor Beckwith, Sari L. Reisner, and Alex S. Keuroghlian. 2020. "Association between Recalled Exposure to Gender Identity Conversion Efforts and Psychological Distress and Suicide Attempts among Transgender Adults." *JAMA Psychiatry* 77 (1): 68–76. https://doi.org/10.1001/jamapsychiatry.2019.2285.
Ussher, Jane M, Alexandra Hawkey, Janette Perz, Pranee Liamputtong, Jessica Sekar, Brahmaputra Marjadi, Virginia Schmied, Tinashe Dune, and Eloise Brook. 2021. "Gender Affirmation and Social Exclusion Amongst Trans Women of Color in Australia." *International Journal of Transgender Health*, 23 (1–2): 79–96. https://doi.org/10.1080/26895269.2021.1947432.
Wall, Catherine S.J., Alison J. Patev, Eric G. Benotsch. 2023. "Trans Broken Arm Syndrome: A Mixed-Methods Exploration of Gender-Related Medical Misattribution and Invasive Questioning." *Social Science & Medicine* 320: 115748. https://doi.org/10.1016/j.socscimed.2023.115748.
White Hughto, Jaclyn M, Sari L. Reisner, and John E. Pachankis. 2015. "Transgender Stigma and Health: A Critical Review of Stigma Determinants, Mechanisms, and Interventions." *Social Science & Medicine* 147: 222–231. https://doi.org/10.1016/j.socscimed.2015.11.010.
World Health Organization (WHO) (n.d.). "Suicide Worldwide in 2019: Global Health Estimates." *World Health Organization*. https://www.who.int/publications/i/item/9789240026643.

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ORIGINAL ARTICLE

Attitudes of Medical Students on Transgender People in Vietnam: A Survey of Medical Students at Hanoi Medical University

Eric Ardman
is a resident physician in the Department of Family Medicine at Oregon Health and Science University. His areas of interest include medical education, gender affirming care, birth work, and addiction medicine.
✉ eaardman@gmail.com

Vu Minh Anh
is a graduate student and researcher in the Center for Training and Research on Substance Abuse and HIV.

Dao Thi Dieu Thuy
is a PhD candidate in the Department of Epidemiology at University of North Carolina at Chapel Hill and researcher in the Center for Training and Research on Substance Abuse and HIV.

Le Minh Giang
is the chair of the department of Global Health and Graduate Medical Education at Hanoi Medical University, as well as assistant director of the Center for Training and Research on Substance Abuse and HIV. His research focuses on addiction, HIV, and stigma.

The transgender community faces disproportionate healthcare disparities; stigma and poorly trained providers are likely factors. The objectives of this study were to evaluate the attitudes and opinions of medical students regarding transgender people and to examine which demographic variables correlate with positive attitudes towards transgender people. This cross-sectional study surveyed 561 medical students, across all years of study, at Hanoi Medical University (HMU) in Hanoi, Vietnam. Students were surveyed in December 2018. The survey included demographic data collection and Attitudes Towards Transsexualism Survey. The survey demonstrated adequate internal consistency with a Cronbach's alpha of 0.86. Overall, 78.6% of participants held positive or very positive attitudes towards transgender people. Most students reported there should be more LGBT-related content added to the curriculum. On multivariate regression, identifying as female and wanting more LGBT topics in the school curriculum were significantly associated with positive attitudes towards transgender people. Medical students at HMU held positive views of transgender

people. They would benefit from, and widely accept, more LGBT content, particularly regarding transgender health, in HMU's curriculum.

KEYWORDS medical students; transgender; attitudes; education; Vietnam
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Transgender communities face disease burden as well as healthcare disparities disproportionate to their population size (Hafeez et al. 2017). For example, according to the Centers for Disease Control and Prevention (2019), in 2019–20, the prevalence of HIV in transgender women across seven American cities was 42%, while transgender people only accounted for less than 1% of the total US population. Disparities such as these persist in other parts of the world as well, such as Vietnam. Though not directly comparable, it is still illuminating that a study from 2016 found that the prevalence of HIV among 205 transgender women in Ho Chi Minh City was 18.0% while the prevalence of HIV in the general population was only .4% (Colby et al. 2016; UNAIDS n.d.). Stigma in healthcare is a well-studied influence on healthcare disparities, including HIV care in particular (Hatzenbuehler, Phelan, and Link 2013; Maman et al. 2009). Healthcare professionals across the globe are not exempt from its influence; societal stigma (not adhering to a gender binary in Vietnam was previously considered to be a "social evil") and poor training have been cited as potential contributors to poorer health outcomes for transgender patients globally and Vietnam in particular (Hunt et al. 2017; Lyons et al. 2015; Vijay et al. 2018; Do and Nguyen 2020).

Most of the research examining the attitudes, knowledge, and training of healthcare workers regarding transgender patients has been conducted in high-income countries; there is a modest body of research in Asia, but virtually no peer-reviewed studies have been conducted solely in Vietnam (Kortes-Miller, Wilson, and Stinchcombe 2019; Vijay et al. 2018; Martins et al. 2020). While there are currently no agreed-upon guidelines regarding how transgender health education should be conducted, consensus in the literature suggests integrated, longitudinal, clinical skills-based interventions as ideal for improving knowledge and patient outcomes in the long-term (S. N. Dubin et al. 2018).

The Vietnamese government continues to address many health problems that disproportionally affect transgender people, but there have been no studies that have sought to understand medical student attitudes towards trans people. It has been suggested that one way to combat the stigmatization of marginalized communities is to examine the attitudes of medical students and subsequently provide training and exposure in order to change negative attitudes before they graduate and begin practicing (R. E. Dubin et al. 2017).

Hanoi Medical University (HMU) is the oldest medical university in Vietnam, graduating thousands of health professionals every year in a variety medical fields. In Vietnam, the training that is required to become a medical doctor consists of six years of undergraduate study, followed by graduate study lasting from six months to three years. Students begin this journey in the classroom, learning basic sciences. As they progress through their studies, students spend more time in clinical settings. At

the time of data collection for this study, there was no formal training in transgender health for medical students at HMU. Understanding the attitudes and knowledge of transgender issues of these medical students would be an important first step in improving transgender-related curriculum in medical education in Vietnam.

The objectives of this study were to evaluate the attitudes of medical students regarding trans people and to examine which demographic variables are associated with positive attitudes towards trans people. In order to build a workforce friendly to gender-diverse patients, a clear understanding of the knowledge gaps and stigma of Vietnam's current *and* future doctors is essential.

METHODS

Design and Recruitment

This team conducted a cross-sectional study of medical students from all class years (year 1 to year 6) who were studying on the medical doctor, or đa *khoa*, track during December 2018. Inclusion criteria were that participants had to be 18 years old or older and currently enrolled at HMU in the đa *khoa* track. Exclusion criteria included students who were not currently enrolled at HMU, or currently enrolled in any other area of study at HMU.

Based on the formula provided by Peacock and Peacock (2011), with a desired confidence interval width of .10 and expected population proportion of .50, it was calculated that 384 participants would be an adequate sample size in order to have a confidence interval of 95%. However, because each classroom has about 100 students, with the objective of surveying students from all school years, and to account for the possibility of missing data, losses, and incomplete surveys, it was decided to have a target sample size of 600 students (100 students per year).

Initially, every class in each year of study was assigned a number from one to seven. One class from each year was randomly selected using Google's random number generator to participate in the study. If a class was unavailable (due to scheduling conflicts) to be surveyed, a different class from the same year with an available schedule was selected. Once a time was arranged to survey, two team members went to the classroom of the selected class to introduce the survey and proctor the class while students took the survey. Surveys were handed out to each student by classroom volunteers and the team members; upon completion, surveys were returned to the proctors.

Instruments

This study was done in conjunction with attempting to measure medical student attitudes of lesbian and gay people and knowledge of homosexuality. As such, the survey packet combined demographic questions, including age, sex, gender identity, year in school (see Table 1 for full details), and several questionnaires; one measured the attitudes of students towards lesbians and gay men, one measured attitudes towards transgender people, and one evaluated participant knowledge of homosexuality. Additionally, we collected data regarding student opinions on whether LGBT content should be included in their curriculum (yes/no format), information sources for LGBT information (multiple choice of media sources), and social proximity to LGBT people (multiple choice ranging in proximity from close family to acquaintance) to exam-

Table 1. Socio-demographic characteristics and exposure to LGBT individuals/ organizations (N = 561)

Variable	*n*	% or *M* (*SD*)
Age	553[b]	21.07 (1.77)
Age group		
18–20 years old	152	27.49
> 20 years old	401	72.51
Sex at birth		
Male	286[b]	51.44
Female	270	48.56
Sexual orientation/gender identity		
Heterosexual	518[b]	94.01
Gay	12	2.18
Lesbian	2	0.36
Bisexual	11	2.00
Transgender	0	0.00
Other	1	0.18
Do not answer	7	1.27
Ethnicity		
Kinh (ethnic majority)	531[a]	95.16
Other	27	4.84
Year in school		
Y1	97	17.29
Y2	61	10.87
Y3	124	22.10
Y4	100	17.83
Y5	57	10.16
Y6	122	21.75
Religion		
Buddhist	45[a]	8.05
Cao Dai	1	0.18
Christian	15	2.68
Atheist	498	89.09
Are you currently practicing your religion?		
No	507[c]	92.52
Yes	27	4.93
Sometimes	14	2.55
Living place before university		
Urban	157[a]	28.04
Rural	403	71.96

Variable	*n*	% or *M* (*SD*)
Should there be more LGBT information in the curriculum?		
Yes	403[b]	72.62
No	127	22.88
Too early	25	4.50
Are you aware of any resources or organizations available for LGBT patients in the community?		
Yes	64[a]	11.49
No	493	88.51
Have you met an LGBT person before?		
Never met before	203[a]	36.25
A few LGBT	304	54.29
Many LGBT	53	9.46
Where you have heard about or seen LGBT information		
Friends/family	349[a]	62.77
Television show, i.e. the news	491	87.99
Movie, such as a documentary	456	81.72
Internet	492	88.01
Social media	477	85.48
Newspaper or magazine	461	82.47
Books	245	44.22
Class, seminar, or community event	231	41.62

Note. [a]Missing < 5 observations, [b]missing 5–10 observations, [c]missing > 10 observations

ine whether these could be potential factors to explain participant attitudes towards transgender people. Data on attitudes towards lesbians and gay men and knowledge of homosexuality, which was collected at the same time and location as the current study, have previously been published by Ardman and colleagues (2021).

Briefly, the Attitudes Toward Lesbians and Gay Men Scale Revised survey has 10 questions that use a 5-point Likert scale to assess the respondents' attitudes towards lesbians and gay men (Herek 1994). The Knowledge About Homosexuality Questionnaire consists of 32 true/false questions; this survey had previously been validated and used among university and medical students (Harris 1998).

The Attitudes Towards Transsexualism survey (Landén and Innala 2000) is a total of 13 questions (some with multiple parts) that measures the attitudes of the respondent regarding trans persons. It was first used in Sweden by Landen and Innala (2000). Each question has 3 or more answers each (e.g., yes, no, or no opinion). This survey was chosen because it has been used to assess the attitudes of students in the past, albeit within an American context (Kooy 2010). Additionally, our research team was limited by time and funding to create a validated survey from scratch; we were also unable to find a previously validated survey whose goal was to assess attitudes not only towards transgender people themselves but also their access to gender-affirming medical care (several questions ask about gender-affirming surgeries and hormone therapies). Some questions were rewritten to make them appropriate for the Vietnamese context, i.e., changing the location for certain questions from the USA to Vietnam.

Table 2. LGBT exposure and proximity (N = 561)

Variable	Lesbian		Gay		Bisexual		Transgender	
	n	%	*n*	%	*n*	%	*n*	%
What is your closest relationship with…?								
Don't know any	424[a]	75.85	277[b]	50.18	452[a]	80.71	506[a]	90.36
Siblings	1	0.18	0	0	2	0.36	0	0
Partner	3	0.54	9	1.63	2	0.36	0	0
Friends	75	13.42	188	34.06	73	13.04	27	4.82
Teacher	1	0.18	1	0.18	1	0.18	0	0
Coworker/colleague	1	0.18	2	0.36	0	0.00	0	0
Acquaintance	53	9.48	68	12.32	27	4.82	21	3.75
Other	1	0.18	7	1.27	3	0.54	6	1.07

Note. [a]Missing < 5 observations, [b]missing 5–10 observations, [c]missing > 10 observations

While the English vocabulary is outdated, the vocabulary was modernized in translation to Vietnamese; modern interpretations of the vocabulary are used forthwith in this manuscript.

The survey was translated from English to Vietnamese by a native Vietnamese speaker who is also fluent in English. A pilot group of 20 Vietnamese medical students then completed the survey and provided feedback to fix any unclear passages and assess internal consistency. The survey was then edited and given a final review by two native Vietnamese team members.

Data Review and Analysis

Epidata 3.1 was used to create the database. The Kolmogorov-Smirnov test was used to assess the normality of the distribution for knowledge and attitudes scores; none of them fit a normal distribution. Cronbach's alpha was used to assess the internal consistency of attitudes towards transgender people; a value of at least 0.6 was used as the cut-off indicating acceptable internal consistency. For analysis by multivariate regression, the dependent variable was a continuous variable and variables were entered into the multivariate model if the univariate p value was less than .05. Stata/MP 14.0 was used to analyze the data. While it is more common to use p value of less than .1 or .2 for variable selection into a multivariate model, due to the presence of multiple variables with p-values < .2 in the univariate analysis, we chose a relatively strict threshold to be considered for multivariate analysis. This variable selection approach aligns with our goal of assessing several factors related to the outcome. The primary outcome is the attitudes towards trans people score, derived from a student's survey responses. A linear model was used for this analysis.

Ethical Considerations and Funding Sources

This study was approved by the Hanoi Medical University institutional review board, approval number 44.18/HMUIRB. Before completing the survey, participants were directed to read the letter of informed consent highlighting the risks, benefits, and precautions for securing anonymity on the front page of each survey. They were told

Table 3. Summary of attitudes towards transgender people scores (N = 561)

Variable	*n*	% or *M* (*SD*)
Overall attitudes towards transgender people	561	8.38 (3.01)
Level of attitudes towards trans people		
Very negative (0–3 points)	52	9.27
Negative (3–6 points)	68	12.12
Positive (6–9 points)	190	33.87
Very positive (9–12 points)	251	44.74

verbally and in writing that the survey was completely voluntary and anonymous. Students were told that by beginning the survey, they agreed to give their informed consent.

RESULTS

Participant Characteristics

Our final sample size was 561 students (Table 1). Two-hundred eighty-six respondents (51.4%) identified themselves as assigned male at birth while 270 respondents (48.6%) identified themselves as assigned female at birth. Regarding gender identity, 94% of respondents reported identifying as cisgender; no one reported identifying as transgender. Regarding participant age, 72.5% of students were older than 20 years old.

Regarding the current medical school curriculum, most students (72.6%) responded that there should be more LGBT-related content. Only 4.5% of students said that it is too early in their school careers to know and 7.9% of students felt there should not be more LGBT-related content. Additionally, the majority (83.5%) of respondents did not know of any community resources/services for the LGBT community in Hanoi.

In our sample, 63.8% of respondents had met at least some people from the LGBT community (Table 2). When separated into specific gender identities, the percentages of students who had never met a trans person was 90.4%.

Attitudes Towards Transgender People Survey

The measure demonstrated adequate internal consistency with a Cronbach's alpha of 0.86. Overall, 441 participants (78.6%) held positive or very positive attitudes towards trans people (Table 3).

Upon looking at individual questions, most students responded in favor of trans people being allowed to change their name (72.3%), change their identity on their identification cards (61.6%), obtain hormones (80.7%) and obtain gender-affirming surgery (86.9%). Most students answered that patients should be responsible for paying for gender-affirming surgery themselves (82.4%) while only 4.0% of respondents said the public should be the source of funds.

Most students also responded that trans people who had already transitioned should be allowed to marry (87.0% for, 1.3% against). The majority of students marked that they would be comfortable with a trans person as a colleague (61.7%) or a friend (61.7%), while 16.6% of respondents reported that they would feel comfortable being in

Table 4. Summary of multiple linear regression analysis of factors associated with attitudes towards transgender people (N = 561)

Variable	*B* [95%CI]	*p*
Sex at birth		
Female	ref.	
Male	−0.57 −[1.03, 0.11]	**.015**
Should there be more LGBT information in the curriculum?		
Yes	ref.	
No	−0.76 [−1.32, 0.21]	**.007**
Too early	−1.30 [−2.39, 0.21]	**.020**
If you know a lesbian, what is your closest relationship?		
Don't know any	ref.	
Siblings/partner/friends	−0.08 [−0.81, 0.64]	.818
Others	0.67 [−0.13, 1.47]	.098
If you know a gay person, what is your closest relationship?		
Don't know any	ref.	
Siblings/partner/friends	0.53 [−0.03, 1.09]	.063
Others	0.42 [−0.31, 1.14]	.262
If you know a bisexual person, what is your closest relationship?		
Don't know any	ref.	
Siblings/partner/friends	0.38 [−0.37, 1.13]	.361
Others	0.78 [−0.26, 1.81]	.140

Note. Bolded *p*-values are statistically significant.

a romantic relationship with a trans person.

In society at large, most students felt that the media coverage of trans people and trans issues was "adequate" (42.1%); 17.5% responded "too much coverage" while 20.9% responded "too little coverage." Most students also reported that the transgender population has increased in Vietnam over the last 20 years (70.9% agreed, 3.9% disagreed, 25.1% had no opinion).

The last question on the survey asked what respondents believed were the reason(s) for a person to be transgender. For that question, which allowed students to choose more than one answer, 74.2% of respondents believed being transgender was a choice while 33.2% believed that trans people were born that way. Additionally, 22.9% believed being trans stemmed from childhood experiences. Only 36 respondents (6.5%) believed being trans was a disease that could influence others and 1.6% of respondents answered "reason other than those listed" as an answer.

On multivariate regression (Table 4), being female (p = .015 compared to male participants) and wanting more LGBT topics in the school curriculum (p = .007 compared to participants who did not believe so) were significantly associated with positive attitudes towards trans people.

DISCUSSION

Research relating to transgender people is scarce in Vietnam. Furthermore, based on a thorough review of Pubmed and SCOPUS by an experienced librarian, this is the first peer-reviewed study in Vietnam to examine medical student attitudes and knowledge of transgender people and health topics.

It is important to discuss the attitudes towards transgender people in Vietnam in particular as they face unique threats of violence, a large degree of stigma and discrimination, and limited access to healthcare (HIV/AIDS Data Hub for the Asia Pacific n.d.; Human Rights Watch 2020; Knight 2020;). Overall, students held positive attitudes and opinions of trans people. This is in line with similar studies among medical students in Asia (Lee et al. 2020; Martins et al. 2020). Other studies also report positive attitudes towards LGBT people among medical students, but didn't explicitly study attitudes towards transgender people, which may mask the variability of participant attitudes towards people of different genders (Manalastas et al. 2017).

Student ideas of what makes a person trans were varied. Students were allowed to choose more than one answer; a fair number of students believed being trans stems from multiple origins. As society and health officials accept transgender people as normal, through behaviors and policy actions, there is hope that misconceptions around gender origins will continue to decrease in prevalence (Human Rights Watch 2022). Though not specifically studied, stigma against trans people was likely present, given that about 7% of respondents believed being trans was a disease state and about 20% did not agree that trans people should have access to hormone therapies. Misconceptions about transgender people, as discussed earlier, affect how healthcare workers perceive and treat transgender people and may prove to be a barrier to trans people receiving the care they need in the future as well as population health at large (Hatzenbuehler, Phelan, and Link 2013; Link and Hatzenbuehler 2016; Madera et al. 2019). While legal reform has begun, no formal, country-specific guidelines, policies, or laws exist to guide clinicians on providing hormone therapies and surgeries that align one's body with one's "true gender;" as such, they are *de facto* inaccessible for most transgender/gender-diverse people in Vietnam with several exceptions, one of which being a diagnosis of ambiguous genitalia at birth (United Nations Development Programme and United States Agency for International Development 2014). Without structural changes, significant difficulties remain with implementing education initiatives for healthcare providers and students.

Though not necessarily related to medical care, one of the more surprising findings was that 16% of respondents said they would be comfortable with having a trans person as a romantic partner. This was higher than the US student sample (though the US study was smaller in size) from Kooy's study and the Swedish national sample from Landen's study (Kooy 2010; Landén and Innala 2000). This is despite the fact that the respondents were not as affirmative about transgender people being allowed to change their name and identity or having trans coworkers and friends compared with Kooy's students. Additionally, less than 10% of respondents reported personally knowing a trans person. This may be a sign of cisgender/heterosexual students' openness to trans people and more positive portrayals of trans people in their environment as a majority of respondents reported hearing about LGBT topics through the media and personal relationships. Another possibility is that there are more non-cis/hetero-

sexual, including transgender, participants in the student body who simply did not self-identify on the survey.

Religiosity has been cited as an important factor in negative attitudes towards gender-diverse people, at least in the United States (Bunting et al. 2021; Wilson et al. 2014). In our population of study, the vast majority of students reported not currently practicing their self-identified religion, which may also indirectly support religiosity as an important factor of individual attitudes. At the very least, this suggests confounding variables are influencing the relationship between educational interventions and attitudes of students. Interestingly, Bunting et. al comments that confounding factors on this relationship potentially include lack of quality and quantity of medical education at US medical schools, though this is changing rapidly (Nolan et al. 2020; Obedin-Maliver et al. 2011).

Future interventions in medical education regarding transgender health, at least at HMU, may not need to entirely focus on changing attitudes of students but can focus more on the task that is more easily aligned with the university's mission: providing students with accurate information throughout the curriculum, guidelines for care, and adequate clinical training in LGBT-health topics. These students, as future healthcare providers, will play an influential role in the health of the Vietnamese people, including their trans patients, in the very near future. Their attitudes matter (Powell 2018). If they can provide a sensitive, accepting environment for these patients, it will be one step closer to closing the health disparities between transgender people and the general population.

Limitations

There are several limitations in this study. While we were able to assure students that their answers were anonymous to those outside of the classroom, it proved impossible to guarantee anonymity within the classroom. Classrooms were crowded and not private; it was up to the participant to guard their answers if they chose to do so. It was also difficult to keep students from talking amongst themselves during the survey. This would likely affect the results of the more sensitive questions, such as participant sexuality, and questions that students felt were difficult to answer. This could mean that students' responses may have been influenced by those around them who thought they might have known the "correct" answers. Students may also have withheld from disclosing attitudes that may cause embarrassment or shame if known to their classmates.

Given the resource limitations of our study, we were unable to directly examine participant knowledge of transgender people with a validated tool. The Attitudes Towards Transgender People survey was not a validated survey and as such, may not achieve the objectives of the survey. That being said, we used a survey that had previously been used in a student population. We issued a pilot survey to assess clarity and consistency, which was acceptable. In translation of the survey, vocabulary was modernized and adjusted for a Vietnamese context. Given these points, we still believe the survey was appropriate and captured relevant data where none existed prior.

Our study's generalizability was limited by our sample, which only included students from one health track at one medical school in Vietnam and may not reflect the attitudes of students in other health profession tracks or at other universities. How-

ever, the data do provide a first glimpse of a population that has yet to be thoroughly studied in Vietnam. While the team intended to select classes by randomization, it was not always possible due to class scheduling. About half of the data was collected by approaching classes with convenient schedules for collection. Even so, this research team has no reason to believe that one class of students would be significantly different from another class. We assumed that the students in each class would be a "random" selection of the student body.

This survey was entirely voluntary; some students chose not to participate. However, this study had no way of knowing how many students did not participate or why they chose not to participate. Some students may not have attended class on the day of surveying, several students handed back blank surveys, and several students walked out of class after the team members introduced the survey. However, because research team members proctored the classes during data collection (we were able to visualize when and how many students walked out), and because we did not receive any surveys with more than a few missing answers, we are confident that there were very few students who chose not to participate.

Future Research

Future research should focus on understanding medical student knowledge of transgender health, as well as expand its scope to examine the attitudes, knowledge, and opinions of students in other health care professions and at other schools and regions in Vietnam regarding trans people. Additionally, research in creating interventions that improve student knowledge, reduce stigma, and, ultimately, improve trans patient outcomes, is needed.

CONCLUSIONS

Medical students at Hanoi Medical University hold positive views of trans people and want to learn more about LGBT-health topics in their curriculum. Similar to students in other parts of the world, it would seem that they would benefit from, and widely accept, more LGBT-related content in HMU's curriculum and more contact with trans people inside and outside of educational environments.

REFERENCES

Ardman, Eric, Vu Minh Anh, Dao Thi Dieu Thuy, and Le Minh Giang. 2021. "Attitudes and Knowledge of Medical Students in Hanoi Regarding Lesbian and Gay People." *Journal of Homosexuality* 68 (14): 2359–74. https://doi.org/10.1080/00918369.2020.1804257.

Bunting, Samuel R., Marianne G. Chirica, Timothy D. Ritchie, Sarah S. Garber, and Tamzin J. Batteson. 2021. "A National Study of Medical Students' Attitudes Toward Sexual and Gender Minority Populations: Evaluating the Effects of Demographics and Training." *LGBT Health* 8 (1): 79–87. https://doi.org/10.1089/lgbt.2020.0288.

Centers for Disease Control and Prevention. 2019. "Transgender People." *CDC*, April 16. https://www.cdc.gov/hiv/group/gender/transgender/index.html.

Colby, Donn, Ngoc Anh Nguyen, Bao Le, Trang Toan, Dinh Duc Thien, Hoang Thi Huyen, Thi Doan Anh Mai, Mackey R. Friedman, and Ron Stall. 2016. "HIV and Syphilis Prevalence Among Transgender Women in Ho Chi Minh City, Vietnam." *AIDS and Behavior* 20 (Suppl 3): 379–85. https://doi.org/10.1007/s10461-016-1485-8.

Do, Trang Thu, and Anh T. Van Nguyen. 2020. "'They Know Better than We Doctors Do': Providers' Preparedness for Transgender Healthcare in Vietnam." *Health Sociology Review* 29 (1): 92–107. https://doi.org/10.1080/14461242.2020.1715814.

Dubin, Ruth E., Alan Kaplan, Lisa Graves, and Victor K. Ng. 2017. "Acknowledging Stigma." *Canadian Family Physician* 63 (12): 906–8.

Dubin, Samuel N, Ian T Nolan, Carl G Streed, Richard E Greene, Asa E Radix, and Shane D Morrison. 2018. "Transgender Health Care: Improving Medical Students' and Residents' Training and Awareness." *Advances in Medical Education and Practice* 9 (May): 377–91. https://doi.org/10.2147/AMEP.S147183.

Hafeez, Hudaisa, Muhammad Zeshan, Muhammad A Tahir, Nusrat Jahan, and Sadiq Naveed. 2017. "Health Care Disparities Among Lesbian, Gay, Bisexual, and Transgender Youth: A Literature Review." *Cureus* 9 (4). https://doi.org/10.7759/cureus.1184.

Harris, Mary B. 1998. "Knowledge About Homosexuality Questionnaire." In *Handbook of Sexuality Related Measures*, edited by Clive M. Davis, William L. Yarber, Robert Bauserman, George Schreer, and Sandra L. Davis, 383. Thousand Oaks, CA: SAGE.

Hatzenbuehler, Mark L., Jo C. Phelan, and Bruce G. Link. 2013. "Stigma as a Fundamental Cause of Population Health Inequalities." *American Journal of Public Health* 103 (5): 813–21. https://doi.org/10.2105/AJPH.2012.301069.

Herek, Gregory M. 1994. "Assessing Heterosexuals' Attitudes toward Lesbians and Gay Men: A Review of Empirical Research with the ATLG Scale." In *Lesbian and Gay Psychology: Theory, Research, and Clinical Applications*, edited by Beverly Greene and Gregory M. Herek, 206–28. Thousand Oaks, CA: SAGE.

HIV/AIDS Data Hub for the Asia Pacific. n.d. https://www.aidsdatahub.org.

Human Rights Watch. 2020. "Vietnam: LGBT Youth Unprotected." *Human Rights Watch*, February 12. https://www.hrw.org/news/2020/02/12/vietnam-lgbt-youth-unprotected.

Human Rights Watch. 2022. "Vietnam Adopts Global LGBT Health Standard." *Human Rights Watch*, August 18. https://www.hrw.org/news/2022/08/18/vietnam-adopts-global-lgbt-health-standard

Hunt, Jennifer, Katherine Bristowe, Sybille Chidyamatare, and Richard Harding. 2017. "'They Will Be Afraid to Touch You': LGBTI People and Sex Workers' Experiences of Accessing Healthcare in Zimbabwe—an in-Depth Qualitative Study." *BMJ Global Health* 2 (2). https://doi.org/10.1136/bmjgh-2016-000168.

Knight, Kyle. 2020. "'My Teacher Said I Had a Disease.'" *Human Rights Watch*, February. https://www.hrw.org/report/2020/02/13/my-teacher-said-i-had-disease/barriers-right-education-lgbt-youth-vietnam.

Kooy, Rachel E. 2010. "Knowledge and Attitudes Toward Trans Persons Humboldt State University." Master's thesis, California State Polytechnic University, Humboldt.

Kortes-Miller, Katherine, Kimberley Wilson, and Arne Stinchcombe. 2019. "Care and LGBT Aging in Canada: A Focus Group Study on the Educational Gaps among Care Workers." *Clinical Gerontologist* 42 (2): 192–97. https://doi.org/10.1080/07317115.2018.1544955.

Landén, M., and S. Innala. 2000. "Attitudes toward Transsexualism in a Swedish National Survey." *Archives of Sexual Behavior* 29 (4): 375–88.

Lee, Sa Ra, Min-A Kim, Mun Nyeong Choi, Suyeon Park, Jaehyun Cho, Chulmin Lee, and Eun Sil Lee. 2020. "Attitudes Toward Transgender People Among Medical Students in South Korea." *Sexual Medicine* 9 (1): 100278. https://doi.org/10.1016/j.esxm.2020.10.006.

Link, Bruce, and Mark L. Hatzenbuehler. 2016. "Stigma as an Unrecognized Determinant of Population Health: Research and Policy Implications." *Journal of Health Politics, Policy and Law* 41 (4): 653–73. https://doi.org/10.1215/03616878-3620869.

Lyons, Tara, Kate Shannon, Leslie Pierre, Will Small, Andrea Krüsi, and Thomas Kerr. 2015. "A Qualitative Study of Transgender Individuals' Experiences in Residential Addiction Treatment Settings: Stigma and Inclusivity." *Substance Abuse Treatment, Prevention, and Policy* 10 (1). https://doi.org/10.1186/s13011-015-0015-4.

Madera, Sheilla L. Rodríguez, Nelson Varas Díaz, Mark Padilla, Alíxida Ramos Pibernus, Torsten B. Neilands, Eliut Rivera Segarra, Carmen M. Pérez Velázquez, and Walter Bockting. 2019. "'Just Like Any Other Patient': Transgender Stigma among Physicians in Puerto Rico." *Journal of Health Care for the Poor and Underserved* 30 (4): 1518–42. https://doi.org/10.1353/hpu.2019.0089.

Maman, Suzanne, Laurie Abler, Lisa Parker, Tim Lane, Admire Chirowodza, Jacob Ntogwisangu, Namtip Srirak, Precious Modiba, Oliver Murima, and Katherine Fritz. 2009. "A Comparison of HIV Stigma and Discrimination in Five International Sites: The Influence of Care and Treatment Resources in High Prevalence Settings." *Social Science & Medicine (1982)* 68 (12): 2271–78. https://doi.org/10.1016/j.socscimed.2009.04.002.

Manalastas, Eric Julian, Timo Tapani Ojanen, Beatriz A Torre, and Vizla Kumaresan. 2017. "Homonegativity in Southeast Asia: Attitudes Toward Lesbians and Gay Men in Indonesia, Malaysia, the Philippines, Singapore, Thailand, and Vietnam." *Asia-Pacific Social Science Review* 17 (1): 25–33.

Martins, Russell S, Raisa Saleh, Hasan Kamal, Mishal Gillani, Asma A H Merchant, Muhammad M Munir, Hamza M Iftikar, et al. 2020. "The Need for Transgender Healthcare Medical Education in a Developing Country." *Advances in Medical Education and Practice* 11 (June): 405–13. https://doi.org/10.2147/AMEP.S255483.

Nolan, Ian T, Gaines Blasdel, Samuel N Dubin, Laura G Goetz, Richard E Greene, and Shane D Morrison. 2020. "Current State of Transgender Medical Education in the United States and Canada: Update to a Scoping Review." *Journal of Medical Education and Curricular Development* 7: 2382120520934813. https://doi.org/10.1177/2382120520934813.

Obedin-Maliver, Juno, Elizabeth S. Goldsmith, Leslie Stewart, William White, Eric Tran, Stephanie Brenman, Maggie Wells, David M. Fetterman, Gabriel Garcia, and Mitchell R. Lunn. 2011. "Lesbian, Gay, Bisexual, and Transgender–Related Content in Undergraduate Medical Education." *JAMA* 306 (9): 971–77. https://doi.org/10.1001/jama.2011.1255.

Peacock, Janet, and Philip Peacock. 2011. Oxford Handbook of Medical Statistics. New York: Oxford University Press.
Powell, Alvin. 2018. "Health Care Providers Need Better Understanding of LGBTQ Patients, Harvard Forum Says." *Harvard Gazette*, March 23. https://news.harvard.edu/gazette/story/2018/03/health-care-providers-need-better-understanding-of-lgbtq-patients-harvard-forum-says/.
United Nations Development Programme, and United States Agency for International Development. 2014. "Being LGBT in Asia: Viet Nam Country Report." *United States Agency for International Development*. https://www.usaid.gov/document/being-lgbt-asia-vietnam-country-report-vietnamese-language.
UNAIDS. n.d. "Hiểu về Dịch HIV." http://unaids.org.vn/hieu-ve-dich-hiv/.
Vijay, Aishwarya, Valerie A. Earnshaw, Ying Chew Tee, Veena Pillai, Jaclyn M. White Hughto, Kirsty Clark, Adeeba Kamarulzaman, Frederick L. Altice, and Jeffrey A. Wickersham. 2018. "Factors Associated with Medical Doctors' Intentions to Discriminate Against Transgender Patients in Kuala Lumpur, Malaysia." *LGBT Health* 5 (1): 61–68. https://doi.org/10.1089/lgbt.2017.0092.
Wilson, Christina K., Lindsey West, Lara Stepleman, Margo Villarosa, Brittany Ange, Matthew Decker, and Jennifer L. Waller. 2014. "Attitudes Toward LGBT Patients Among Students in the Health Professions: Influence of Demographics and Discipline." *LGBT Health* 1 (3): 204–11. https://doi.org/10.1089/lgbt.2013.0016.

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ORIGINAL ARTICLE

Toward Proactive Support for Transgender and/or Gender Nonconforming Students in Teacher Education: Initial Findings of an Action Research Study

Lee Airton
is an Assistant Professor of Gender and Sexuality Studies in Education at Queen's University in Kingston, Ontario. Their research focuses on the enactment of gender identity and gender expression human rights in K–12 schools and teacher education.
✉ lee.airton@queensu.ca

Michelle Searle
is an Assistant Professor of Educational Evaluation at Queen's University. Her research focuses on program evaluation, evaluation use and influence, arts-informed inquiry, and knowledge mobilization.

Sofia I. Melendez
is a doctoral student in clinical psychology at Toronto Metropolitan University, Ontario. Their research focuses on using participatory action research to transform professional training programs to better support trans and nonbinary people of diverse backgrounds.

Katrina Carbone
is a PhD candidate in the Faculty of Education at Queen's University, and member of the Ontario College of Teachers certified to teach K–12. Her dissertation focuses on transforming assessment practices in higher education to support student learning.

Beck Watt
is a Master of Education graduate from Queen's University and music educator in Winnipeg, Manitoba. Their research focuses on exploring the unique experiences of gender had by transgender and/or gender nonconforming individuals participating in instrumental music education.

Kel Martin
is a Master of Education graduate, and Sexual and Gender Diversity Advisor at Queen's Yellow House Student Centre for Equity and Inclusion. Through TransFamily Kingston,

he supports local gender diverse community, and through Yellow House they design and deliver programming and advising for 2SLGBTQ+ students.

Natalie Lefebvre
is the Practicum Manager and part-time Master of Education student at Queen's University, and a member of the Ontario College of Teachers. Her research focuses on increasing teacher education program staff capacity to support transgender and/or gender nonconforming teacher candidates.

Despite a relatively supportive social and legal context, and growing societal awareness of gender diversity, transgender and/or gender nonconforming (TGNC) people remain woefully under-represented in the Canadian teaching profession. Many Canadian teacher education programs are taking steps to improve supports for TGNC teacher candidates given the recent addition of gender identity and gender expression protected grounds in almost every piece of Canadian human rights legislation. However, a "reactive" approach dominates, meaning that barriers faced by TGNC teacher candidates tend to be addressed *after* harm has occurred. Our action research project aims to collaboratively shift a teacher education program at a mid-sized Ontario university toward a "proactive" stance where known gender-based barriers are mitigated *before* TGNC teacher candidates encountering them. This article shares findings from the project's first phase, focusing on barriers identified and mitigated four program areas: recruitment, application and orientation; practicum; career planning; and certification and graduation.

KEYWORDS teacher education, transgender, barriers, action research, evaluative inquiry
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Transgender and/or gender nonconforming (TGNC) people face numerous discrimination-related barriers to their social and economic participation in society, including in the areas of employment, housing, medical care, and education (see Gaetz et al. 2016; Grant et al. 2011; Peter, Campbell, and Taylor 2021; Scheim et al. 2021; Taylor et al. 2011). Despite the recently added protections against gender identity- and gender expression-based discrimination in Ontario, Canada's Human Rights Code, there remains much to be done in addressing systemic barriers, including in the preparation of teachers for the province's publicly funded schools. The Ontario Human Rights Commission (2014, 7) defines gender identity as "each person's internal and individual experience of gender," and "gender expression" as "how a person publicly presents their gender." Gender identity discrimination protection "is generally required only for transgender people (whose gender identity differs from their assigned sex at birth) and only if their transgender status is apparent, self-declared, or disclosed by another" (Airton et al. 2019, 1157). However, gender expression discrimination protection "may be a universal right" (1157) where every Canadian, whether transgender or not, conceivably has the right to express masculinity or femininity (or both/neither) in their

own way and not experience discrimination (see also Kirkup 2018; Kirkup et al. 2020). These distinct protections each carry implications that are not well understood in provincially regulated public sectors, including the post-secondary institutions where K–12 teachers receive their education and introduction to the teaching profession. This is especially notable in a profession which traditionally has held spoken and unspoken expectations of how to "do gender" in a way that signals professionalism and fitness to serve in this socially valued role (Ingrey 2023; Iskander 2021).

As more K–12 students express or identify their gender in ways that run counter to cisnormative expectations (Goodman et al. 2019), the lack of gender diversity in the teaching profession is becoming a site of considerable tension. Emerging research suggests that TGNC teacher candidates (TCs)—people enrolled in university-based pre-service teacher education program—generally encounter teaching environments and expectations that are gendered in rigid binary ways (e.g., Iskander 2021; Silveira 2019). The present study directly addresses gaps in the literature on gender diversity in teacher education (see Airton and Koecher 2019; Payne, Airton, and Smith 2022), which has yielded findings on program curricula and TGNC TCs' experiences as units of analysis but has typically not turned its attention to program policy, procedures, and structures.

Our study interweaves action research (Loewenson et al. 2014) and evaluative inquiry (Coghlan and Brydon-Miller 2014) to identify and address gender-based barriers in the teacher education program at Queen's University. Queen's is a medium-sized, research-intensive university in the small and majority-white city of Kingston, Ontario. The Faculty of Education welcomes approximately 600 Bachelor of Education students (TCs) into its sixteen month-long after-degree teacher education program each year. Upon graduation TCs are certified to teach in the province by the Ontario College of Teachers. Since 2018, our research team and staff collaborators have been participating in barrier identification and mitigation processes and studying these processes in four key program areas: (1) the application and orientation process, (2) school practicum placement, (3) career planning services, and (4) graduation and certification. The project's central aim is shifting our program from a *reactive* (i.e., *after* a TGNC TC has had a negative experience, including but not limited to gender identity or gender expression discrimination) to a *proactive* approach (i.e., one that mitigates barriers *in advance* of any TC encountering them).

Our project is guided by the following research questions: (1) what structural barriers to transgender and/or gender nonconforming teacher candidates exist within our conventional post-degree, university-based teacher education program? (2) What does the process of identifying and removing these barriers reveal about making *proactive* gender diversity-inclusive changes in teacher education as it is currently organized? In this article, we report on the study's first phase, sharing two sets of findings: barriers to TGNC TCs that exist in teacher education programs (these are addressed in order by the change areas enumerated above) and a meta-finding on the change process itself which accounts for commonalities across the change areas.

CONCEPTUAL FRAMEWORK AND LITERATURE REVIEW

Our study uses a conceptual framework of cisnormativity (Bauer et al. 2009) and contributes to the emerging literature on the barriers TGNC individuals face when engaging with education systems—from kindergarten to grade 12 through post-secondary and into professional preparation programs—that struggle to imagine their presence (Blount 2000). Cisnormativity refers to social expectations and structures that assume everyone will (and should) identify with the gender they were assigned at birth throughout their lives (Bauer et al. 2009). Cisnormativity hinges on gender and biological essentialisms which expect: (1) sexed anatomy and gender identity to be congruent, immutable, and fixed at birth and (2) that a person's assigned gender corresponds with a mutually exclusive set of masculine or feminine attributes and desires (Serano 2016; Simmons and White 2014; Worthen 2016).

In educational systems permeated by cisnormativity, TGNC students often take the role of the "sacrificial lamb" in their school, outing themselves and exposing themselves to scrutiny in order to educate staff and pave the way for others (Meyer, Tilland-Stafford, and Airton 2016). Similarly, TGNC people who are training to become teachers find themselves in teacher education programs where instructors, staff, practices, policies, and structures are often unprepared to support them (Payne, Airton, and Smith 2022). Teacher education courses typically include little curricular content on transgender peoples' lives and experiences (Gorski et al. 2013, Macgillivray and Jennings 2008), or content that may unhelpfully conflate being transgender with being non-heterosexual (Kean 2020) by broadly addressing the needs of "LGBTQ" students writ large. In fact, the presence and contributions of TGNC TCs themselves may serve as a significant "gender diversity curriculum" for cisgender peers (Bartholomaeus et al. 2017; Murray 2011; Payne, Airton, and Smith 2022). Further, the scant research on teacher education administrators' preparedness to support TGNC TCs suggests that such is greatly lacking in universities (Horn et al. 2010; Shedlock 2013) and the school districts in which TGNC TCs must be placed to complete mandatory practicum or practice teaching placements (Hart and Hart 2018).

Current literature (see Payne, Airton, and Smith 2022 for an exhaustive review) paints a picture of TGNC TCs battling unique stressors and obstacles as they work through program requirements, despite the inclusion of human rights protections for minoritized gender expressions and gender identities across many jurisdictions (Airton et al. 2019; Meyer and Keenan 2018). For example, navigating legal names on student records and misgendering by professors are common experiences (e.g., Silveira 2019). Keenan (2017) introduced the language of drag to describe how cisnormativity and rigid gender binary expectations create specific gender boxes which TGNC TCs are expected to fit into to receive recognition as teachers. Keenan argues that these expectations inhibit TGNC TCs' ability to express their gender in the name of "professionalism." Iskander's (2021) ground-breaking study with nonbinary TCs uncovered gatekeeping behaviours from program staff and instructors via suggestions that disclosing one's self as trans and/or nonbinary would be a detriment to entering the career. Murray's (2011) research followed a trans TC—Jack—who was peer-supported during on-campus coursework, but struggled with the decision to come out to his students on practicum for fear of community and parent backlash; Jack, like many others, ultimately decided that he could "pass" more easily as female and did not come

out. Khayatt and Iskander (2020) further note the lack of TGNC representation among in-service teachers which reinforces messages that the teaching profession is no place for gender diversity. Iskander notes how these experiences ultimately discouraged them from continuing into a career at the K–12 education level despite successfully completing their program and having a history as a successful trans activist in high school (Khayatt and Iskander 2020).

Overall, pre-service TCs, both cisgender and transgender, are increasingly advocating within their programs for education and supports related to gender diversity; however, TGNC TCs experience obstacles precisely related to their gender identities and gender expressions due to pervasive cisnormativity in their programs and the teaching profession, including historically (Blount 2000). Research on teacher education programs and not only TGNC TCs' experiences within them is needed to interrogate and disrupt the cisnormativity shaping policy, procedure and structures. This approach is in line with calls for researchers in trans studies to take cisnormativity as their object of analysis rather than trans people themselves (Cumming-Potvin and Martino 2018; Serano 2016).

METHODOLOGY

The study features a purposeful interweaving of action research (Loewenson et al. 2014) and evaluative inquiry (Paydon and Ensminger 2021; Preskill and Torres 1999). These complementary approaches intentionally bring together multiple voices and people representing varied roles in shared inquiry for the purpose of taking action and working toward positive outcomes. These approaches recognize our position as researchers who are also community members, embedded within the context we are seeking to understand and change. In this section we describe the two approaches and their complementarity before describing data collection.

Action research and evaluative inquiry

Action research (Bell et al. 2008; Levin and Greenwood 2008; Luce-Kapler, Sumara, and Davis 2002) is a systematic process of inquiry that is conducted by, with and for those who are taking a particular action. A primary characteristic of action research is researchers working with others in a particular context to create knowledge (Anderson 2015). Community members whose roles do not typically include research serve as key contributors in understanding challenges and negotiating power dynamics. Levin and Greenwood (2008, 10) assert that an "action researcher works directly with problem owners in collaborative problem identification and knowledge generation processes. By so doing, action researchers necessarily demonstrate, enact, and justify their values and professional skills in front of a collaborating group that includes a 'public' that is capable of judging them." The epistemology underlying action research speaks to the belief that knowledge can be created through lived experience, and that collaborative experiences brought to bear on the research process can foster knowledge in context (Bell et al. 2008; Jacobs 2016; Wells 2015).

Evaluative inquiry (Paydon and Ensminger 2021) focuses on embedded and continuous learning to support change in a complex institutional environment (Patton 2011) and examine complex interventions in sites with diverse populations (Yin 1994).

For the past three decades, evaluative inquiry has been recognized as an approach that brings organizational communities together through dialogue and reflective practice (Argyris 1991; Coghlan and Brydon-Miller 2014; Goh et al. 2004; Preskill and Torres 1999; Schön 1987; Senge 2006). Evaluative inquiry emerged alongside other forms of evaluation that, like action research, emphasise the value of a joint approach in effecting change (e.g., Cousins and Earl 1992; Fetterman et al. 2014; Gamble 2008; Greene 1998; King et al. 2007; O'Sullivan 2012; Patton 2011; Shulha et al. 2016). This literature often pairs evaluative inquiry with organizational learning to create contexts within organizations that foster communication, learning, and growth toward organizational change at multiple levels (Cousins et al. 2014a; Paydon and Ensminger 2021). Intertwining action research with evaluative inquiry enabled our research team to draw on the knowledge, expertise, capacities, and insights of multiple people and roles in our teacher education program.

Data and the participant-collaborator role

Data for this study were both generated and collected through our collaboration with internal participant-collaborators: people whose daily work would be affected by the change process as barriers to TGNC TCs' participation and wellbeing were removed. Data were initially generated through a barrier-mapping exercise in March 2019 to identify where a TGNC TC (prospective or current) would likely experience a gender-related barrier within the B.Ed. program (Wright and Wallis 2019). This exercise enabled the identification of the four change areas, and of participant-collaborators who had student-facing roles in Student Services, the Practicum Office, and the Office of the Associate Dean of Teacher Education. All were invited to take part. Worth noting, however, is that the informed consent process guaranteed that data was collected solely pertaining to a participant collaborator's duties and responsibilities related to their staff role; personal views about gender diversity and personal experiences of the change process were not under study. This is not to say that any participant collaborator necessarily holds views contrary to the aims of the project, but that structures and processes, not individual staff members themselves, were objects of study.

In total, 31 staff completed the LOI process, in addition to the seven members of the core research team (authors). Taken together, our varying roles and backgrounds (e.g., teaching courses or having been a TC in our own program, collaborating on research, and/or experiencing forms of gender-based discrimination) surfaced different vantage points on the barriers faced by TGNC TCs. Notably, current and past research team members included cisgender and transgender young adults who are graduate students and recent graduates of the teacher education program under study, working alongside cisgender and transgender faculty members.

We generated and collected multiple forms of data across the change areas including: meeting minutes; communications; research plans and timelines; observational data/field notes made during the change process; notes from collegial dialogues and experience sharing; ongoing participant-collaborator reflections about change process collected informally; existing and readily available Faculty data on the B.Ed. program; Faculty documents and policies, both staff/instructor-facing and student-facing; and a two-hour focus group facilitated at the end of year one by a facilitator external to the research team. Following Braun and Clarke (2006), we used the

phases of thematic analysis whereby we first familiarized ourselves with the data and generated initial codes through inductive descriptive coding across the various change areas in a systematic fashion. The same codebook was applied across the entire data set. After inductive coding was completed, we reviewed all data by change area to yield an account of the barriers to TGNC TCs in each change area: the first findings shared below. We then identified a meta-finding across all four change areas that emerged from studying the first phase of our change process.

FINDINGS

In this section, we share findings in response to our first research question. These findings are organized by change area. Below, each section: (i) illustrates identified barriers to TGNC TC success and well-being identified *before* the change process; and (ii) describes completed or planned changes *in response* to the identified barriers since the initial barrier mapping process. The section concludes with a meta-finding on the change process—that we were able to make primarily document-based changes—and what this entails for welcoming TGNC TCs in teacher education and the profession more broadly. This meta-finding answers our second research question.

Recruitment, application, and orientation before the change process

The first point of exposure to the B.Ed. program begins during initial recruitment. Every fall, the Faculty staffs a booth at the Ontario Universities Fair, where a representative from Student Services greets potential applicants, answers questions, and circulates program materials. Before the change process, program recruitment and advertising materials lacked any visible signalling that gender diversity is welcome and expected in the program, and, by extension, in the teaching profession. For example, there was no imagery depicting gender nonconforming individuals, no information and signage pertaining to relevant supports and clubs on campus, and no building maps indicated the location of all-gender washrooms.

Recruitment webinars allow for more individualized questions from prospective applicants, and, at any time, potential applicants are welcome to come to the Faculty, where a Student Services representative can offer a tour of the building during which prospective applicants can chat informally with staff about the program and what it is like to be a TC at Queen's. These are many applicants' first interactions with our program. However, before the change process, staff responsible for conducting recruitment webinars (before and after acceptance), staff at the Ontario Universities Fair booth, and staff leading Faculty tours lacked specific training and guidance on gender diversity-inclusive practices.

Interested applicants apply through a third-party website called the Teacher Education Application System (TEAS), administered by the Ontario Ministry of Education. TEAS applications collect legal name and sex/gender information, which is copied to the database from the university's online portal called SOLUS Student Centre (hereafter, SOLUS) upon an admission offer. Offer letters are generated by Student Services using the applicant's TEAS information, meaning that offer letters and initial communications use the student's legal name. Before the change process, the legal

name, title, and "gender"[1] required by the TEAS system were also used by program staff in several orientation processes including publicly, without offering TCs information how that information would be used. However, application information may not reflect a TC's gender identity. TCs can indicate a preferred name and title in SOLUS, but navigating this process was unclear and inaccessible. If accepted, Consecutive B.Ed. students start the 16-month program in May. Undecided successful applicants have an additional opportunity to ask questions during online webinars usually facilitated by the Associate Dean of Teacher Education.

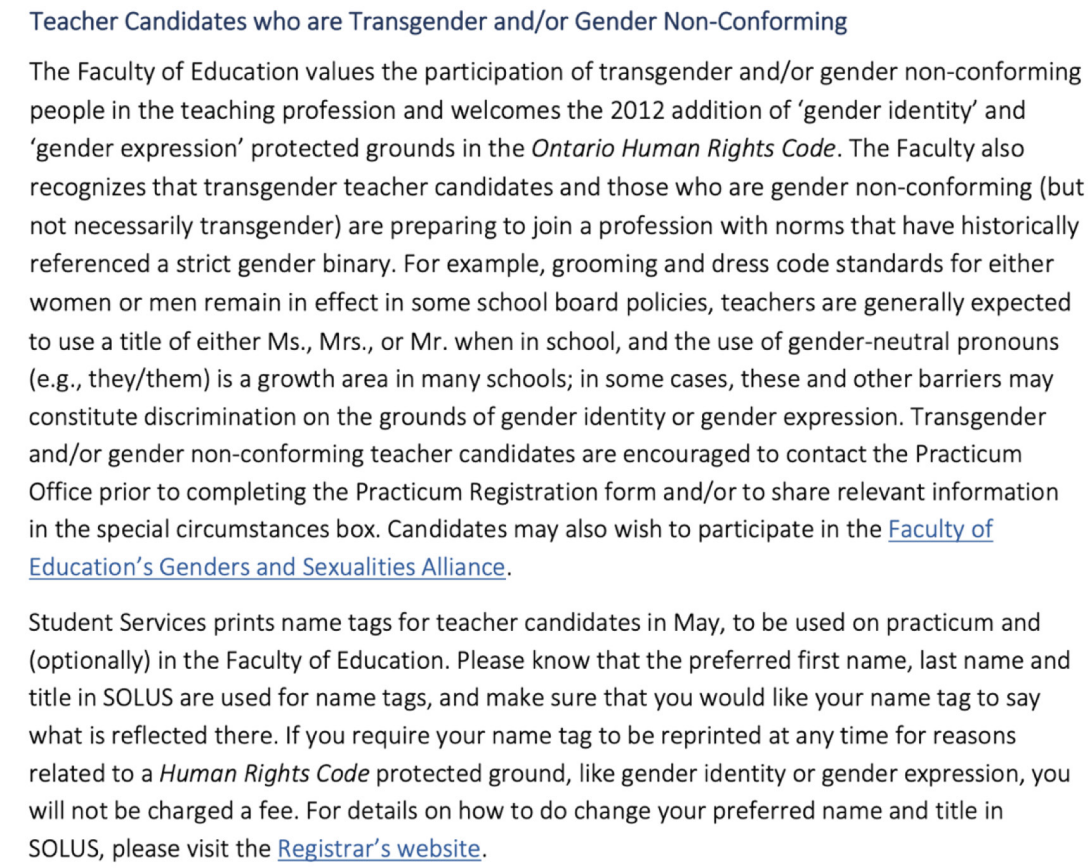
Once an offer of admission is accepted, a professional name tag is created for each TC by Student Services; using a query function in SOLUS, the TC's prefix (or title) is collected for their name tag, as well as their first and last names. The TC's name tag is distributed during orientation, and it is expected that TCs wear their name tags during practicum placements (showing the side with a title) and suggested—but rarely followed through—during on-campus course work (showing the side with their first name). Creating name tags prior to students arriving on campus did not allow for TCs to ensure this information is correct before name tags were printed and distributed.

Orientation consists of three full days of programming: a combination of whole-cohort sessions in the Faculty auditorium, as well as breakout group sessions and optional social activities. A key aspect of orientation is preparing TCs for the first practicum, and the entire incoming TC cohort is instructed on professional conduct, including dress and grooming. Questions are typically not invited from TCs during the sessions, and practicum preparation before the change process offered no relevant information to TGNC TCs. The B.Ed. Handbook, provided at orientation, outlines academic and professional expectations for TCs both inside and outside of the classroom, as well as resources and opportunities available to students on the Queen's campus. This included information about TCs' expected professionalism, conduct, academic integrity, accommodations, and necessary essential skills. The latter portion of the Handbook contained contact information for services and supports available to students but lacked any information about gender expression and gender identity human rights nor related resources and campus, local community supports, or guidance on navigating the expectations of a rigidly gendered profession. We also noted the omission of "gender expression" in sections that itemized protected grounds in human rights legislation (see Airton et al. 2019); this is inaccurate and omits the gender expression discrimination often experienced by cisgender gender nonconforming TCs as well.

Recruitment, application, orientation after the change process

The change process in this area addressed countless messages TGNC TCs receive from the Faculty before and shortly after arriving: that they are unexpected here. Such messages came in documents provided to applicants/TCs and were delivered by program staff and administrators in formal communications and presentations. Necessary document-based changes identified with staff collaborators took place in recruitment

1 The quotes convey that the information collected here was assumed to be a TC's sex on their legal identification documents—male or female—and not gender: man, woman, nonbinary, gender-fluid, etc.



Teacher Candidates who are Transgender and/or Gender Non-Conforming

The Faculty of Education values the participation of transgender and/or gender non-conforming people in the teaching profession and welcomes the 2012 addition of 'gender identity' and 'gender expression' protected grounds in the *Ontario Human Rights Code*. The Faculty also recognizes that transgender teacher candidates and those who are gender non-conforming (but not necessarily transgender) are preparing to join a profession with norms that have historically referenced a strict gender binary. For example, grooming and dress code standards for either women or men remain in effect in some school board policies, teachers are generally expected to use a title of either Ms., Mrs., or Mr. when in school, and the use of gender-neutral pronouns (e.g., they/them) is a growth area in many schools; in some cases, these and other barriers may constitute discrimination on the grounds of gender identity or gender expression. Transgender and/or gender non-conforming teacher candidates are encouraged to contact the Practicum Office prior to completing the Practicum Registration form and/or to share relevant information in the special circumstances box. Candidates may also wish to participate in the Faculty of Education's Genders and Sexualities Alliance.

Student Services prints name tags for teacher candidates in May, to be used on practicum and (optionally) in the Faculty of Education. Please know that the preferred first name, last name and title in SOLUS are used for name tags, and make sure that you would like your name tag to say what is reflected there. If you require your name tag to be reprinted at any time for reasons related to a *Human Rights Code* protected ground, like gender identity or gender expression, you will not be charged a fee. For details on how to do change your preferred name and title in SOLUS, please visit the Registrar's website.

Figure 1. Text added to the B.Ed. Handbook as part of the change process

materials, prospective student webinars, Faculty tours, and orientation. As a critical document provided to all TCs on their first day of orientation, the Handbook saw multiple changes to include text and language anticipating TGNC TCs' arrival in the Faculty and the teaching profession. Initial edits involved adding "gender expression" to the list of protected grounds which TCs are expected to respect during practicum and generally as members of the teaching profession. A section (see Figure 1) was also added to the handbook that combats the latent cisheteronormativity within expectations for teacher conduct and professionalism (see Mizzi 2016), and a section titled "Gender and Sexuality Diversity Resources" that explicitly acknowledges the presence of TCs who may require them.

Unsurprisingly, the impact of the COVID-19 pandemic did not allow for identified changes to be enacted in webinars and campus tours. University closure forced these activities to change format or be cancelled altogether. The pandemic's extreme disruption prevented us from requesting time and energy from staff participant-collaborators to pursue TGNC TC-specific changes while they were learning to navigate their now fully online workplace. At the time of writing, however, participant-collaborators have changed recruitment texts, initiated changes to imagery and scripts for campus tours and orientation; updated name tag creation and dissemination practices; and integrated resources and events for TGNC (and LGBQ+) TCs into orientation events for the past two years.

Practicum before the change process

In our 16-month B.Ed. program, each TC completes four school practicum placements with increasing responsibility for instruction and assessment. The first practicum (summer one) takes place immediately upon entry to the program in May after mere days of orientation; it is observation-based, with the goal of acclimating TCs to school life in the role of a teacher. Given that often over 350 students must be placed immediately after they arrive on campus, placement begins weeks before arrival and therefore without staff or instructors getting to know incoming TCs and their needs. Sending TCs out to schools so quickly means that they have likely not connected with supportive program faculty or staff as resources should difficulties arise that a Faculty Liaison, School Liaison, or host teacher may be ill-equipped to address;[2] here, the structure presumes that these connections are unnecessary because such difficulties are unlikely, which is not the case for many TGNC TCs.

As above, the limited preparation offered before the May practicum began typically did not address gender expression or gender identity discrimination as barriers to participating in the teaching profession, or how to act in defence of one's human rights if a host teacher or other staff member in a position of power is the locus of discrimination, whether active or passive, intentional or unintentional. However, TCs were counselled at the outset and again throughout the program that any negative communication about their host teacher must be kept confidential. This is because, under section 18.1.b of a Regulation made under the Teaching Profession Act in Ontario, an adverse report about a fellow Ontario Teachers Federation (OTF) member requires a formal letter be sent to the principal, which names the source of the complaint.[3] Although OTF member status is beyond the purview of any program, a corresponding lack of any workplace human rights education may directly disincentivize TGNC TCs from seeking support if they do experience discrimination or harassment from a school staff member during practicum.

Before the change process, a TC's first observational practicum was not informed by any knowledge of them as a person beyond their physical address in their selected school board's catchment area. While some information about a TC (Catholic or public school board preference, Primary/Junior or Intermediate/Senior teaching division, whether they have access to a car) was gathered via a Practicum Registration Form, the form produced TGNCs' presence and gender-related needs as unthinkable. While "preferred name" was solicited, the examples provided on the form ("Bob, Katie, Joe, Liz") conveyed the expectation that this field was to be used only for diminutives

2 A Faculty Liaison is an instructor hired by Queen's who visits TCs in their placements for the purpose of observing their teaching and offering any needed support. A School Liaison is a school staff member who coordinates all TCs' placements at their school. A host teacher is the classroom teacher who directly supervises a TC and solely evaluates their practicum performance.

3 TCs are Associate Members of the Federation, which is an umbrella organization of all four Ontario teacher unions; while all teachers are nominally OTF members, the Federation does not function like a union and provides no individual support to its members. TCs are not members of unions (e.g., Elementary Teachers Federation of Ontario) and as such would not be supported by any union during a harassment investigation, etc.

of conventional gendered names (e.g., Robert, Katherine, Joseph, Elizabeth), not for an altogether different name from one's legal documents, which is the case for many transgender people. "Title" was solicited, but no examples offered, leaving a TGNC TC with no sense of whether gender-neutral titles were welcome or even known about by the form's end users. While there was a Special Circumstances box, the accompanying text clearly discouraged its use by TGNC TCs. Its instructions dictated brevity (i.e., "Be as brief as possible"), and examples mostly related to parenting or marriage: "Please indicate below if there are special needs of which the Practicum Office needs to be aware (i.e. single parent, medical condition, child-care responsibilities, married candidate, etc.)." While a TGNC TC may experience gender dysphoria, we infer most would be highly unlikely to disclose this as a "medical condition" in a box of this kind when it was not clear where information collected via the Practicum Registration Form would go or how it would be used.

Initial practicum placement was also not facilitated by any knowledge of prospective host teachers—upon whose reference a future career in that board may depend—including whether they possess the requisite capacities and disposition to provide a TGNC TC with a practicum experience conducive to their learning. For example, a host teacher may be unable to recognize gender expression- or gender identity-related discrimination as barriers to a TGNC TC's success if—but, more likely, when—these arise. Even if a TGNC TC does not experience harassment from their host teacher—which does take place—having to educate an unprepared host teacher who, for example, consistently misgenders them can stress a pivotal hierarchal relationship critical to a TC's practicum success and career induction.

Intentionally recruiting a suitable host teacher for a TGNC TC was impossible in most instances because a growing number of school boards in Ontario and across Canada allow direct contact about placements only with a central school board office, not with schools or prospective associate teachers. Before the change process, which boards are centrally placing and which are not was withheld from TCs as they made their initial school board selection. This was to avoid introducing confusion into the already complex task of initial placement. As such, many TCs unknowingly selected only centrally placing school boards, meaning that practicum staff knowledge of prior TGNC TCs' successful (or disastrous) school placements could not guide future placements. In boards that are *not* centrally placing, practicum staff also struggled to activate their rich knowledge of partner school climates and host teacher suitability because of an understandable reluctance to maintain a written record of past negative experiences; this emerged as a reputational and relational concern, in that a "red flag" list of schools where past TGNC TCs had experienced discrimination could be thought defamatory or, if accessed via a Freedom of Information and Privacy Act request, damage a crucial placement relationship with a school board. Without these relationships and the practicum placements they provide, a program cannot run. Whether or not a host teacher had any prior experience of—or better yet, success with—supporting a TGNC TC was irrelevant, however; as above, there was no discernible way for a TGNC TC to make themself known as such to practicum staff in advance.

After selection and still well before arrival, TCs who selected centrally placing boards had their legal names, preferred first names, titles and local addresses shared with a board. Board personnel assigned TCs to schools, conveying TC information di-

rectly to principals and assigned host teachers. TCs were instructed not to contact their host teacher far in advance, but just prior to arriving on the first day, where they are typically greeted by a School Liaison. The School Liaison was instructed in the Practicum Handbook to "provide a tour of the school, provide a placement schedule for each teacher candidate and the Faculty Liaison, discuss expectations and responsibilities with the teacher candidates concerning the practicum, and provide copies of policies and procedures" including teacher "dress code." Being discouraged from contacting the school meant that, upon a TGNC TC's arrival, a typical School Liaison likely had no idea that they were expecting a TC who may require an all-gender washroom, who may not align with the Liaison's or host teacher's expectations for men's or women's physical appearance or gender expression, or who may have a nonbinary title or pronouns. The school may not have all-gender washrooms for staff, which would only become apparent as a barrier (if applicable) once a TGNC TC had arrived on site.

It is uncommon for TCs to have contact with any B.Ed. program instructors or staff during practicum, apart from the Faculty Liaison. During the initial May observational practicum and in all three subsequent practicum placements, a Faculty Liaison visited and supported TCs, and checked in with the School Liaison and host teacher in support of each TC's progress. While a Faculty Liaison can serve as a reference when a TC enters the teacher job market, the host teacher is solely responsible for assessing practicum performance, and their letter of reference is a standard enclosure in future job applications. Its absence is noticeable and noticed by potential employers.

Before the change process, the second, third, and fourth school practicums (fall, winter, and summer two) typically took place in a different school from summer one and involved teaching as opposed to observing and assisting. TCs completed a Background Form to assist boards and schools with locating suitable placements for their remaining practicums. One's response to each question below could be up 1,500 characters long (including spaces):

1. What special strengths, interests/talents (e.g., athletics, arts, travel, computers, etc.), and experiences will you bring to the students and staff in your associate school?
2. Academic background (not marks): (Do not list all university courses, only those supporting your subjects.)

While the Background Form may have offered the opportunity for a TC to signal identities and community memberships that disrupt the profession's latent expectations (e.g., that teachers are white, straight, cisgender, gender-conforming, non-disabled, a speaker of English with a "local" accent, etc.), the Form's examples only invited subject-area related knowledge and skills. Further, the Form was only sent if a TC would be at a new school (i.e., not the summer one school); in other words, TCs were not re-asked if anything had changed such that they may require a new Background Form, and it was unclear how and when information within it could be changed prior to subsequent placements. For TGNC TCs, key information like their names, pronouns, and gendered titles may have changed in the meantime, but this possibility was systematically erased.

Practicum after the change process

With staff collaborators, we made changes that would hopefully signal the Practicum Office's gender diversity competency and openness to hearing from TGNC TCs about their needs very early on. Our research team conducted a close reading of the Practicum Handbook, Practicum Registration Form, and Background Form and (1) made changes that would embed TC gender diversity as an expectation and (2) identified places where TGNC TCs could be invited to approach Practicum Office staff to request a placement that considered their unique barriers. For example, "Mx." was added as a title option, the binary preferred name examples were deleted, and the "Special Circumstances" instructions on the Registration Form were updated to include the following: "Candidates who may face barriers related to their gender identity and/or gender expression may also use this space to request consideration." On the Background Form, the invitation to share experiences was edited to indicate that "personal, professional, or community-based" experiences were welcome.

Changes made to the Practicum Handbook (see Figure 2) were intended to address the issue of School Liaisons being unprepared to support and altogether not expecting TGNC TCs. Text (italicized in Figure 2) was added to the Handbook in two places (TC responsibilities and School Liaison responsibilities). In addition to advising School Liaisons on how common norms of professionalism may constitute illegal discrimination, this text also offers TCs a clear indication of what they should experience in a placement where gender identity and gender expression discrimination are mitigated at the outset. This is critical in summer one, given that there is no time to build supportive relationships with program instructors and staff before arriving at their practicum school. Our intention prior to the onset of COVID-19 was to work with the Practicum Office to explicitly 'signpost' these changes to those receiving the Handbook, encouraging School Liaisons to contact the office with questions or concerns. The insertions, we reasoned, could be used to perhaps prevent a negative situation for a TGNC TC in advance (e.g., only learning that the host school does not have an all-gender washroom once a nonbinary TC has already arrived, or that the school's climate is presently or particularly hostile and unsafe for transgender people).

Practicum staff members carry and use knowledge of schools where TGNC TCs have experienced unliveable placements, including to the extent of requiring "covert extrication": removal from a placement in such a way as to not alert the host teacher or school administrators of the reasons, as this could trigger a formal adverse reporting process which would identify the TC as the source of an accusation. Extrication has been accomplished by and with practicum staff support so as to prevent further harm to a TGNC TC as well as their future employment prospects in that school board. While a "red flag" list was not possible, we initiated a "green flag" list of trans-competent host teachers and schools friendly to gender diversity. Given that targeted placement is only possible in boards that are not centrally placing, and that our local public school board was not centrally placing,[4] the first author and practicum staff pooled their networks and memories to populate a list of green-flagged teachers and schools. This was created in case a TGNC TC "picked up what we were putting down" with our docu-

4 At the time of publication, the board has followed most other Ontario school boards into some form of centralized placement. The work of managing this new barrier is ongoing.

PRACTICUM HANDBOOK

Roles & Responsibilities of School Liaisons

Orientation

- distribute the candidates' background information forms to the appropriate Associate Teachers
- welcome Teacher Candidates and introduce them to the school community
- Consult with the Teacher Candidate about the name, title (e.g., Ms., Mr., Mx.) and pronouns (e.g., she, he, they) to be used when they are in the school, including preferred first name for colleagues' use, and last name with title to be used with students. It is best to ask this of the TC in person regardless of the information that you may have received in advance.
- introduce the Teacher Candidate to the school community, using all of the above information (name, title, pronouns)
- provide a tour of the school; show Teacher Candidates the locations of all washrooms in the school, including but those accessible to staff as well as students; be sure to include all-gender washrooms.
- provide a placement schedule for each Teacher Candidate and the Faculty Liaison
- discuss expectations and responsibilities with the Teacher Candidates concerning the practicum
- provide copies of policies and procedures (first aid and emergencies; fire drills; harassment, equity, curriculum documents; *dress code; use of materials)

**In keeping with the Ontario Human Rights Code, our program welcomes and supports Teacher Candidates who are transgender, and who are gender non-conforming. If your school's staff dress code contains different expectations for staff members on the basis of gender, it may not apply to a Teacher Candidate. Teacher Candidates understand that they are expected to dress/groom in a way that does not inhibit them from carrying out their duties during school hours; if a Teacher Candidate requires feedback about professional dress and grooming, please focus feedback on practical considerations.*

Figure 2. Text added to and edited in the Practicum Handbook during the change process

ment-based changes and contacted the Practicum Office before completing the Practicum Registration Form, or learned after summer one that it is possible in our Faculty to access a more supportive process for subsequent placements once we have had time to get to know TCs better. Furthermore, after learning more about the barriers facing TGNC TCs by participating in the action research process, practicum staff have kept an open line of communication with the first author—a transgender professor—so that they can advise on placement as needed; we note, however, that this is not a structural or necessarily sustainable solution.

Career planning before the change process

Like all teacher education programs, ours assists TCs with the process of finding employment after graduation. Career planning services typically begin with course presentations in which Academic and Career Advisors talk about available supports and highlight upcoming career-related events. These include optional workshops throughout the year on topics such as job search strategies, teaching in independent and international schools, teaching-adjacent careers, and supply or substitute teaching.

Before the change process, TGNC TC-specific concerns such as name discrepancies on documents, disclosure of one's gender identity or transgender status in the hiring process, and how to navigate gender expression in a historically conservative profession were not addressed at any time within the Faculty's career programming. While all TCs were given the option of making an appointment with an Advisor for one-on-one support with career planning, staff participant-collaborators shared that they felt unprepared to support TGNC TCs with processes such as interviewing, resume development, and cover letter writing.

Until 2021, Student Services hosted two career-related events each year: Teachers' Overseas Recruiting Fair (TORF) and Options Career Fair. TORF was an on-site fair held at the Faculty of Education in January that brought together international school recruiters and locals interested in teaching internationally, including TCs and in-service teachers. In some countries represented at TORF, laws enable the arrest of people suspected of being queer or transgender, and in some cases for being gender nonconforming. Before the change process, international school recruiters were not required to disclose information related to local laws that may criminalize and endanger TGNC and/or 2SLGBQ+ staff members, if hired. TGNC TCs had to conduct their own research leading to decisions that may impact their future safety or wellbeing. Given that interviewing actively took place at TORF, time available for this research was minimal. Options Career Fair (Options), the second career-related event, largely brought in school boards from Canadian provinces to host booths and give presentations. Much like TORF, interviewing and on-site hiring could occur. The name tags and registration materials used at both TORF and Options did not invite pronouns or preferred first names. This created a complicated relationship been employers and TGNC TCs who may use a name other than the one printed on their name tag and wish to be interviewed on site.

In addition to teaching internationally or at out-of-province public secular school boards, TCs have the option of teaching in publicly funded Ontario Catholic schools. TGNC TCs so interested have questions about working for Catholic school boards, including considerations for applying therein given that adherence to Catholic doctrine in one's conduct is named in board employment contracts (Callaghan 2018; Ruiz and Bleasdale 2022). Prior to the change process, staff participant-collaborators reported feeling unprepared to answer questions and support TGNC TCs who wished to explore teaching in Catholic schools. Taken together, these barriers meant that Faculty programming and supports conveyed a message that TGNC TCs were absent from the program because basic issues pertaining to their career induction were unknown and unaddressed.

Career planning after the change process

As part of the change process, the first author developed a mini-professional development series for Advisors. Five sessions were planned from March to May 2020, spanning all barriers highlighted above; the plan included topics and advanced reading or viewing materials to be debriefed with the first author. The series was however cancelled to due fatigue and adaptation-related workloads during the early COVID-19 pandemic. Both Advisors who initially collaborated would go on to leave their positions during the pandemic, with four new Advisors onboarded by Fall 2021; all but one did not participate in the original barrier mapping process and until June 2023 had no familiarity with our project.

The change process led to the addition of two items to the questionnaire completed by international school recruiters at TORF:

- "The jurisdiction in which our school (etc.) is located and/or in which a successful TORF attendee would be teaching has enacted laws that criminalize same-sex sexual activity, that require persons to use bathrooms or other gendered facilities that correspond with their assigned sex at birth (as op-

posed to their gender identity or legally-changed sex on a Canadian or other birth certificate), and/or that otherwise create a hostile legal environment for LGBTQ+ (lesbian, gay, bisexual, transgender, or queer) people. Select one: Yes, No, I don't know.

- If you answered 'Yes' or 'I don't know' to the above question, can you suggest a website or other resource for prospective candidates to access in order to inform their decision-making process?"

Responses were made available to any interested TC attendees, providing TGNC TCs and Advisors with the requisite information to make decisions, or offer advice, respectively. The assumption that a TC or teacher attending TORF is necessarily cisgender and heterosexual was disrupted by the necessity of providing this information. Similarly, TORF name tags attendees included optional pronoun spaces. Regardless of these efforts, TORF is no longer offered by the Faculty of Education as of 2022 for reasons unrelated to the topic of this article. The changes made with staff collaborators may endure as learnings for other schools that partner with schools in other countries, and for all staff members who worked on TORF and who remain at the Faculty.

Certification and graduation before the change process

Four months before the end of the program, TCs apply to be certified by the Ontario College of Teachers (OCT). Completing any application that involves the collection of legal name(s), common names, and gender markers poses unique barriers for TGNC TCs. Indeed, a majority of TGNC people do not report a linear gender transition (Scheim and Bauer 2015) such that, at the time of their applications to the OCT and to graduate from Queen's, many TGNC TCs may not be ready to nor feel safe publicly disclosing their chosen first name (if applicable) and/or their gender identity.

TCs are first made aware of the certification process during an annual presentation from an OCT representative given to over 400 TCs in an auditorium. The presentation covers a variety of OCT-related matters (e.g., role of the OCT, ethical standards, and professional misconduct) but only briefly outlines the OCT application: one presentation slide providing tips such as "don't wait," "declare all your past and present names," and "pay your fees." Typically, TCs begin to complete their OCT applications following this OCT presentation.

Before the change process, TGNC TCs received no guidance or invitation to learn more about how their own circumstances might affect certification. Many filled out the OCT application form using a legal name that they no longer use in their daily life. Staff did not know whether the information a TC provided upon application could be changed and were unprepared to answer such questions. Few (34%) TGNC people in Ontario have completed a legal name change given the cost and barriers associated with this process (Scheim and Bauer 2015), meaning that TGNC TCs who want to change their legal name may not have had the opportunity to do so by the time they apply to the OCT or apply to graduate. This means that diploma, transcript, Convocation program, and OCT certification documents as well as the public searchable record of all OCT-certified teachers may all contain a TC's deadname, outing them as transgender.

The application to graduate begins after TCs apply to be certified by the OCT. A TC's legal name appears on their diploma, on their transcript, and in the convocation

program. To change the name on official documents, TCs must submit a name change form with supporting information by an early deadline. Convocation typically takes place in a location where there are no all-gender washrooms, and information about facilities in nearby buildings was not provided to attendees of the convocation before the change process, nor were any in-building washrooms designated all-gender for the day. During the convocation ceremony, names are read out, one at a time, from a card that each graduand passes to the reader. The name is written by the graduand along with a phonetic pronunciation, if desired.

Certification and graduation after the change process

Changes in this area resulting from our research largely pertained to locating and sharing information with TGNC TCs. We created a TGNC TCs Frequently Asked Questions resource that has now been disseminated as a model to teacher education programs across Canada, many of which report creating their own. The FAQ clarifies exactly when and how a TC's gender-related information is collected, used, and shared centrally by the University, the Faculty of Education, and the OCT. Additional sections clarify how a TGNC TC may seek support for gender identity and/or gender expression discrimination or harassment at any point in their B.Ed., whether in the Faculty or during practicum, whether they can use a gender-neutral title such as Mx. or other options, and how to manage gendered dress and grooming expectations. It was not possible to source all answers from public websites; some required staff participant-collaborators writing to contacts within the OCT, for example. Sourcing definitive answers required a level of labour and insider knowledge which illustrated how inaccessible this process can be for TCs.

META-FINDING: COPING WITH BUT NOT CHANGING STRUCTURES

This section shares a meta-finding about our change process which answers our second research question: what does the process of identifying and removing these barriers reveal about making *proactive* gender diversity-inclusive changes in teacher education as it is currently organized? The meta-finding is as follows: *most of the changes we were able to make are document-based,* whether editing existing documents or creating new ones. We edited documents to make information more transparent and easier to find for TGNC TCs (e.g., the B.Ed. Handbook provided during orientation, the Practicum Handbook, etc.), and we changed documents so that TGNC TCs can indicate a need for specialized supports (e.g., the Practicum Registration Form) or share relevant information with the program (e.g., preferred names, pronouns). We also edited documents with non-TC users in mind, such as the Associate Teacher and School Liaison sections in the Practicum Handbook, and the TORF overseas school registration form. Lastly, we created documents (e.g., the TGNC TC Frequently Asked Questions document) to collect information TGNC TCs require but that is not generally offered via ordinary program communications.

Document-based changes are ways to cope with structural barriers in teacher education, but do not change cisnormative structures that simply do not imagine a TC could be TGNC. For example, during recruitment, application, and orientation before the change process, information relevant to TGNC TCs was not provided. Students

are offered many opportunities to ask questions during recruitment fairs, webinars, Faculty tours, and at orientation; in theory, this provides opportunities for prospective and newly admitted TGNC TCs to raise specialized concerns. However, the public setting would require that TGNC people asking such questions "out" themselves to others whom they do not yet know. As questions are not typically encouraged during orientation presentations conveying key information about "professional conduct," teacher dress and grooming, and being careful about sharing "private" information with students on practicum the following week, we doubt that TGNC TCs would avail themselves of a question period even if it were offered. If they did, a speaker or facilitator may not have answers to TGNC TCs' questions, producing both question and questioner as unexpected and therefore not belonging in teacher education. After all, if TGNC people were expected in the teaching profession, these answers would be known.

Document-based changes may enable TGNC-relevant information to be elicited and provided but are merely a coping mechanism intended to make teacher education structures slightly less harmful to a population hitherto unimaginable within it: less harmful because they prevent a TGNC TC from having to publicly or privately out themself, and because they show a TGNC TC they are expected. For example, changes to the Practicum Registration Form endeavour to signal to TGNC TCs that they can share information that may lead to a specialized placement: where there is capacity to support an out or apparent TGNC person learning to teach. The TGNC TC FAQ lets TCs know where to seek support if they experience gender identity- or gender expression-based discrimination on practicum, and the B.Ed. Handbook distributed at orientation echoes this information. However, these changes are necessary because our program's length—a mere sixteen months—requires that TCs must be placed in schools before they arrive on campus, and they go out to practicum within mere days of arriving.

Placements must be organized long before TCs form relationships with staff and instructors through which needs can surface and resources can activate. Furthermore, an increasing number of Ontario school boards—as well as other large urban boards across Canada—are enacting centralized placement policies that prevent program staff or instructors from matching TCs to particular schools and host teachers. Centralized placement combines with program length and sequence to produce an expectation that any TC can be 'slotted in' to any school. However, schools remain distinctively hostile spaces for many TGNC people who are at a high and virtually predictable risk of discrimination in schools. Placement respecting this risk is conceivably a TGNC TC's human right in the province of Ontario due to gender identity and gender expression anti-discrimination protections but requires intentional pairing of TCs with schools and host teachers. Structurally, this is impossible in most cases. And so, instead of making structural changes (e.g., to our program's length or sequence, to how TGNC TCs are placed in schools, etc.), we largely changed documents.

Overall, document-based changes are supportive but normalize coping with structures that assume all TCs are cisgender and gender-conforming. That said, working on document-based changes alongside the research team grew staff participant-collaborators' understanding of gender diversity and related barriers in teacher education, and fostered strong relationships. Since our initial change process, participant-collaborators have undertaken changes or reached out to us for assistance with a

gender diversity-specific issue because they are now aware of barriers faced by TGNC TCs and committed to proactively mitigating them as much as possible. However, of the initial group of staff participant-collaborators (*N*=18) who participated in the professional development and timeline exercise that launched the action research project in 2018, by September 2022 three-quarters had left the Faculty or changed roles. The COVID-19 pandemic likely exacerbated this attrition, with a wave of early retirements or increased stressors that made some roles untenable for staff due to personal factors and responsibilities. The change process depends on staff taking initiative, and the research team being able to identify staff who are prepared to support TGNC TCs because they had participated in this project.

Dependence on particular staff further reveals our work to be coping with but not changing structures that systematically discriminate against TGNC TCs and likely TCs from other groups under-represented in the profession. COVID-19 not only exacerbated staff attrition but brought our project to an absolute standstill given that our changes are not structural but depend on staff initiative. As an example, a structural barrier is the OCT collecting gender information from applicants; if this barrier were removed, staff would not need to know how to support a TGNC TC who has questions about that process. In turn, our research team would not need to on-board successive new staff members to ensure that they know this information and can "walk beside" a TGNC TC. As with so many other structural barriers, because it exists, we cope by mitigating the message it sends: that TGNC TCs are out of place in a profession that still does not expect them.

CONCLUSION

We conclude with recommendations. In light of our meta-finding, our recommendations below for teacher education programs are few because they engage larger structural issues with which we and our participant-collaborators daily cope as we labour to prevent foreseeable harm to TGNC TCs preparing to join a profession that remains cisnormative. Therefore, our first recommendation is not for individual programs, but for the teacher education "systems": that program administrators—deans, associate deans, directors, etc.—across programs take action together to change structures and processes established by school boards, certification and oversight bodies, education ministries or departments and any other entities that have—however inadvertently—created barriers to TGNC TCs.

Our first program-level recommendation involves program sequence and addresses the many barriers resulting from having to assign TGNC TCs to schools for first practicum long before they arrive on campus with few days on site for orientation. A substantial coursework block on campus at the start of a program would combat the cisnormative assumption that TCs require little support prior to entering high-stakes situations in sites where TGNC people face considerable discrimination and harassment: K–12 schools. A second recommendation to programs is that TGNC TCs are placed in schools with the maximum degree of intentionality born of the expectation, at this time, that they will face gender identity and/or gender expression discrimination or even harassment in schools. Even in programs where many partner school boards are centrally placing, there exist creative possibilities for mitigating this

entirely foreseeable harm. Lastly, our final recommendation to programs is that each complete a barrier mapping exercise comparable to that which began our own action research project. In addition to surfacing unique barriers in our facilities, bespoke online systems and documents, participation greatly enhanced staff participant-collaborators' capacities and confidence in relation to supporting TGNC TCs. This is a worthy and enduring outcome of the change process.

In sharing our findings, we hope that other teacher education programs within and beyond Canada are better supported in undertaking change processes of their own. While we remain encouraged by what we have achieved with participant-collaborators, we offer a caution. The aspects of a teacher education program that might be most transparently 'about' gender diversity, gender identity, gender expression or transgender lives and issues may not contain the most pressing barriers to TGNC TCs' well-being. Rather, how long a program takes, how rigid its structure, or the timing of its practicum placements require foundational reconsideration, so that welcoming TGNC people into this profession is not solely enabled by the laudable yet exhaustible efforts of transgender people and willing cisgender collaborators working within a program. We must all act from the knowledge that "the harm of teacher education for transgender and/or gender nonconforming candidates is so endemic that it is barely apparent as harm, because it is so much a part of 'just what happens' when one is learning to teach" (Airton and Martin 2022, 297).

REFERENCES

Airton, Lee, and Austen Koecher. 2019. "How to Hit a Moving Target: Thirty-Five Years of Gender and Sexual Diversity in Teacher Education." *Teaching and Teacher Education* 80: 190–204. https://doi.org/10.1016/j.tate.2018.11.004.

Airton, Lee, and Kel Martin. 2022. "How Teacher Education Mundanely Yet Profoundly Fails Transgender and/or Gender Nonconforming Candidates." *Teachers College Record* 124 (8): 287–300. https://doi.org/10.1177/01614681221124198

Airton, Lee, Kyle Kirkup, Allison McMillan, and Jacob DesRochers. 2019. "What is 'Gender Expression'? How a New and Nebulous Human Rights Construct is Taking Shape in Ontario School Board Policy Documents." *Canadian Journal of Education* 42 (4): 1154–1182. https://www.jstor.org/stable/26954670.

Bartholomaeus, Clare, Damien W. Riggs, and Yarrow Andrew. 2017. "The Capacity of South Australian Primary School Teachers and Pre-Service Teachers to Work with Trans and Gender Diverse Students." *Teaching and Teacher Education* 65: 127–135. https://doi.org/10.1016/j.tate.2017.03.006.

Bell, E., Fals Borda, Patricia Maguire, P. Park, Peter Reason, and J. Rowan. 2008. "Groundings." In *The SAGE Handbook of Action Research*, edited by Peter Reason and Hilary Bradbury, 11–13. Thousand Oaks, CA: SAGE.

Blount, Jackie M. 2000. "Spinsters, Bachelors, and Other Gender Transgressors in School Employment." *Review of Educational Research* 70 (1): 83–101.

Braun, Virginia, and Valerie Clarke. 2006. "Using Thematic Analysis in Psychology." *Qualitative Research in Psychology* 3 (2): 77–101. https://doi.org/10.1191/1478088706qp063oa.

Callaghan, Tonya D. 2018. *Homophobia in the Hallways: Heterosexism and Transphobia in*

Canadian Catholic Schools. Toronto: University of Toronto Press.
Coghlan, David, and Mary Brydon-Miller, eds. 2014. *The SAGE Encyclopedia of Action Research*. Thousand Oaks, CA: SAGE.
Cumming-Potvin, Wendy M., and Wayne Martino. 2018. "Countering Heteronormativity and Cisnormativity in Australian Schools: Examining English Teachers' Reflections on Gender and Sexual Diversity in the Classroom." *Teaching and Teacher Education* 74: 35–48. https://doi.org/10.1016/j.tate.2018.04.008.
Gaetz, Steven, Erin Dej, Tim Richter, and Melanie Redman. 2016. *The State of Homelessness in Canada 2016*. Toronto: Canadian Observatory on Homelessness Press. https://www.homelesshub.ca/SOHC2016.
Goodman, Michael, Noah Adams, Trevor Corneil, Baudewintje Kreukels, Joz Motmans, and Eli Coleman. 2019. "Size and Distribution of Transgender and Gender Nonconforming Populations: A Narrative Review." *Endocrinology and Metabolism Clinics* 48 (2): 303–321. https://doi.org/10.1016/j.ecl.2019.01.001.
Gorski, Paul C., Shannon N. Davis, and Abigail Reiter. 2013. "An Examination of the (In) Visibility of Sexual Orientation, Heterosexism, Homophobia, and Other LGBTQ Concerns in US Multicultural Teacher Education Coursework." *Journal of LGBT Youth* 10 (3): 224–248. https://doi.org/10.1080/19361653.2013.798986.
Grant, Jaime M., Lisa A. Mottet, Justin Tanis, Jack Harrison, Jody L. Herman, and Mara Keisling. 2011. *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey.* Washington, DC: National Center for Transgender Equality and the National Gay and Lesbian Task Force. https://transequality.org/sites/default/files/docs/resources/NTDS_Report.pdf.
Hart, Walter H., and Laura Hart. 2018. "When Johnny Becomes Janie: An Investigation of the Attitudes of School Leaders on the Placement and Hiring of Transgender Teacher Candidates." *Journal of School Leadership* 28 (1): 110–136.
Horn, Stacey S., Pamela Konkol, Kathleen McInerney, Erika R. Meiners, Connie North, Isabel Nuñez, Therese Quinn, and Shannon Sullivan. 2010. "Visibility Matters: Policy Work as Activism in Teacher Education." *Issues in Teacher Education* 19: 65–80. https://eric.ed.gov/?id=EJ902676.
Ingrey, Jennifer C. 2023. "Affirming Trans and Queer Teachers' Lives: Rethinking Teacher Professionalization and Pedagogy." In *International Encyclopedia of Education,* edited by Robert J. Tierney, Fazal Rizvi, and Kadroye Ercikan, 204–212. Amsterdam: Elsevier. https://doi.org/10.1016/B978-0-12-818630-5.04033-1.
Iskander, Lee. 2021. "Nonbinary Beginning Teachers: Gender, Power, and Professionalism in Teacher Education." *Teachers College Record* 123 (9): 199–222. https://doi.org/10.1177/01614681211052007.
Kean, Eli. 2020. "Locating Transgender Within the Language of Queer in Teacher Education." *Multicultural Perspectives* 22 (2): 57–67. https://doi.org/10.1080/15210960.2020.1741371.
Keenan, Harper B. 2017. "Khaki Drag: Race, Gender and the Performance of Professionalism in Teacher Education. In *Confronting Racism in Teacher Education: Counternarratives of Critical Practice,* edited by Bree Picower and Rita Kohli, 97–102. New York: Routledge.
Khayatt, Didi, and Lee Iskander. 2020. "Reflecting on 'Coming Out' in the Classroom."

Teaching Education 31 (1): 6-16. https://doi.org/10.1080/10476210.2019.1689943.
Kirkup, Kyle. (2018). "The Origins of Gender Identity and Gender Expression in Anglo-American Human Rights Law." *University of Toronto Law Journal* 68 (1): 80–117.
Kirkup, Kyle, Lee Airton, Allison McMillan, and Jacob DesRochers. 2020. "The Aftermath of Human Rights Protections: Gender Identity, Gender Expression, and the Socio-Legal Regulation of School Boards." *Canadian Journal of Law and Society* 35 (2): 245–268. https://doi.org/10.1017/cls.2020.7.
Levin, Morten, and Davyyd Greenwood. 2008. "The Future of Universities: Action Research and the Transformation of Higher Education." In *The SAGE Handbook of Action Research,* edited by Peter Reason and Hilary Bradbury, 211–226. Thousand Oaks, CA: SAGE. https://doi.org/10.4135/9781848607934.
Loewenson, Rene, Asa Christina L., Christer Hogstedt, Lucia D'Ambruoso, and Zubin Shroff. 2014. *Participatory Action Research in Health Systems: A Methods Reader.* Harare: ARSC, AHPSR, WHO, IDRC Canada, EQUINET. https://idl-bnc-idrc.dspacedirect.org/handle/10625/53867.
Luce-Kapler, Rebecca, Dennis Sumara, and Brent Davis. 2002. "Rhythms of Knowing: Toward an Ecological Theory of Learning in Action Research." *Educational Action Research* 10 (3): 353–372. https://doi.org/10.1080/09650790200200191.
Macgillivray, Ian K., and Todd Jennings. 2008. "A Content Analysis Exploring Lesbian, Gay, Bisexual, and Transgender Topics in Foundations of Education Textbooks." *Journal of Teacher Education* 59 (2): 170–188. https://doi.org/10.1177/0022487107313160.
Meyer, Elizabeth J., and Harper B. Keenan. 2018. "Can Policies Help Schools Affirm Gender Diversity? A Policy Archaeology of Transgender-Inclusive Policies in California Schools." *Gender and Education* 30 (6): 736–753. https://doi.org/10.1080/09540253.2018.1483490.
Meyer, Elizabeth J., Annika Tilland-Stafford, and Lee Airton. 2016. "Transgender and Gender-Creative Students in PK–12 Schools: What We Can Learn from their Teachers." *Teachers College Record* 118 (8): 1–50. https://doi.org/10.1177/016146811611800806.
Mizzi, Robert C. 2016. "Heteroprofessionalism." In *Critical Concepts in Queer Studies and Education: An International Guide for the Twenty-First Century,* edited by Nelson M. Rodriguez, Wayne J. Martino, Jennifer C. Ingrey, and Edward Brockenbrough, 137–147. Dordrecht: Springer.
Murray, Olivia J. 2011. "Outing Queer Issues in Teacher Preparation Programs: How Pre-Service Teachers Experience Sexual and Gender Diversity in Their Field Placements." PhD diss., Portland State University. https://pdxscholar.library.pdx.edu/open_access_etds/635/.
Ontario Human Rights Commission. 2014. *Policy on Preventing Discrimination on the Basis of Gender Identity and Gender Expression*. https://www.ohrc.on.ca/en/policy-preventing-discrimination-because-gender-identity-and-gender-expression.
Patton, Michael Q. 2011. *Developmental Evaluation: Applying Complexity Concepts to Enhance Innovation and Use*. New York: Guilford Press.
Paydon, Marie E., and David C. Ensminger. 2021. "The Engine of Evaluative Inquiry:

Social Learning Processes." *International Journal of Training and Development* 25 (1): 77–94. https://doi.org/10.1111/ijtd.12208.

Payne, Elizabeth, Lee Airton, and Melissa Smith. 2022. "Accounting for Transgender in Pre-Service and In-Service Teacher Education." In *Trans Studies in K–12 Education: Creating an Agenda for Research and Practice,* edited by Melinda Mangin and Mario I. Suárez, 101–131. Cambridge, MA: Harvard Education Press.

Peter, Tracey, Christopher P. Campbell, and Catherine Taylor. 2021. *Still in Every Class in Every School: Final Report on the Second Climate Survey on Homophobia, Biphobia, And Transphobia in Canadian Schools. Key Takeaways.* Toronto: Egale Canada Human Rights Trust. https://egale.ca/awareness/still-in-every-class/.

Preskill, Hallie, and Rosalie T. Torres. 1999. *Evaluative Inquiry for Learning in Organizations*. Thousand Oaks, CA: SAGE.

Ruiz, Ish, and Jane Bleasdale. 2022. "Mixed Blessings: Understanding the Experience of LGBTQIA+ Educators in Catholic Schools." *Journal of Homosexuality* 69 (12): 2148–2166. https://doi.org/10.1080/00918369.2021.1984787.

Scheim, Ayden I., and Greta R. Bauer. 2015. "Sex and Gender Diversity Among Transgender Persons in Ontario, Canada: Results from a Respondent-Driven Sampling Survey." *The Journal of Sex Research* 52 (1): 1–14. https://doi.org/10.1080/00224499.2014.893553.

Scheim, Ayden I., Todd Coleman, Nathan Lachowsky, and Greta R. Bauer. 2021. "Health Care Access Among Transgender and Nonbinary People in Canada, 2019: A Cross-Sectional Survey." *CMAJ Open* 9 (4): E1213–1222. https://doi.org/10.9778/cmajo.20210061.

Serano, Julia. 2016. *Whipping Girl: A Transsexual Woman on Sexism and the Scapegoating of Femininity*. Berkeley, CA: Seal.

Shedlock, Nancy S. 2013. "Teaching Teachers on the Topic of GLBT Issues: The Current Conditions of Teacher Education Programs." PhD diss., Alfred University.

Silveira, Jason M. 2019. "Perspectives of a Transgender Music Education Student." *Journal of Research in Music Education* 66 (4): 428–448. https://doi.org/10.1177/0022429418800467.

Simmons, Holiday. and Fresh White. 2014. "Our Many Selves." In *Trans Bodies, Trans Selves: A Resource for the Transgender Community*, edited by Laura Erickson-Schroth, 3–23. New York: Oxford University Press.

Taylor, Catherine, Tracey Peter, TL McMinn, Tara Elliott, Stacey Beldom, Allison Ferry, Zoe Gross, Sarah Paquin, and Kevin Schachter. 2011. *Every Class in Every School: The First National Climate Survey on Homophobia, Biphobia, and Transphobia in Canadian Schools Final Report.* Toronto: Egale Canada Human Rights Trust. https://egale.ca/awareness/every-class/.

Worthen, Meredith G. F. . 2016. "Hetero-Cis–Normativity and the Gendering of Transphobia." *International Journal of Transgenderism* 17 (1): 31–57.

Wright, Bernadette, and Steven E. Wallis. 2019. *Practical Mapping for Applied Research and Program Evaluation*. Thousand Oaks, CA: SAGE.

Yin, Robert K. 1994. "Discovering the Future of the Case Study: Method in Evaluation Research." *Evaluation Practice* 15 (3): 283–290. https://doi.org/10.1177/109821409401500309.

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ORIGINAL ARTICLE

Super Straights: Heterosexuality, White Supremacy, and Transphobia without Transphobes

Brandon Andrew Robinson
is Chair and Associate Professor of Gender and Sexuality Studies at the University of California, Riverside. They are the author of *Coming Out to the Streets: LGBTQ Youth Experiencing Homelessness* (University of California Press, 2020) and the coauthor (with Cristina Khan and Salvador Vidal-Ortiz) of *Race & Sexuality* (Polity Press, 2018).
✉ brandon.robinson@ucr.edu

This article turns to super straights—a sexual identity adopted by straight people who claim that they are not attracted to transgender people—in order to more broadly examine discourses around how people engage in transphobia without wanting to be seen as transphobic. In analyzing over 200 online discussion threads on Reddit, this article documents how in this moment of trans visibility, some people are using bioessentialist frames of biological sex, "born this way" ideologies of sexual identity, and personal preference discourses to construct heterosexuality as superior and to position their desires and ideologies as not transphobic. Notably, as constructions of biological sex, inherent sexual identities, and personal preferences have meanings rooted in racism and eugenics, this article situates these super straight discourses and strategies within this white supremacist history. Ultimately, this article argues that understanding more covert, and at times progressive and liberal, ways that transphobia operates is crucial in addressing trans antagonism and working toward gender liberation.

KEYWORDS heterosexuality, white supremacy, transphobia, sexual identity, personal preferences
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"I made a new sexuality. It's called super straight," stated TikTok user KyleRoyce. "Straight men like myself get called transphobic because I wouldn't date a trans woman. But that's not a real woman to me, I want a real woman. So now I'm super straight." A 20-year-old, white and Asian heterosexual, KyleRoyce is credited for coining the term "super straight." As he goes on to explain in his now viral TikTok video, "I only date the opposite gender—women that are born women. So, you can't say I'm transphobic now because that's just my sexuality."

In this article, I turn to the super straights (SS) in order to more broadly examine strategies and discourses around how people engage in transphobia without wanting to be seen as transphobic. Super straight is a sexual identity adopted by some straight people who claim that they are not attracted to transgender people (Costello 2021). This sexual identity began from KyleRoyce's viral TikTok video in February 2021. The concept of super straight then diffused all over social media from Twitter to Reddit to 4chan (Costello 2021). In asserting SS as a sexual identity, super straights such as KyleRoyce argue that their sexual desires are not transphobic. It is their sexuality. They were born that way. It is just who they are.

Specifically, I explore how the super straights assert a particular heterosexual identity politics in this historical moment of both an anti-trans backlash and as there is an increase in visibility and support for trans people. Indeed, as gay and lesbian people gained more rights and visibility in a "post-closet" culture, heterosexual people could not as easily rely on explicit homophobia and heteronormative assumptions that everyone is heterosexual in order to assert their straightness (Dean 2014). In turn, many heterosexual people deployed various strategies such as announcing their heterosexuality and foregrounding traditional understandings of gender within their relationships to make their heterosexuality visible and to avoid being seen as gay (Dean 2014). Now, within this moment of trans visibility, some heterosexual people are once again finding strategies to reassert a distinct type of superior straightness as ideas around gender and sexuality are continuing to shift.

To figure out the super straights, I analyzed over 200 online discussion threads on Reddit about dating or not dating trans people. As I will show, the super straights are not a monolithic group. There are many tensions, conversations, and contradictions with them trying to figure out heterosexuality in relation to desires for trans people. But through these conversations, posters on Reddit engage in several discursive strategies—biological essentialist, "born this way," and "personal preference" discourses—to both maintain their heterosexuality and to claim that they are not transphobic.

I examine, then, these discursive strategies through building on the work of Bonilla-Silva (2010) who documented how people used various frames and discursive strategies to perpetuate racist ideologies, while simultaneously seeing and constructing racial inequality as a result of non-racist processes. For instance, the frame of naturalization allows white people to explain away how racist policies and practices created racial segregation through white people seeing segregation as just people of different racial backgrounds "naturally" wanting to live together and by each other (Bonilla-Silva 2010). This study turns to the super straights to document several discursive strategies on how people use logics around their identity to claim that their sexuality is a natural occurrence, and hence, their identity, their sexuality, and their practices cannot amount to discrimination—cannot be transphobic. This examination of these discursive strategies will both illuminate and challenge how straightness utilizes various transphobic rhetoric and tactics to assert its superiority.

THE SCIENTIFIC RACIST ORIGINS OF SEX, HETEROSEXUALITY, AND PERSONAL PREFERENCES

The Western invention of sexual identities has a long history connected to race and racial formations (Vidal-Ortiz, Robinson, and Khan 2018). Before heterosexuality gets coined, white colonizers and imperialists justified violence, genocide, and colonization on Indigenous communities and people in the Global South because the colonizers saw people of color as having expansive expressions of gender and sexuality that went against the Eurocentric gender binary and the man-woman-reproduction nuclear family norm (Patil 2018; Morgensen 2010). Through the transatlantic slave trade, the Eurocentric gender binary also gets constructed in and through whiteness, whereby Black people became ungendered—seen as not having a gender but only seen as a slave—and whereby only white people were seen as being a man or a woman (Spillers 1987). Then, in the 19th and 20th centuries, heterosexuality becomes classified as an identity and cultural ideal alongside of white supremacist sciences, such as craniometry and eugenics (Ward 2021). It is no coincidence that heterosexuality and homosexuality get invented at the same time as the end of slavery and the beginning of Jim Crow. As biological models of race were being undermined, new models of classifying desires were formed where both interracial desires and homosexual desires were constructed as "abnormal" sexual object choices. Homosexuality—like interracial relationships—was seen as a threat to the perceived decline in white reproduction (Somerville 2000). Heterosexuality became the norm not only to discipline people into reproducing but also to keep white people in intraracial relationships—to reproduce for the white race (Ferguson 2005; Foucault 1976; Somerville 2000).

One way this history of race, gender, sex, and sexuality continues to intertwine, especially in relation to desires, is through the notion of "personal preference." The term sexual identity itself privileges gender as one's sexual object choice and promotes this gendered sexual attraction as biological, self-evident, and natural (Stearns 1995). While other social categories such as race are often not seen as part of defining sexual identity anymore, desires around race and other social categories still take on meaning, often through the discourse of "personal preference." That is, like sexual identity and gendered sexual attraction, people use the notion of "personal preference" to claim that they are also inherently attracted to a particular race, body type, and/or some other social category. As Robinson (2015, 2016) has shown though, larger cultural ideas around race and racism and ideas around health and fatphobia shape these desires. Moreover, in the case of racial preferences, white people still maintain superiority and determine the value of racial erotic currency (Han 2021). For instance, under personal preference discourses, people of color are often not desired or only desired within fetishized and objectified ways (Han 2021; Robinson 2015). Race, then, comes to define someone's worth as a partner (Han and Choi 2018). Moreover, views about gender and trans people can also shape the worth of someone as being a potential partner, as a recent study found that 87.5% of people would not date a trans person (Blair and Hoskin 2019). Importantly, desire is more than just partner selection, whereby lacking desirability also often negates a marginalized group of people and makes them seen as not worthy of attention or resources (Han 2021).

This article explores how super straights use discourses of biological sex and personal preferences to both construct their superior heterosexuality and to engage in

transphobia without wanting to be seen as transphobic. Notably, as biological sex, heterosexuality, and personal preferences have histories and meanings rooted in racism and eugenics, this article situates super straight discourses within this white supremacist history. Ultimately, this research both exposes how super straights further discrimination against trans people—while claiming not to do so—and substantiates the need to address how sexual identities, the concept of biological sex, white supremacy, maintaining the Eurocentric gender binary, and heterosexuality as a political institution all intertwine today.

BORN THIS WAY AND BIOLOGICAL ESSENTIALISM'S TRANS EXCLUSIONS

A strategy of the mainstream gay rights movement has been the adoption of the slogan "born this way." Certain gay people argue that no one would choose a life of discrimination (i.e., choose being gay); therefore, homosexuality must be biological (Ward 2012). This "born this way" strategy hinged on an investment in biological authority to try to claim legitimacy and on legal authority of having an ascribed characteristic that should be a protected class (Walters 2014). Notably, turning to biology does not actually guarantee legitimacy. Biological arguments have been used to demean and subordinate marginalized groups through categorizing them as biologically and physically less than, through justifying medical experimentation, and through actively working to annihilate groups who are seen as biologically inferior (Walters 2014). That is, biological claims can just bolster eugenicist arguments. White cisgender men have often thought they were biologically superior to other groups of people and used biological arguments to justify their status and privilege (Schilt 2015). If gay, then, is biological, it could be classified as a disease to cure or get rid of, not necessarily to be accepted or celebrated (Walters 2014).

Given this context and history, it is critical for scholars to think empirically about "born this way" discourses and biological essentialism, especially as these logics shape everyday interactions around social difference (Schilt 2015). "Born this way" logic can do very different cultural work depending on the political contexts (Schilt 2015). It can reveal and try to address social inequality such as how gay rights have used the logic and how trans people have taken up this narrative as well in order to strategically challenge cissexism (Schilt 2015; Meyers 2019). But "born this way" can also entrench social inequalities such as the eugenic uses of the concept that work to justify that people of color are innately inferior and less intelligent than white men and that poor people and people of color should be sterilized (Schilt 2015).

Another part of the problem of "born this way" discourse, and even the concept of sexual identity, is the assumption of gender essentialism. To be born gay or straight or bisexual assumes not only that someone is biologically attracted to men, women, or both but that the categories of men and women are also natural, obvious, inherent, unchanging, and biological as well (Stearns 1995; Walters 2014). Gender essentialism has often led to the discrimination of people of color, as people of color have often been positioned as outside the dominant notions of masculinity and femininity (Collins 2005; Patil 2022). Moreover, gender essentialism has also been used to subjugate trans people and to see them as not really the gender they are (Broussard and Warner 2019).

In this article, I turn to how super straights take up and use logics of the main-

stream gay rights movement. That is, this study examines how super straights take up the "born this way" logic—a logic that was used by a group to challenge inequality—but the super straights use the same logic to now justify and entrench inequality against trans people, while trying to mask their transphobia. While some super straights may be trolling, their usage of biological essentialism can reveal limits and problems of these gay rights strategies. Indeed, the fact that people of color and trans people have often been positioned outside of the mainstream gay movement and then for super straights to use gay rights logics to maintain white supremacy and discriminate against trans people may not be all that coincidental. What might seem like odd bedfellows—the super straights and gay rights discourses—might not actually be.

STUDYING THE SUPER STRAIGHTS

For this study, I analyzed numerous Reddit threads and subreddits. Reddit is an online community or "a community of communities" (Massanari 2017, 331) comprised of forums, discussion posts and threads, subreddits devoted to specific community posts and topics, and a social news aggregation website (Maxwell et al. 2020). As of September 2021, according to Statista—a market and consumer data company—Reddit is the 19th most visited site in the world and the 7th most visited site in the United States. A study by Pew Research found that YouTube and Reddit were the only two online social media platforms that saw statistically significant growth since 2019, with Reddit being the 10th most used online platform as reported by U.S. adults (Auxier and Anderson 2021). While increasingly everyday life is mediated by much of technology, studying online forums is important, especially since people may say and reveal information online that they would not in face-to-face settings. Moreover, online forums allow people who may not often interact with one another in everyday life offline to interact online with one another (Farber 2017).

I engage, then, in a discourse analysis of Reddit posts. Critical discourse analysis examines how ideologies shape talk and texts and inspects the impact of talk and texts (Rogers and Christian 2007). As meanings around social categories such as race are constantly shifting, people often engage in rhetorical strategies and cultural conventions to try to make sense of this shifting meaning; in turn, examining discourses can reveal the instability of these conventions and meanings (Hartigan Jr. 2010). Indeed, as this study will document, as meanings around gender and sexuality are shifting, super straights rely on strategies—biological essentialism, "born this way," and personal preference discourses—to try to make sense of these shifting meanings and to try to restabilize the heterosexual dominant order. Therefore, a discourse analysis of online comments is important to document these discursive strategies, the ideologies shaping them, and their impact. Notably, while online comments might be performative (Preston, Halpin, and Maguire 2021) and who people say they are online might not be who they are offline, all identities are performative, and studying online forums can document one way that people manage, negotiate, and reformulate their identities and desires (Robinson and Vidal-Ortiz 2013; Ward 2008). The internet, as well, has a become a tool for both cis and trans people to learn about trans-related issues and policies that they can apply to offline interactions (Tompkins 2014). In all these instances, examining Reddit is an apt place to engage in a discourse analysis to understand

meanings around gender, sexuality, identity, trans people, and desire today.

I examined Reddit posts from April 2021 to June 2021. The overall study was focused on examining online discourses about dating and having sex with trans people. I used search terms such as "transgender," "dating transgender," "sex transgender," and "transamorous" to find posts. I also explored subreddits such as r/asktransgender, r/transpersonals, r/t4m, r/m4t, r/chasersrisseup, and r/transamorous. I quickly discovered discussions around super straights—a term I had not heard of until conducting this study. I then started searching for other terms such as "super straight," "genital preference," and "personal preference" based on the key terms I was seeing in the initial posts that I was examining.

I downloaded over 200 threads. Many threads were recent and from the past year, but some threads were also from over five years ago. Some threads had no comments. Some had around 20 comments. Some had hundreds of comments, with one thread having over 10,000 comments. I should note that I often clicked on threads related to the thread I was reading and explored Reddit in a way that a user would. Through this process, I found discussions about the super straight identity and "not transphobic" claims about one's sexuality across a variety of subreddits, including on LGBTQI+ subreddits such as r/lgbt and r/transeducate, on the subreddit r/FeMRADebates that discusses feminism and men's rights activism, and on numerous general subreddits such as r/NoStupidQuestions, r/Discussion, and r/AskReddit. The various types of subreddits can shape the audience for who the posters may be trying to perform for and convince that their logics and actions are not transphobic. Given, then, that these discourses were across a variety of subreddits, one can assume the audience is potentially a general audience. Moreover, I also do not anonymize the usernames as the posts are public and the usernames are another form of data and mean-making.

Similar to Taylor and Jackson's (2018) study about masculinity on a Reddit forum about pornography abstinence, I began with close readings of the selected forums to become familiar with the patterns of how users talked and engaged with each other. From there, I analyzed all downloaded threads in MAXQDA. Following a grounded theory analytical approach, I coded the close readings of the selected forums following a line-by-line coding (Charmaz 2006) to get an analytical grasp on how people were discussing heterosexuality, trans people, and desire on the threads. I, then, moved to flexible coding (Deterding and Waters 2021), whereby I used the analytical insights from the initial coding to then code larger swaths of threads and posts. I generated over 100 codes (e.g., super straight, genital preference, eugenics, racial preference, biological sex). Notably, the analysis is not trying to reveal some "truth" about sexuality, but rather, to see how super straights construct their sense of their sexual identity discursively in relation to their non-desires of trans people (Taylor and Jackson 2018).

HETEROSEXUAL DISCURSIVE LOGICS OF BIOLOGICAL SEX, REPRODUCTION, AND EUGENICS

Although SS gets coined in early 2021, similar discourses and conversations had been occurring on Reddit for years, especially around if it is transphobic to not want to date or have sex with trans people. This section explores how these discourses relate to notions of biological sex, reproduction, and eugenics, and hence, how these discours-

es are linked to histories of white supremacy. This section also shows how discourses around biological sex are used to justify transphobia without wanting to be seen as transphobic.

A post by ggtab asks, "Why is it okay for transgender people to call other people transphobic if they don't want to have sex with a transgender person? (not as rude as the [question] ? sounds, read the full post)." The poster went on to say, "[…] given the whole sex does not equal gender thing, this particular scenario confuses me to no end. I completely understand that in some cases, the reason may be down to transphobia, however I don't see that this is always the case. Let me use a heterosexual cisgender woman and a heterosexual transgender man as an example."

The poster, in their example, gave some definitions:

> Heterosexuality: "sexual attraction to people of the opposite sex"
> Transgender: "assigned gender does not correspond with birth sex"
> Sex: "either of the two main categories into which humans and most other living things are divided on the basis of their reproductive functions"
> I.e. sexuality is linked with biological sex, rather than gender identification.

As ggtab notes, *sex*uality should be about attraction to biological *sex*—not gender or gender identification.

Many straight posters on Reddit acknowledge that gender is a social construct and changeable. Indeed, another poster DorianMaximus writes, "Idk [I don't know] why you are trying to deny science since gender and sex are two different things. You cannot change your chromosomes or your biological sex since they are permanent. […] The issue is who people are attracted to, so it makes sense to focus on sex in this instance." For these posters, gender is malleable, but sex is binary, immutable, and unchangeable.

The concept of sexual identity itself has often privileged a biological essentialism around both sexuality and sex, erasing how sex and sexual identities are also socially constructed (Fausto-Sterling 2000; Stearns 1995). For example, the concept of biological sex is rooted in white supremacy and imperialism, whereby white people constructed themselves as more civilized than people of color and people in the Global South through arguing that white people were more sexually dimorphic and that sexual dimorphism was a sign of modernity (Patil 2018; 2022; Henderson 2020). This biological essentialist discourse erases this colonial and racist history of the invention of sex. Notably, while some posters may not explicitly engage in white supremacy, the point is that their discursive strategies are rooted in white supremacist logics and concepts that now are utilized to try to justify not desiring trans people and to not be seen as transphobic.

This biological essentialist logic also allows posters such as ggtab and DorianMaximus to claim a type of progressiveness of seeing trans people for the gender they are. Simultaneously, though, these posters also construct trans people as different—as outside of heterosexual desires—by claiming that sex is not a social construct and different from gender. Biological essentialism becomes a frame, strategy, and logic that allows for transphobia without supposedly transphobes.

Moreover, ggtab also defines sex based on "reproductive functions." This repro-

ductive logic clings to the historical notion that heterosexuality—or dominant sexuality—should be about procreation (Blank 2012; Katz 1995; Ward 2021). Other Reddit posters, though, push back against this reproduction logic as linked to heterosexuality. An example comes from mazotori, who is "a trans person who is usually T4T [trans for trans]" and who stated, "That's… not how attraction works? Like are you gonna try and tell me as straight men can sense infertility issues?? Or are not attracted to women over 35??" This reproduction logic, then, ignores that there are cis men and cis women who cannot reproduce either; and yet, most people would still see them as men and women. Moreover, while patriarchal society may construct infertile cis women as less than, infertile straight cis women are still often seen as heterosexual. Nonetheless, in privileging reproductive functions, ggtab constructs sexuality—as attraction to sex and genitals—as ggtab concludes, "If we were to say that the heterosexuality of a person must include transgender people, regardless of the genitals and reproductive functions they possess, then surely that wipes out the whole concept of sexuality too?"

In sexualized, intimate settings, biology-based criteria, especially a heightened focus on genitals, is often used to assess and discriminate against trans people, especially trans women (Schilt and Westbrook 2009; Westbrook and Schilt 2014). The obsession with genitals also has a long racist history of white people constructing themselves and their sexed bodies as the norm through pathologizing people of color's bodies and people in the Global South's bodies, including their sexed bodies and genitals as supposedly excessive and abnormal (Henderson 2020; McKittrick 2010; Snorton 2017; Patil 2022). This logic points to how genitals hold a primary function in how people understand race and sexuality, especially heterosexuality. Nevertheless, for ggtab, trans people trouble (or "wipe out") these dominant understandings of sex and sexuality as tied to genitals. Posters on Reddit try to reassert and maintain heterosexuality and its link to sex and genitals by denying desires for trans people through reproductive and biological essentialist frames.

Other posters on Reddit push back against this biological essentialist logic and genitals discourse. In specific response to DorianMaximus's post about chromosomes and biological sex, QuestionableParadigm replied, "I'm not denying science, however, if you reduce someone to literal chromosomes that you can't see to someone who has the same appearance and genitals of gender they are-you are just transphobic. By that definition as well, you'd date a trans man because he was born female." In reply, DorianMaximus uses the discourse of "sexual preferences" and states, "Why do you give a fuck if I am not attracted to women who are not of the biological female sex? That is literally no different than going around dictating the sexual preferences of other people too. […] Also, I would only date biological females who identify as women. So I don't see where the problem is."

QuestionableParadigm shows how gender affirming surgery and the reality of trans men can both trouble the genital discourse asserted by some heterosexual Reddit posters. This poster also displays the illogic of tying attraction to chromosomes. Most people are not tested for chromosomes at birth. Therefore, sex assigned at birth has nothing to do with chromosomes. Sex is also more complicated than just chromosomes, as science has constructed sex through genitals, hormones, chromosomes, and other sex characteristics (Fausto-Sterling 2000).

DorianMaximus quickly dismisses the claim about trans men by stating a sexual

preference for just "biological females who identify as women." "Sexual preference" relies on biological essentialist notions of sexual identity to dismiss any discriminatory claims without explanation. DorianMaximus and others may claim a progressiveness of seeing gender as a social construct—to not look transphobic—but in practice, when their logics around sex, sexuality, and trans people are further challenged, they use ideas around biological essentialism to justify their exclusionary practices and desires.

In fact, a "single trans guy," whose username was deleted, wrote how these posters keep constantly changing the goalposts when their logics are undermined. The user wrote:

> Transphobic: Constantly shifting the goalposts to explain why you're not attracted to trans people. e.g. "I'm not attracted to vaginas" / "Ok, what about these trans men with dicks?" / "I'm not attracted to high voices" / "What about these trans men with super deep voices?" / "I'm not attracted to people who were raised as girls" / "What about this guy who transitioned at 2?" / "I'm not attracted to XX chromosomes" / [...] At some point, there's no longer any basis for the blanket rejection (note: not individual rejection) other than transphobia.

But another user—Unshackledai—still gives reasonings for why they are not attracted to trans men. They post, "I'm not into trans men because they tend to have feminine features which I find unattractive. I don't think that's transphobic, you can't help what you're attracted to." Posters on Reddit were downvoting this post, to which, Unshackledai then edited their post to add: "Not sure why I'm being downvoted. I just don't like 'men' that look like women. [...] I'm sorry I'm not into 11 year olds boys, ok?"

The "single trans guy" on Reddit noted that people were not rejecting trans individuals for specific reasons that should matter to dating, sex, and relationships (such as maybe not sharing similar interests and hobbies). Instead, for this single trans guy, once the heterosexual logics are completely undone, these discourses boil down to transphobia. And indeed, Unshackledai's post confirms this point. Unshackledai engages in biological essentialism that all trans men still "tend to have feminine features." They also put men in quotes, suggesting that trans men are not real men. They also infantilize trans men by saying trans men look like boys. While Unshackledai states that one cannot help who they are attracted to—the preference logic of transphobic without transphobes—they still give many transphobic reasons to justify their desires.

Notably, while many of these biological essentialist logics are shaped by histories of white supremacy but not explicitly racist, some users did use explicit eugenic logics to justify not desiring trans people. As Fit_Historian states, "But a preference for cis women among straight men mainly exists because of their innate sexual orientation based on biological sex (to subconsciously find a healthy mate to procreate with)." Eugenics is the racist and ableist science and ideology of "improving" the white race by bearing "healthy" and "fit" offspring (Hobson and Margulies 2018). Fit_Historian links this eugenic logic of finding a "healthy mate" to procreation, biological sex, and sexuality as all being natural and inherent. Even more explicitly, on a thread titled "Is is truly transphobic to not want to date Trangenders?," Reddit user Vadoff writes:

> Sexual attraction is usually a narrow band for most people. We avoid people who look too much like us (because they could be family/closely related genes), who look too different from us (may be another species),

> those that are of the same gender (can't reproduce), those that are too young (can't reproduce), too old (can't reproduce or high chance of offspring being unhealthy/dying), or those that aren't physically fit (signs of being unhealthy/weak genes/lower life span). It's not just absence of attraction either, usually we feel repulsion at the thought of having sex with any of the above in order to make sure we stay away. It's purely biological.

For Vadoff, it is "purely biological" to be ageist, ableist, and homophobic—at least in one's sexual desires—as sexual attraction and its supposed natural link to reproduction has people avoiding others who are too young, old, of the same gender, and not physically fit. It should be noted that eugenics privilege reproductive choices for middle-class white people. The same logic has been used against poor people, especially poor women of color, to take away their reproductive choices, including forcefully sterilizing them (Nelson 2003). This link, then, of sexuality—and particularly heterosexuality—to bioessentialist eugenic logics continues this long ableist, heterosexist, and racist history to now be used against trans people. It also allows people to claim to not be transphobic as it is supposedly purely biological to desire a young non-disabled cis person of the opposite gender. Biological essentialism, including its link to eugenics, becomes a discursive strategy of justifying transphobia without wanting to be seen as transphobic.

THE SUPER STRAIGHT STRATEGIES OF BORN THIS WAY AND OTHER GAY RIGHTS DISCOURSES

This notion of biological sex also delves into the gay rights logic of "born this way"—that sexuality identity is also natural, inherent, and unchanging. Posters on Reddit use biological essentialist ideas of sexual identity to also claim to not be transphobic. As Reddit poster babno stated, "How can an orientation be transphobic? People are born that way, they can't help it." And indeed, many Reddit posters took up this logic to argue that their sexuality—of not desiring trans people—is biological, and hence, not discriminatory and not something to be ashamed of. Poster DeltaMx11 stated:

> No, because I shouldnt be shamed for my sexuality. I have as much of a right to be not attracted to a transgender person as a gay man has a right not to be attracted to a woman or a lesbian has the right not to be attracted to a man. I have no personal problem with transgender people, but I cant force myself to be attracted to a biological man with a female brain.

Other users similarly expressed that there should not be stigma or shame in not desiring trans people. As doorkn00b posted, "I'm not sexually attracted to transgender people. There shouldn't be stigma for being heterosexual." Trunk-Monkey also said, "Still, it [calling straight people who don't desire trans people as transphobic] strikes me as a rather dishonest way to shame straight men for their sexual preferences." Dontwanttogooglethat posts, "Fight the good fight! Down with superphobes!" CherryKnockout even asks, "If a transgendered couple refuses to date cisgendered people, would you call that cisphobic?" Poster drteeth69r also writes, "Why is it, if I, a cis male, dont want to date a MTF [male-to-female] I'm transphobic, but is it ok for the MTF not

want to date women? Would that make them cis phobic?" Poster drteeth69r went on, "Not trolling or joking. Serious question from a cis male who has no interaction from transgenders, as none live in my area."

Notions of biological sex merge with notions of biological sexuality. DeltaMx11 links their sexuality to notions of biological sexed brains. This notion of "female brain" is rooted in phrenology and eugenic sciences that tried to justify the difference of women and Black people in comparison to white men (Bessant 2008). That is, this notion of a female brain was used by eugenicists to try to justify gender inequality (Bessant 2008). For DeltaMx11, this logic is used to both justify their non-desire for trans people and to establish this non-desire as an inherent, biological sexuality.

Moreover, in adopting anti-shame, anti-stigma, and "born this way" discourses, straight posters on Reddit use mainstream gay rights discourses and tactics to argue that they are naturally not interested in dating or having sex with trans people. The notion, however, of Gay Pride was an attempt to transform homosexuality from being a perversion into a positive social identity (Halperin and Traub 2009). It was an attempt to combat the isolation, stigma, and internalized homophobia that many gay people experience growing up in a heteronormative society. In a heteronormative society, there is no actual shame for being straight, as straight people do not face isolation and stigma for their heterosexual desires. That is, this discursive move around shame and stigma misses how stigma is about possessing a marginalized position or identity (Goffman 1963), erasing the power dynamics of sex and sexuality under heteronormativity.

This concept of "cisphobic" or "superphobic" also misses power dynamics—that to not date a cis person does not lead to structural discrimination and violence against cis people. It also misses how many trans people may not want to date cis people because of how cis people discriminate against them and treat them poorly (zamantakis 2020). While some posters may be genuine and are seeking to learn from trans people on Reddit—as they do not think they live by any trans people—other users seem to be more strategically using gay rights discourses as a way to troll and to try to be transphobic without being seen as transphobes.

Moreover, the coining of super straight itself is seen as an important corrective now that heterosexuality (according to the super straights) includes desiring trans people and that certain straight people claim to be discriminated against—by being called transphobic for not desiring trans people. As barbodelli states:

> Look at any such conversation here. There is bound to be a couple of people claiming that..... "If you are initially attracted to the person but then lose interest because you find out that they are trans. You are transphobic". So basically they are calling the majority of heterosexual men transphobic. I don't know how common this view is in the real world. But it is definitely widespread here. Which is why the Super Straight movement is no surprise at all to me. If being straight is not enough to only be interested in members of the opposite biological sex. Then I guess call me super straight.

Similarly, randomasshole874 posted:

> How? "Straight" now has changed to include women with or that had a penis and secondary male characteristics. I am a straight man, who

> likes vagina. Anything penis or man related is completely unattractive to me (including born and still women). But the word "straight" doesn't describe me anymore as it was recently redefined.

For the super straights, heterosexuality has moved beyond desire for biological sex. The social maintenance of heterosexuality, though, often requires policing trans people and genitals, especially within intimate settings (Schilt and Westbrook 2009). For certain straight people to maintain heterosexuality and to reinvest in heteronormativity, they developed a new concept. This concept of super straight reasserts notions of bioessentialism, especially gender essentialism, as the heart of sex, sexuality, and sexual identity (Stearns 1995). That is, some super straights work to reassert genitals and dominant notions of biological sex as essential to heterosexuality—or what makes it *super*.

Super straights simultaneously argue that their sexuality is inherent and hence cannot be transphobic, but also that straight people who do not desire trans people are different from straight people who do desire trans people. Reddit poster FaZe_Pickle01 even stated, "The movement seems transphobic. Although it is simply an attraction, the way they call it 'superstraight' doesn't sit right with me cause it's as though they're straighter than other people who date trans people which makes it sound like they're saying trans people aren't their desired gender." In making straight desires not for trans people as its own identity, super straights maintain structures that further discrimination against trans people, including the notion that trans people are not really the gender they are. Indeed, as the opening quote of this article stated from KyleRoyce who coined the term, "But that's not a real woman to me, I want a real woman." Born this way discourses and constructing super straight identities become other strategies to engage in transphobic discourses and actions without trying to be seen as transphobic.

But as many trans posters point out, including trans poster maybri, these discourses and posts are a dog whistle—speaking in coded language to a targeted audience to often convey hostility toward a marginalized group (Haney López 2014). As maybri writes, "In the past few days I've seen people repeatedly claim that some cisgender people are being pressured into dating transgender people against their will, specifically by being shamed and called transphobic. Often the people making this claim say they support trans people in general and attribute this problem to a problematic 'vocal minority'." Poster maybri goes on, "I don't think there is such a vocal minority. I don't think this happens at all. I believe the phenomenon has been completely fabricated as part of a recent far-right troll campaign to fuel animosity towards trans people." In this regard, super straight discourse is not only used to be transphobic without transphobes, but as a dog whistle, it actually fuels further prejudice against trans people.

GENITAL PREFERENCE AS THE NEW TRANSPHOBIA

The logic of "just a preference" was predominant on many of the Reddit threads about super straights and about not desiring trans people. Many users compared this cis preference or genital preference as having a racial preference when it comes to dating and sex. User bigjdman stated, "No tf [the fuck]? It's a preference. Just like how it's not racist to not want to date a certain race, not homophobic to be straight." Poster ggtab

also wrote, "[…] if you are in a situation where you meet someone, start dating them, they tell you they are trans and then you find out that they have the genitals of the biological sex that you are not attracted to, then that isn't transphobic, that's simply just your preference." Another example includes:

> Or at least it's not more prejudiced than for any other trait. It's just the same as someone not liking brown hair even though they find the other person attractive otherwise, and would date them if that person dyed their hair blond. Besides, when dating, prejudice doesn't matter. That's one area where no one has the right to complain about it. Whether it's racial prejudice, trans prejudice (not the same as transphobia) etc. you can be disappointed but if you're upset about it you're being entitled. -assolf_shitler

Super straights rely on the personal preference discourse to justify their non-desire for trans people. They explicitly make the comparison to having a racial preference, which for them is "not racist" or with dating "prejudice doesn't matter." But as Robinson (2015) has shown, notions of having a "personal preference" around race works to erase the racist cultural assumptions often shaping these desires. This discourse also leads to the devaluing of people of color, excluding them from dating and intimate contact, and maintains whiteness as the most desirable race (Robinson 2015; Han 2021). Personal preference around race, then, is another discursive strategy to engage in what is perceived as more respectful language—language that is not explicit racism—but that maintains racial inequality (Robinson 2015; Forbes and Stacey 2022). In these instances, personal preference becomes another frame of transphobia without transphobes.

Moreover, user assolf_shitler—which notably is a play on curse words for Adolf Hitler—compares trans prejudice to hair color prejudice. This framing erases the larger structural causes shaping desires and ignores how these dating prejudices can have larger impacts on people outside of just dating such as the discrimination trans people face in the workplace or in the public sphere (Westbrook and Schilt 2014). In replying to assolf_shitler, LibraryLass stated, "Except that, generally, no one is murdering their partner for not being a natural blonde. No one is trying to legislate what bathrooms brunettes can use. No one considers brunettes to categorically be sexual deviants." LibraryLass deconstructs the personal preference discourse to show how these desires link to larger structural and political battles.

One poster, though, wanted to be able to cleanse trans people from their viewing practices on dating apps, showing how these "personal preference" beliefs also shape actions. Full_Conversation823 said, "There should be an option to select and deselect transgender people from your dating app preferences." Like using filter systems to cleanse Black and Asian people, HIV positive people, and fat people from dating sites and apps (Robinson 2015, 2016, 2018), this cleansing practice is another type of way to uphold not only white, HIV negative, and fit people as the most desirable but also to uphold the gender binary and cis people as the most desirable as well. Moreover, in not even having to see trans people when browsing dating and hookup apps, some super straights can reinforce their idea that only cis people are desirable. That is, if super straights have to see trans people, they might actually find certain trans people to be desirable. In turn, their notions of desire might expand.

Intriguingly, there were Reddit posters against the super straights but who also

bought into the "genital preference" discourse. These users pointed out that trans people are not a monolith and have various genitals. They argued, though, that while it is okay to have a genital preference, it becomes discriminatory when someone blanketly applies this preference to all trans people. As heydemonsitsmeyaboo—someone who "transitioned while dating a very religious guy" and whose "gender fluctuates from feeling very masculine to very non-binary"—wrote, "If you have a legitimate genital preference for sex, that's fine. If you go out of your way to not date trans people, even post op [post-operative], then that is transphobic. Anyone who calls themselves Super Straight is transphobic (and it's a neo nazi idea to begin with)." User frozen_hell66 even wrote, "It isn't transphobic to be attracted to cis people. I wouldn't make a word for it like he did, but there's nothing wrong with having a genital preference." Moreover, peridot_rae13—"just a trans girl trying to make it through life"—elaborates:

> Genital preferences are fine. That's why if you wouldn't date a specific trans person because they dont have the genitals you prefer, that isn't transphobic. But assuming all trans people have genitals they were born with and that's why you don't date them, not only is that transphobic, but it's just wrong to assume that. And if a transgender person claimed to only want to date people with their agab [assigned gender at birth], then they too would be transphobic. Trans people can be transphobic too; just look at all the transmen snobs. Generally speaking, it's only transphobic if you make a blanket statement that you don't date ANY trans people, or even worse, you only date "real" men or "real" women. This whole "super" crap is 100% transphobic because it's a blanket statement against dating trans people, not to mention it originated in Neo-Nazi circles and SS [the Schutzstaffel]… come on.

In these instances, certain Reddit users challenge the super straight logic to argue that super straights are transphobic if they construct trans people as a monolith, especially around the genitals they have. However, these users still buy into the genital preference discourse. This discourse objectifies and reduces trans people to their genitalia (Schilt and Westbrook 2009; Westbrook and Schilt 2014). The discourse also upholds the personal preference logic, eclipsing larger structural forces shaping desires (Robinson 2015). The notion of genital preference also reinscribes genitals as being a defining feature of sex, gender, and sexuality. This re-inscription can maintain a type of genital gender essentialism as part of sexual desire and identity (Stearns 1995). In these regards, those who are trying to challenge the super straights but who still also buy into larger personal preference discourses still uphold certain ideologies that harm trans people.

Other challenges come, though, from a transgender subreddit r/transgendercirclejerk. This subreddit is a parody, whereby trans people mock transgender-related topics. As a parody, trans man poster sammcollum writes, "No one should assume anyone wants to have sex with transgenders. It's sick they always try to push their beliefs onto us. I only like BIOLOGICAL FEMALES!!!! That's not transphobic! It's called a preference people!!!" In utilizing the infamous Am I the Asshole? (AITA) type posts on Reddit, another poster ThatsALotOfOranges made the mock post: "AITA for not wanting to have sex with a transgender?" They went on to write, "I'm a straight man. I fully support the LGBTs [lesbian, gay, bisexual, and transgender] and think gay marriage

should be legal and all that. But it's not my thing. I am only into biological females." ThatsALotOfOranges went on to pretend to be this straight man at the bar. They continued, "I was at bar with some friends when I saw what looked like a woman from behind. But when she (yes, I'm using her preferred pronouns instead of her biological pronouns. As stated, I'm an ally to the LGBT) turned around and I saw her face, noticed she was actually a transwoman." Going on, ThatsALotOfOranges wrote, "I didn't want anyone to think I'm gay. So I politely explain to this dude (gender neutral term) that I'm straight, that I only am attracted to females, and that her penis disgusted me." The poster goes on to say the trans woman was rude and concludes, "How is it transphobic to not want to have sex with someone? I had even told him I support the transgenders! Why do that transgenders think they're entitled to sex with me?"

Parody is a reflexive strategy that both imitates and makes fun of social practices while destabilizing reality (Pullen and Rhodes 2013). Parody can be a form of queer resistance that deconstructs discourses through subverting them through textual strategies including exaggeration (Dhaenens and Van Bauwel 2012). On the subreddit r/transgendercirclejerk, parody becomes a form of trans resistance and play. This parody mocks and subverts dominant transphobic discourses, including discourses and logics used by super straights. Famously, Butler (1990; 1993) turns to drag to examine how parody can denaturalize the gender binary. Parody becomes a type of performance that can undo gender and an important part of a gender politics (Pullen and Rhodes 2013). On r/transgendercirclejerk, trans posters parody and exaggerate super straight discourses—making fun of how super straights claim to not be transphobic while engaging in transphobic discourses. This parody becomes a different way of exposing the illogic of the super straights while also working to undo dominant discourses around heterosexuality and non-desires for trans people. The subreddit r/transgendercirclejerk exposes the illogic of transphobia without transphobes by revealing how they are actually just transphobic.

TRANSPHOBIA WITHOUT TRANSPHOBES

In this time of both rising trans visibility and anti-trans laws, this article turned to Reddit and super straights in order to examine discourses about heterosexuality and how people engaged in discursive strategies to claim to not be transphobic while still engaging in transphobia. As gay people gained more rights in U.S society, heterosexuality shifted, whereby heterosexuality, especially heterosexual masculinity, could often not rely on explicit homophobia to shore up itself (Dean 2013). Now with more visibility of trans people, some heterosexual people are finding new ways to shore up heterosexuality without relying on explicit transphobia. That is, in this moment of changing ideas around gender and sexuality, some people are using bioessentialist frames of biological sex, "born this way" ideologies of sexual identity, and personal preference discourses to both assert and construct their heterosexuality as superior and naturally occurring and to try to legitimate their non-desire of and exclusion toward trans people without wanting to be seen as explicitly transphobic. Interestingly, people are partly using diverging discourses around gender and sexuality—that gender is socially constructed but sexuality (and sex) is inherent and natural—to try to engage in a type of progressiveness of supposedly accepting trans people and the malleability of gender

while still engaging in discriminatory practices toward and beliefs about trans folks.

Importantly, these discursive strategies are similar to the naturalization frame that is central to how people engage in racist actions and logics while reinforcing the myth of nonracialism (Bonilla-Silva 2010). For example, people may think segregation—both neighborhood segregation and only having intraracial friendships and partners—is naturally occurring or almost biologically driven ignoring how policies and practices and socialization processes shape why neighborhoods are segregated and why people form friendships with people of similar racial backgrounds (Bonilla-Silva 2010). Similarly, biological essentialism, "born this way" and personal preferences—all work to construct sexuality, identity, and desire as naturally occurring, erasing larger historical and current practices and processes that shape sexuality, identity, desire, and transphobia today.

More specifically, one strategy used to engage in transphobia without wanting to be seen as transphobic is bioessentialist frames of biological sex, reproduction, and eugenics. Notably, the notion of biological sex was born out of evolutionary science, whereby white scientists constructed white people as the most evolved for having the most sexual dimorphism (Henderson 2020; Patil 2022). Black people—including the long racist history of associating Black women with masculinity as part of denying their humanity (Collins 2005; Spillers 1987)—were seen and constructed as having low sexual dimorphism, and hence, seen as not being as evolved or as civilized (Henderson 2020; Patil 2022). Even today, this notion of biological sex has been used to deny African women such as Caster Semenya from competing in Olympic sports (Adjepong 2020). These discourses around biological sex work to maintain the sex binary and its link to sexual dimorphism and middle-class whiteness. These discourses and the white middle-class constructions of biological sex and sexual dimorphism also exclude people of color, especially trans people of color, from being desired and recognized as human (Gill-Peterson 2018). This current bioessentialist strategy, then, of denying trans people, especially trans people of color, their full humanity through relying on notions of biological sex—while still claiming to not be transphobic—comes from this larger white supremacist history.

People also rely on bioessentialist notions of sexuality and being "born this way" to engage in another discursive strategy of excluding trans people while claiming to not be transphobic. Notably, the concept of sexual identity is also tied to this white supremacist eugenic history, whereby sexual identity, and especially heterosexuality, gets invented to discipline people to reproduce—and mainly, to get middle-class white people to reproduce to further the white race (Ferguson 2005; Foucault 1976; Somerville 2000). Indeed, "born this way" and biological essentialist discourses and ideologies have often been used by people in power to actually justify and legitimate inequality and to further eugenic visions of society (Schilt 2015; Bessant 2008). And some posters on Reddit adopt this logic to argue that their heterosexual or super straight identity is inherent, and hence cannot be discriminatory toward trans people. Intriguingly and insidiously, super straights adopt a strategy used to expose inequality—gay rights uses of "born this way"—to now reassert heterosexuality as superior and to entrench inequalities against trans people, while claiming to not be transphobic.

Furthermore, people also use the contemporary dating and hookup discourse of "personal preference" to also engage in exclusionary actions toward trans people while

claiming to not be transphobic. As scholars have shown though, especially in relation to personal preference discourses around race, personal preference might be perceived as more respectful language but this discourse still maintains inequality (Robinson 2015; Forbes and Stacey 2022). Importantly, desire, "personal preference," and partner selection are not really about the individual, as notions of desirability shape people's life chances whereby lacking desirability can translate into negating and ignoring people and denying them resources (Han 2021). Personal preference discourse, especially the over-focus on discussing trans people's genitals and having a genital preference, can also impact trans people outside of just dating such as the discrimination they face in the workplace, in bathrooms, and in the public sphere (Schilt and Westbrook 2009; Westbrook and Schilt 2014). While people utilize personal preference and genital preference discourses to claim that one's exclusive desires for cis people are inherent and hence cannot be transphobic, these discourses and ideologies can have larger trans antagonistic consequences in the public and political realms.

While overt transphobia is on constant display in this historical moment of rising anti-trans laws and anti-trans backlash, understanding more covert—and at times progressive and liberal—ways that transphobia operates is also crucial in addressing trans antagonism and working toward trans liberation. Indeed, the logics and discourses examined on Reddit such as biological essentialist discourses of sex often operate in other settings, including some feminist spaces, to exclude trans people. As these logics of transphobia without transphobes might be harder to challenge compared to more overt transphobia, it is imperative to name and expose these ideologies and logics, including their historical links to white supremacy, in order to resist them. We can learn from trans people pushing back against these discourses and logics through reason, parody, and play to continue the work of ending violence and discrimination and building a world of gender liberation.

REFERENCES

Adjepong, Anima. 2020. "Voetsek! Get[Ting] Lost: African Sportswomen in 'the Sporting Black Diaspora.'" *International Review for the Sociology of Sport* 55 (7): 868–83. https://doi.org/10.1177/1012690219834486.

Auxier, Brooke, and Monica Anderson. 2021. "Social Media Use in 2021." *Pew Research Center: Internet, Science & Tech*. https://www.pewresearch.org/internet/2021/04/07/social-media-use-in-2021/.

Bessant, Judith. 2008. "Hard Wired for Risk: Neurological Science, 'the Adolescent Brain' and Developmental Theory." *Journal of Youth Studies* 11 (3): 347–60. https://doi.org/10.1080/13676260801948387.

Blair, Karen L., and Rhea Ashley Hoskin. 2019. "Transgender Exclusion from the World of Dating: Patterns of Acceptance and Rejection of Hypothetical Trans Dating Partners as a Function of Sexual and Gender Identity." *Journal of Social and Personal Relationships* 36 (7): 2074–95. https://doi.org/10.1177/0265407518779139.

Blank, Hanne. 2012. *Straight: The Surprisingly Short History of Heterosexuality*. Boston: Beacon Press.

Bonilla-Silva, Eduardo. 2010. *Racism Without Racists: Color-Blind Racism and the Per-*

sistence of Racial Inequality in the United States. Lanham, MD: Rowman & Littlefield.
Broussard, Kristin A., and Ruth H. Warner. 2019. "Gender Nonconformity Is Perceived Differently for Cisgender and Transgender Targets." *Sex Roles* 80 (7): 409–28. https://doi.org/10.1007/s11199-018-0947-z.
Butler, Judith. 1990. *Gender Trouble: Feminism and the Subversion of Identity*. New York: Routledge.
Butler, Judith. 1993. *Bodies That Matter: On the Discursive Limits of "Sex."* New York: Routledge.
Charmaz, Kathy. 2006. *Constructing Grounded Theory: A Practical Guide Through Qualitative Analysis*. Thousand Oaks, CA: SAGE.
Collins, Patricia Hill. 2005. *Black Sexual Politics: African Americans, Gender, and the New Racism*. 1st edition. New York: Routledge.
Costello, Cary Gabriel. 2021. "The 4chan '#SuperStraight' Troll Campaign." *Medium* (blog). March 7, 2021. https://transfusion.medium.com/the-4chan-super-straight-troll-campaign-ac99ef3b2fdb.
Dean, James Joseph. 2013. "Heterosexual Masculinities, Anti-Homophobias, and Shifts in Hegemonic Masculinity: The Identity Practices of Black and White Heterosexual Men." *The Sociological Quarterly* 54 (4): 534–60. https://doi.org/10.1111/tsq.12036.
Dean, James Joseph. 2014. *Straights: Heterosexuality in Post-Closeted Culture*. New York: New York University Press.
Deterding, Nicole M., and Mary C. Waters. 2021. "Flexible Coding of In-Depth Interviews: A Twenty-First-Century Approach." *Sociological Methods & Research* 50 (2): 708–39. https://doi.org/10.1177/0049124118799377.
Dhaenens, Frederik, and Sofie Van Bauwel. 2012. "Queer Resistances in the Adult Animated Sitcom." *Television & New Media* 13 (2): 124–38. https://doi.org/10.1177/1527476411412397.
Farber, Rebecca. 2017. "'Transing' Fitness and Remapping Transgender Male Masculinity in Online Message Boards." *Journal of Gender Studies* 26 (3): 254–68. https://doi.org/10.1080/09589236.2016.1250618.
Fausto-Sterling, Anne. 2000. *Sexing the Body: Gender Politics and the Construction of Sexuality*. New York: Basic Books.
Ferguson, Roderick A. 2005. "Race–Ing Homonormativity: Citizenship, Sociology, and Gay Identity." In *Black Queer Studies*, edited by E. Patrick Johnson and Mae G. Henderson, 52–67. Durham, NC: Duke University Press.
Forbes, TehQuin D., and Lawrence Stacey. 2022. "Personal Preferences, Discursive Strategies, and the Maintenance of Inequality on Gay Dating Apps." *Archives of Sexual Behavior* 51 (5): 2385–97. https://doi.org/10.1007/s10508-021-02223-1.
Foucault, Michel. 1976. *The History of Sexuality: An Introduction*. Paris: Éditions Gallimard.
Gill-Peterson, Jules. 2018. *Histories of the Transgender Child*. Minneapolis: University of Minnesota Press.
Goffman, Erving. 1963. *Stigma: Notes on the Management of Spoiled Identity*. New York: Touchstone.
Halperin, David M., and Valerie Traub. 2009. *Gay Shame*. Chicago: University of

Chicago Press.
Han, C. Winter. 2021. *Racial Erotics: Gay Men of Color, Sexual Racism, and the Politics of Desire*. Seattle" University of Washington Press.
Han, C. Winter, and Kyung-Hee Choi. 2018. "Very Few People Say 'No Whites': Gay Men of Color and the Racial Politics of Desire." *Sociological Spectrum* 38 (3): 145–61. https://doi.org/10.1080/02732173.2018.1469444.
Haney López, Ian. 2014. *Dog Whistle Politics: How Coded Racial Appeals Have Wrecked the Middle Class*. New York: Oxford University Press.
Hartigan Jr., John. 2010. *What Can You Say? America's National Conversation on Race*. Stanford: Stanford University Press.
Henderson, Kevin. 2020. "J.K. Rowling and the White Supremacist History of 'Biological Sex.'" *The Abusable Past* (blog). July 28, 2020. https://www.radicalhistoryreview.org/abusablepast/j-k-rowling-and-the-white-supremacist-history-of-biological-sex/.
Hobson, Kathryn, and Sophia B. Margulies. 2018. "A Forgotten History of Eugenics: Reimagining Whiteness and Disability in the Case of Carrie Buck." In *Interrogating the Communicative Power of Whiteness*, edited by Dawn Marie D. McIntosh, Dreama G. Moon, and Thomas K. Nakayama, 133–52. New York: Routledge.
Katz, Jonathan. 1995. *The Invention of Heterosexuality*. University of Chicago Press.
Massanari, Adrienne. 2017. "#Gamergate and The Fappening: How Reddit's Algorithm, Governance, and Culture Support Toxic Technocultures." *New Media & Society* 19 (3): 329–46. https://doi.org/10.1177/1461444815608807.
Maxwell, December, Sarah R. Robinson, Jessica R. Williams, and Craig Keaton. 2020. "'A Short Story of a Lonely Guy': A Qualitative Thematic Analysis of Involuntary Celibacy Using Reddit." *Sexuality & Culture* 24 (6): 1852–74. https://doi.org/10.1007/s12119-020-09724-6.
McKittrick, Katherine. 2010. "Science Quarrels Sculpture: The Politics of Reading Sarah Baartman." *Mosaic: An Interdisciplinary Critical Journal* 43 (2): 113–30.
Meyers, Ashley Elizabeth. 2019. "Beyond 'Born This Way': Reconsidering Trans Narratives."
Morgensen, Scott Lauria. 2010. "Settler Homonationalism: Theorizing Settler Colonialism within Queer Modernities." *GLQ: A Journal of Lesbian and Gay Studies* 16 (1–2): 105–31. https://doi.org/10.1215/10642684-2009-015.
Nelson, Jennifer. 2003. *Women of Color and the Reproductive Rights Movement*. New York: New York University Press.
Patil, Vrushali. 2018. "The Heterosexual Matrix as Imperial Effect." *Sociological Theory* 36 (1): 1–26.
Patil, Vrushali. 2022. *Webbed Connectivities: The Imperial Sociology of Sex, Gender, and Sexuality*. Minneapolis: University of Minnesota Press.
Preston, Kayla, Michael Halpin, and Finlay Maguire. 2021. "The Black Pill: New Technology and the Male Supremacy of Involuntarily Celibate Men." *Men and Masculinities* 24 (5): 823–41. https://doi.org/10.1177/1097184X211017954.
Pullen, Alison, and Carl Rhodes. 2013. "Parody, Subversion and the Politics of Gender at Work: The Case of *Futurama's* 'Raging Bender.'" *Organization* 20 (4): 512–33. https://doi.org/10.1177/1350508412447246.
Robinson, Brandon Andrew. 2015. "'Personal Preference' as the New Racism: Gay

Desire and Racial Cleansing in Cyberspace." *Sociology of Race and Ethnicity* 1 (2): 317–30. https://doi.org/10.1177/2332649214546870.
Robinson, Brandon Andrew. 2016. "The Quantifiable-Body Discourse: 'Height-Weight Proportionality' and Gay Men's Bodies in Cyberspace." *Social Currents* 3 (2): 172–85. https://doi.org/10.1177/2329496515604638.
Robinson, Brandon Andrew. 2018. "Doing Sexual Responsibility: HIV, Risk Discourses, Trust, and Gay Men Interacting Online." *Sociological Perspectives* 61 (3): 383–98.
Robinson, Brandon Andrew, and Salvador Vidal-Ortiz. 2013. "Displacing the Dominant 'Down Low' Discourse: Deviance, Same-Sex Desire, and Craigslist.Org." *Deviant Behavior* 34 (3): 224–41. https://doi.org/10.1080/01639625.2012.726174.
Rogers, Rebecca, and June Christian. 2007. "'What Could I Say?' A Critical Discourse Analysis of the Construction of Race in Children's Literature." *Race Ethnicity and Education* 10 (1): 21–46. https://doi.org/10.1080/13613320601100351.
Schilt, Kristen. 2015. "Born This Way: Thinking Sociologically about Essentialism." In *Emerging Trends in the Social and Behavioral Sciences*, edited by Robert A Scott and Stephan M Kosslyn, 1–14. Hoboken, NJ: Wiley. https://doi.org/10.1002/9781118900772.etrds0027.
Schilt, Kristen, and Laurel Westbrook. 2009. "Doing Gender, Doing Heteronormativity: 'Gender Normals,' Transgender People, and the Social Maintenance of Heterosexuality." *Gender & Society* 23 (4): 440–64. https://doi.org/10.1177/0891243209340034.
Snorton, C. Riley. 2017. *Black on Both Sides: A Racial History of Trans Identity*. Minneapolis: University of Minnesota Press.
Somerville, Siobhan B. 2000. *Queering the Color Line: Race and the Invention of Homosexuality in American Culture*. Durham: Duke University Press.
Spillers, Hortense J. 1987. "Mama's Baby, Papa's Maybe: An American Grammar Book" 17 (2): 64–81.
Stearns, Deborah C. 1995. "Gendered Sexuality: The Privileging of Sex and Gender in Sexual Orientation." *NWSA Journal* 7 (1): 8–29.
Taylor, Kris, and Sue Jackson. 2018. "'I Want That Power Back': Discourses of Masculinity within an Online Pornography Abstinence Forum." *Sexualities* 21 (4): 621–39. https://doi.org/10.1177/1363460717740248.
Tompkins, Avery Brooks. 2014. "'There's No Chasing Involved': Cis/Trans Relationships, 'Tranny Chasers,' and the Future of a Sex-Positive Trans Politics." *Journal of Homosexuality* 61 (5): 766–80. https://doi.org/10.1080/00918369.2014.870448.
Vidal-Ortiz, Salvador, Brandon Andrew Robinson, and Cristina Khan. 2018. *Race and Sexuality*. New York: Polity Press.
Walters, Suzanna Danuta. 2014. *The Tolerance Trap: How God, Genes, and Good Intentions Are Sabotaging Gay Equality*. New York: New York University Press.
Ward, Jane. 2008. "Dude-Sex: White Masculinities and `Authentic' Heterosexuality Among Dudes Who Have Sex With Dudes." *Sexualities* 11 (4): 414–34. https://doi.org/10.1177/1363460708091742.
Ward, Jane. 2012. "Born This Way: Congenital Heterosexuals and the Making of Heteroflexibility." In *Sexualities: Past Reflections, Future Directions*, edited by Sally

Hines and Yvette Taylor, 91–108. Genders and Sexualities in the Social Sciences. London: Palgrave Macmillan. https://doi.org/10.1057/9781137002785_6.

Ward, Jane. 2021. "Heterosexuality." In *Keywords for Gender and Sexuality Studies*, edited by The Keywords Feminist Editorial Collective, 115. New York: New York University Press.

Westbrook, Laurel, and Kristen Schilt. 2014. "Doing Gender, Determining Gender: Transgender People, Gender Panics, and the Maintenance of the Sex/Gender/Sexuality System." *Gender & Society* 28 (1): 32–57. https://doi.org/10.1177/0891243213503203.

zamantakis, alithia. 2020. "Queering Intimate Emotions: Trans/Nonbinary People Negotiating Emotional Expectations in Intimate Relationships." *Sexualities*, December. https://doi.org/10.1177/1363460720979307.