Beyond the Binary: Gender Identity and Mental Health Among Transgender and Gender Non-Conforming Adults

Chassitty N. Fiani

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Beyond the Binary: Gender Identity and Mental Health among Transgender and Gender Non-Conforming Adults

by

Chassitty N. Fiani

This manuscript has been read and accepted for the Graduate Faculty in Psychology in satisfaction of the dissertation requirement for the degree of Doctor of Philosophy.

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ABSTRACT

Beyond the Binary: Gender Identity and Mental Health among Transgender and Gender Non-Conforming Adults

by

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Advisor: Kevin L. Nadal

Despite increasing endorsement of non-binary gender identities among TGNC (transgender or gender non-conforming) populations, research regarding TGNC experiences often overemphasizes pathology relative to positive psychology and reinforces binary conceptualizations of gender (exclusively male/female). TGNC individuals face increased rates of depression, suicide risk, anxiety, substance abuse, HIV/AIDS, homelessness, victimization, and negative police interactions. These disparities are exacerbated by discrimination, lack of culturally competent resources, and internalized stigma. Despite these negative experiences and increased risks, TGNC individuals hesitate to seek treatment and/or police assistance due to fears of discrimination, cultural incompetence, and/or re-victimization. To address these gaps, the present investigation utilized a mixed-methods design with a sample of 357 self-identified TGNC adults. Study 1 included individual interviews whereas Study 2 included an online survey. Both segments collected socio-demographic and mental health data. Overall, seven hypotheses were investigated: 1) Participant narratives will indicate a greater degree of heterogeneity in later phases of identity development than previously considered; 2) Narratives will reveal common themes of risk (e.g., internalized or environmental stigma) and resiliency (e.g., social support, community connectedness) within developmental processes; 3) Victimization will positively predict depression, anxiety, gender dysphoria, and grit; 4) Victimization will negatively predict
flourishing; 5) Social support will mediate the relationship between victimization and psychological well-being; 6) TGNC community connectedness will mediate the relationship between victimization and psychological well-being; 7) Victimization will relate to decreased help-seeking (mental health or criminal justice services).
Contributors and Funding Sources

This work was supported by an internal dissertation committee consisting of Dr. Kevin L. Nadal (chair), Dr. Chitra Raghavan (committee member), and Dr. Brett Stoudt (committee member) of the City University of New York (CUNY) Graduate Center, John Jay College Psychology Department. Internal committee members contributed to initial revisions to Chapters 1-3, comprising the Second Doctoral Exam and Dissertation Proposal. In addition, this work was supported by two external committee members: Dr. Michelle Fine and Dr. David Rivera. All work conducted for the dissertation was completed by the student independently.

Graduate study was supported by the Five-Year Graduate Center Fellowship of the CUNY Graduate Center. Compensation for interview study participants (in the amount of $50 each) was supported by the Ohio Psychological Association’s Michael Sullivan Diversity Scholarship and by the FPRI grant issued by the Forensic Psychology Research Institute (FPRI) at John Jay College.
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Chapter 1: Introduction to the Study

In 2014, *TIME* magazine published “The Transgender Tipping Point”. This article, punctuated by historical data, quality of life statistics, and quotes from Netflix star and transgender advocate Laverne Cox, chronicled the presence of TGNC individuals in American mainstream media (Steinmetz, 2014). Beginning in 1959 with Christine Jorgensen, a World War II veteran who was born “George”, the history of TGNC media presence was repeatedly reshaped as unique individuals arose to add their stories to this emerging narrative. Over time, this narrative expanded to integrate the voices of Janet Mock, highlighting the role of racial/ethnic intersectionality in TGNC experiences and challenging the misleading ‘girl born in a boy’s body’ paradigm (Mock, 2013) and of Caitlyn Jenner, formerly known as Olympic gold medalist Bruce Jenner, challenging archaic definitions of what makes a “man” a “man” or a “woman” a “woman” through a *Vanity Fair* exclusive that quickly went viral (Bissinger, 2015). While representing only a minute segment of TGNC voices and experiences, these narratives have created a zeitgeist within which society has begun to not only acknowledge the existence of TGNC identities and individuals, but also to understand their complexities.

While at a notably slower pace than media outlets, the discipline of multicultural psychology has explored the unique struggles, strengths, and characteristics of marginalized groups such as racial/ethnic minorities, the lesbian, gay, bisexual, and queer (LGBQ) communities, and transgender and gender non-conforming communities (henceforth referred to by the umbrella term “TGNC”). Much recent research regarding TGNC communities has centered on the use of hormone therapy, gender confirmation surgery (GCS), and HIV/AIDS (for a review see James, Herman, Rankin, Keisling, Mottet, & Anafi, 2016). While these are undeniably relevant topics, there is a dearth of literature in understanding TGNC lived
experiences and identities. For example, increasing numbers of individuals express self-identifications outside of the traditional gender binary, which conceptualizes gender as exclusively “male” or “female”. A growing body of anecdotal and qualitative research has demonstrated this trend; however empirical research has thus far lagged behind thus leaving a gap for current and future researchers to explore.

**Defining Gender Identity**

Gender and gender identity represent complex constructs which have been defined in various ways throughout the years and across different researchers and disciplines. For example, Egan and Perry (2001) conceptualized gender at the intersection of social and personal influences—a combination of one’s perception of gendered social groups (e.g., male, female, transgender, genderqueer, etc.), one’s sense of belonging to a specific group (or lack thereof), and one’s internal experiences and perceptions of those experiences. Shapiro (2007) conceptualized gender not only as a culmination of internal experiences and perceptions of external groups but also accounted for factors such as availability of gender influences (e.g., role models) and opportunities to explore and express gender within personal and social spaces.

The aforementioned two definitions together represent a general and inclusive definition of gender identity; however they do not clearly delineate the differences between three commonly conflated terms: “sex”, “gender”, and “gender identity” (Muehlenhard & Petersen, 2011). The American Psychological Association (APA) (2015a) defines *sex* as “a person’s biological status” whereas they define *gender* as “socially constructed roles, behaviors, activities, and attributes that a given society considers appropriate for boys and men or girls and women”. *Gender identity* is defined as “a person’s internal sense of being male, female or something else” (APA, 2015a).
The term *transgender* represents a broad description of individuals who self-identify as a gender other than that assigned to them at birth (APA, 2006; Kaufman, 2008). The term *cisgender* refers to individuals whose experienced gender identity matches that which they were assigned at birth (e.g., an infant assigned female at birth would grow up and self-identify as a female) (Tate, Bettergarcia, & Brent, 2015). Additional terms have historically been considered synonymous with transgender, including *transvestite*, *transsexual*, and *transgendered persons* (Carroll, Gilroy, & Ryan, 2002), however these terms are largely considered stigmatized at present and have largely been replaced by terms such as *transgender* (GLAAD, 2014).

The root word “trans”, meaning “across” often implies that an individual who identifies as transgender identifies as the opposite of the gender assigned at birth. For example, an infant assigned male at birth may later self-identify as female. This definition, deeply rooted in binary conceptualizations of gender and gender identity, does not adequately represent the full spectrum of gender identities embraced by individuals. Thus, many individuals identify with non-binary gender identities or gender non-conforming (GNC) identities which do not necessarily align with the traditional gender binary. For example, individuals who do not feel that other gender identities such as male, female, or transgender adequately describe their internal experiences of gender may identify as *Genderqueer* (GLAAD, 2014). Some individuals who do not identify with any particular gender identity (binary nor non-binary) may self-identify as *agender* (Nonbinary.org, 2015). Additionally, some individuals experience a gender identity which consists of varying identifications and presentations over time and may identify as *gender fluid* or *bi-gender* (Gender Diversity, 2015). While some researchers and theorists may posit that such non-binary identities represent a state of identity confusion or of rebellion against conformity, data on transgender and non-binary gender identities to date suggest that these identities function
much like cisgender male/female gender identities though they are more highly stigmatized and frequently misunderstood (Currah, 2006; Kaufman, 2008).

**Gender Identity Research**

While transgender and GNC identities represent a smaller body of research than cisgender identity, a growing pool of research has begun to surface and expand. One of the earliest investigations of TGNC identity, conducted by Ellis (1945), investigated experienced gap between socially prescribed gender assignments and experienced gender identity in a sample of intersex individuals (individuals who possess both male and female secondary sex characteristics). Even during this early period, Ellis highlighted the importance of both internal and external factors to gender identity and related experiences, in alignment with the aforementioned body of research defining gender identity. The term “gender identity”, however, was not coined until 1968 when Robert Stoller built upon the theoretical foundations of Ellis while adding the influence of biological factors. Stoller made the powerful claim that individuals experience threats to their gender identity similarly to a threat to their overall sense of self thus emphasizing the imperative nature of appropriate understanding and consideration of gender identity. For more extensive historical overviews of the origins of gender identity theories, see Frable (1997) or Fagot and Leinbach (1985).

In addition to historical overviews of gender identity theory, more modern researchers have attempted to study gender identity development from an empirical perspective. Hill (1997) conducted an early qualitative investigation into the multidimensional facets of gender identity development. Interestingly, Hill’s data challenged contemporary understanding of gender identity as the majority of participants described feeling compelled to select binary categories in daily life (e.g., “male” versus “female” on an application form) despite the fact that they reported
not fully identifying with either term. Hill concludes that a great deal of heterogeneity among
TGNC-identified individuals remains unacknowledged and unexplored and that this may have
detrimental consequences for individuals with non-binary gender identities.

Devor (2004) created a stage model of gender identity formation based upon previous
models of specific identities such as racial/ethnic identity (Cross, 1971; Kim, 1981; Helms,
1990) and lesbian, gay, and bisexual (LGB) identity (Cass, 1984; Fassinger & Miller, 1996;
Mohr & Fassinger, 2000; Johns & Probst, 2004). While Devor’s model represents a fundamental
step toward understanding TGNC identity development, it does so imperfectly. For example, its
assumptions of bodily dysphoria and desire for physical modification reinforce binary
conceptualizations of gender and erroneously assume that each gender has only one specific
physical manifestation (e.g., males must have a penis and no breasts and females must have a
vagina and breasts). Pardo (2008) empirically re-investigated Devor’s model, adding non-binary
and free-response gender identity options. Similar to earlier findings of Roen (2002), Pardo
obtained 343 non-overlapping terms which created a participant-developed spectrum of non-
binary gender identities. This study opened the doors for inclusive investigations which both
acknowledge the existence of non-binary identities and explicitly seek to understand them.
Figure 1 illustrates the multi-dimensionality of gender identity demonstrated by extant research.

**TGNC health disparities.**

Such inclusive investigations and increased awareness have the potential to improve the
well-being of TGNC individuals. In samples of TGNC participants, researchers have uncovered
increased rates of depression, anxiety, post-traumatic stress, conduct disorder, substance abuse,
and suicidality (Benotsch et al., 2013; Bockting, Miner, Romine, Hamilton, and Coleman, 2013;
Simons, Schrager, Clark, Belzer, & Olson, 2013). Interestingly, social and familial support may
moderate these disparities (Bockting et al., 2013; Simons et al., 2013). TGNC populations also face elevated risks regarding other components of well-being including homelessness (Cochran, Stewart, Ginzler, & Cauce, 2002), HIV/AIDS (Herbst, Jacobs, Finlayson, McKleroy, Neumann, & Crepaz, 2008), lower educational attainment, and increased negative interactions with the criminal justice system compared to cisgender peers (Grant, Mottet, Tanis, Harrison, Herman, & Kiesling, 2011; James et al., 2016). Despite increased victimization and psychological distress, TGNC participants often report hesitance to contact the police for assistance during an emergency (Grant et al., 2011) or to seek mental health services due to discriminatory experiences and concerns regarding cultural competence among providers (Burgess, Lee, Tran, & Ryn, 2008).

Researchers have developed a number of theories to account for health disparities among marginalized groups such as the TGNC population. Three noteworthy theories, examined in more detail below, maintain that disparities result not from the marginalized identity itself, but from experiences of victimization, discrimination, and unequal resources associated with social attitudes toward marginalized identities. Minority Stress Theory (Meyer, 1995) posits that stigma toward a marginalized identity and limited social support result in chronic stress which places individuals at increased risk for ailments and distress. Social Justice Theory maintains that unequal distribution of resources such as culturally competent medical and mental health services allow for the production and reproduction of disparities among marginalized groups. Microaggression Theory (Nadal, 2008; Sue, 2010) posits that brief, subtle acts of discrimination which communicate derogatory messages toward marginalized groups contribute to mental health disparities. Cumulative discriminatory experiences whether in the form of internalized stigma, overt assault, lack of culturally competent resources, or subtle verbal and nonverbal
slights contribute to increased disparities and reduced comfort with mental health and criminal justice systems.

**Victimization and resilience.**

In addition to minority stress, limited social resources, and microaggressive experiences, victimization (the process of becoming a victim or of being victimized) and resilience (adaptive and protective characteristics and strategies) contribute to well-being. Victimization significantly predicts suicide risk among TGNC populations (Clements-Nolle, Marx, & Katz, 2006). Victimization risk is highest among participants who endorse feeling different from others (with regard to gender), being told they are different from others, being referred to counseling for gender issues by parents, and identifying as transgender both to oneself and to others (Grossman, D’Augelli, & Salter, 2006). A growing pool of research has begun to frame individuals who experience victimization as “survivors” rather than as “victims”, thus providing a positive connotation to complement a wealth of morose statistics on experiences and outcomes among TGNC individuals (Meyer, Oulette, Haile, & McFarlane, 2011; Nadal, Davidoff, Davis, & Wong, 2014). These findings are consistent with earlier research indicating a sense of increased solidarity and identity positivity following discriminatory experiences among racial/ethnic minorities (Branscombe, Schmitt, & Harvey, 1999; Cronin, Levin, Branscombe, Laar, & Tropp, 2011; Lee, 2005; Singh, Hays, & Watson, 2011).

While the aforementioned literature offers preliminary insights into identity development and well-being among TGNC populations, the body of research specifically investigating gender identity-related disparities remains quite small. In a survey of NIH-funded studies from 1989-2011 listed as examining “LGBT” health issues, only 6.8% of studies specifically investigated transgender concerns or perspectives (Coulter, Kenst, Bowen, & Scout, 2014). The disparities...
experienced by transgender and GNC populations coupled with the disparity of research specifically investigating those disparities and their potential origins or resolution highlights the imperative need for additional culturally competent research into these domains.

**Departing the Gender Binary**

An individual who identifies as non-binary does not identify with the common dichotomous presentation of gender which assumes only male or female options, nor that those categories are static or mutually exclusive. A non-binary individual may identify as *gender non-conforming* (GNC) or by other similar terms such as *genderqueer, pan-gender, or gender fluid* (Kaufman, 2008). A growing pool of research purposefully investigated the unique experiences of non-binary individuals in a trend sometimes referred to as “post-genderism”. Post-genderism proposes that rigid gender binarism incurs harm at both individual and societal levels (Hughes & Dvorsky, 2008). Dvorsky and Hughes (2008) conceptualized TGNC identity research into two historical waves—the first characterized by extreme binarism and the second by increased flexibility in favor of an inclusive spectrum of gender. Extant research on relies upon first-wave binarism, but this tide continues to gradually shift toward second-wave conceptualizations (Pardo, 2008; Roen, 2002; Wilson, 2002). Notably, second wave findings highlight the importance societal influences, as individuals may internally connect to non-binary identifications but may gradually assume binary identities as a result of external pressures and stigma (Gagne, Tewksbury, and McGaughey, 1997; Hill, 1997; Mason-Shrock, 1997; Nestle, Howell, & Wilchins, 2002).

**Summary and Present Investigation**

Multicultural psychology has followed an ever expanding trend seeking to understand the complexities and unique experiences of racial/ethnic minorities and sexual orientation minorities.
The field has now expanded to incorporate research on gender variance and TGNC identities. Unfortunately, the quantity and breadth of research specifically investigating TGNC concerns and experiences remain limited. Of that small pool, a marked paucity of studies explore non-binary gender identities. These gaps become problematic in light of the demonstrated disparities in well-being among TGNC populations. Furthermore, TGNC individuals often refrain from seeking support from mental health and criminal justice agencies due to fears of re-victimization and concerns regarding a lack of cultural competence among service providers. The current state of research and of perpetuated disparities necessitates additional explorations of non-binary gender identity in relation to victimization, resiliency, and mental health.

To address the aforementioned gaps in previous research, the present investigation will explore the following hypotheses via a cross-sectional mixed-methods design using a web-based platform: 1) Participant narratives will indicate developmental processes of gender identity development consistent with extant identity formation literature, but later phases will contain a greater degree of heterogeneity than previously considered; 2) Participant narratives will reveal common themes of risk (e.g., internalized or environmental stigma) and resiliency (e.g., social support, community connectedness) within developmental processes; 3) Higher experiences of victimization will predict higher rates of depression, anxiety, and gender dysphoria; 4) Social support will mediate the relationship between victimization and mental health outcomes; 5) TGNC community connectedness will mediate the relationship between victimization and mental health outcomes; 6) Participants who report more frequent experiences of victimization will report less likelihood of seeking mental health or criminal justice services.
Chapter 2: Literature Review

In recent years, the psychological research community has increasingly turned its focus toward the unique struggles, strengths, and characteristics of socially marginalized groups. This body of literature investigates variables as broad as global cultural characteristics and as specific as individual experiences of marginality, intersectionality, oppression, and opportunity.

Marginalized groups such as racial or ethnic minorities have been particularly heavily researched, but research on the issues of the lesbian, gay, bisexual, transgender, and queer (LGBTQ) community has been a primary focus in recent years as well. The beginning of the year 2014 has watched society take great strides toward acknowledging the least researched sample of the LGBTQ population and researchers have begun following suit.

In addition to this increasing focus on the transgender population, social activists and researchers have begun noting the necessity of identifying transgender individuals as being unique from the larger, more general “LGBT” community (See Worthen, 2013 for a review of this literature). However, grouping the “T” in with the “LGB” promotes a sense of invisibility for the transgender population, creating the guise of inclusion within practices of exclusion. While many policies have been developed to protect citizens against discrimination based upon country of origin, race, ethnicity, religion, disability status, religion, family status (United States Department of Justice, 2000) and sexuality (Baron & Hable, 2013), Taylor, Lewis, Jacobsmeier, & and DiSarro (2012) note that very little legislation has passed in direct protection of the rights of transgender individuals; however as of 2012, 16 states and the District of Columbia have adopted policies which explicitly protect individuals from discrimination based on gender identity or gender expression (Transgender Law and Policy Institute, 2012). This recent increase in research on issues relevant to the transgender population, increasing social attention to this
population, and increasing legal-protections for the rights of this population indicate the imperative nature of effectively understanding the unique characteristics, perspectives, and needs of transgender-identified individuals.

The remainder of this review summarizes literature both empirical and theoretical to date on topics relevant to gender identity from the lens of clinical psychology. Beginning with an exploration of definitions of gender and gender identity, this review then expands to explore conceptualizations of gender and gender identity within the context of both general models of identity development as well as models which pertain to specific sub-groups such as racial/ethnic identities. Models of transgender identity development to date are then described and critiqued from the lenses of Minority Stress Theory (Meyer, 1995, 2003) and Microaggression Theory (Sue, 2010; Nadal, 2010, 2013). This exploration and critique then expands into descriptions of alternative models of gender identity development which depart from the gender binary, alongside definitions and an exploration of non-binary gender identity as a construct and as a clinically-relevant concept. This review concludes with an exploration of gender, diagnostics, and stigmatization including a summary of gender-related diagnoses and revisions in the Diagnostic and Statistical Manual of Mental Disorders (APA, 2013). Current models and recommendations for clinical cultural competence among transgender and non-binary-identified populations are also explored from a critical lens, with implications for clinical psychology and other health and mental health disciplines outlined and framed within Minority Stress and Microaggression Theories.

**Defining Gender and Gender Identity**

Gender is a complex construct comprised of cultural, historical, and social influences. Its meaning and interpretation are malleable across person, place, and time; however a general
understanding of the construct may still be reached. Egan and Perry (2001) defined gender identity as a multi-dimensional construct consisting of four primary domains: recognition of membership to a particular gender category, experienced compatibility (or lack thereof) with said category, experienced societal/interpersonal pressures toward conformity with said gender category, and personal attitudes regarding gender as a construct. Thus, the development of gender identity appears to occur in a multi-dimensional (non-linear) fashion, comprised of a number of intersecting factors and influences.

In a case study of a feminist drag troupe, Shapiro (2007) identified four primary factors as contributing to gender identity development: “imaginative possibility, information and resources, opportunities for enactment, and social support” (Shapiro, 2007, p. 250). Gender, according to these aforementioned researchers is therefore comprised of both internal factors (e.g. self-perceptions, motivations, attitudes, perceptions) and external factors (e.g. societal norms, interpersonal pressures, exposure to gender identity and gender presentation variance). These authors also maintain that gender identity development requires an internal sense of self as well as resources and opportunities to explore and re-shape that sense of self. Definitions of gender and gender identity therefore do not exist in a vacuum, but rather exist at the intersection of a number of personal, interpersonal, and social influences.

Given the complexities associated with defining and studying gender, it is helpful to delineate the differences between the following terms: sex, gender, and gender identity. As noted in Chapter One, the American Psychological Association (APA) defines sex based upon biology, gender based upon intersections of culture, self-perceptions, behaviors, and attitudes, and Gender identity as an individual’s sense of self in terms of gender identity labels (APA, 2011). The construct of gender therefore represents a more external representation of the internal sense
of self which comprises gender identity. Sex, gender, and gender identity are typically defined within the binary (two-gender) system as relating to a person’s biological or chromosomal characteristics (Kaufman, 2008). Unfortunately, over the years “sex” and “gender” have been used synonymously by many, thus resulting in a great deal of conflation of the terms in present understanding, assessment, and measurement (Muehlenhard & Petersen, 2011).

The term transgender is frequently used as an umbrella term to describe individuals who deviate from the prevailing social norm of gender identity matching ascribed sex assigned at birth (APA, 2006; Kaufman, 2008). Historically, a number of other terms have been used interchangeably with transgender, including transvestite, transsexual, and transgendered persons (Carroll, Gilroy, & Ryan, 2002). The term transgenderist has also recently emerged as being largely synonymous with “transgender”, but this term is not yet in wide use (Currah, 2006).

Many of these terms are no longer appropriate for use for a number of reasons. Transvestite is an archaic term which has accumulated a derogatory connotation over the years. Transsexual emphasizes the physiological nature of gender, and may too boldly assume that all transgender-identified or gender non-conforming individuals seek to undergo physical transformation (by surgery and/or through hormone replacement therapy). While the term transsexual has fallen out of favor among some individuals, some individuals may prefer the term transsexual over the term transgender. This preference occurs more commonly among individuals who have completed medical interventions (e.g., hormones and/or surgical procedures) to modify their physical presentation to align with their experienced gender identity (GLAAD, 2014). The present paper also posits that the term transgendered persons holds a negative connotation, the “-ed” suffix implying that the individual’s gender identity is primarily the result of an outside force, presumably societal influences. This assumption may create the
impression of a transgender identity as having less legitimacy than a cisgender male or female identity. The term *cisgender*, frequently used in gender identity research, describes individuals whose experienced gender (gender identity) aligns with their biological gender or the sex assigned at birth. While various authors utilize the aforementioned terms in a number of different ways, the present paper utilizes the term “transgender” as an umbrella including all individuals who do not identify as cisgender. This umbrella can be viewed as encompassing a number of sub-identities described in detail below. Sex, gender, and gender identity all exist independent of sexual orientation such that an individual who identifies as transgender may also identify as heterosexual, lesbian, gay, or bisexual.

Additional terms used to describe the transgender community have included *MTF/FTM* or *Male to Female/Female to Male* indicating people assigned male or female at birth respectively who internally identify and externally present themselves as being female/male respectively. These terms have also undergone a few transformations over time, and will sometimes be seen as *WTM-woman to man* or *MTW-man to woman* to emphasize gender over biological (e.g., chromosomal, hormonal) and secondary sex-characteristics in identification. Individuals who dress according to social expectations for a gender other than their assigned gender, typically as a performance may identify as *Drag Queens/Kings*. These individuals may have no desire to change their experienced or expressed gender, and may spend their daily lives contently in accordance with social expectations pertaining to their assigned gender. Drag Queens/Kings are frequently confused with another term: *Cross-dressing*. Cross-dressing is a behavior rather than an identity, comprised of dressing in attire characteristic of a gender other than one’s predominant gender identity. For example, an individual who was born biologically male and who self-identifies as male in daily life may occasionally dress in traditionally female
attire as a means of satisfying a personal interest or as a fetishist act. These individuals generally
do not identify as transgender, nor does the act of cross-dressing take on the performance aspects
of Drag Queens/Kings (Carroll, Gilroy, & Ryan, 2002; Currah, 2006; Kaufman, 2008).

In addition to the aforementioned frequently misunderstood gender-identity-related
terms, a number of terms have arisen more recently to denote gender identities that are non-
binary (that is those that do not fit within an exclusively two-gender male/female spectrum).
Genderqueer is a term sometimes used to define individuals who do not feel as though any pre-
existing gender category (ex: male, female, transgender) describes their identity (GLAAD,
2014). Other gender-identities also exist off the gender binary such as agender or individuals
who do not identify with any specific gender (Nonbinary.org, 2015). Individuals who identify as
agender may identify more strongly with personality characteristics (e.g., creativity, bravery,
athleticism, intelligence) than with traditional conceptualizations of masculinity/femininity.
Additionally, some individuals may identify as gender fluid or bi-gender. Gender fluid and bi-
gender identifications indicate an individual whose gender identity may vary from one time point
to another (Gender Diversity, 2015). While these identities may not appear stable over time (e.g.
a person may dress, act, and identify as female one day but dress, act, and identify as male the
following day), these daily fluctuations represent gender presentations, not the more stable
overarching gender identity (Currah, 2006; Kaufman, 2008). Appendix A contains a more
detailed list of relevant terms and definitions.

**Multiculturalism and Gender Identity.**

While the majority of extant research focuses on modern Western conceptualizations of
gender and Western gender roles and norms, the conceptualizations of cultures outside of this
lens warrant inclusion. While the binary male/female system of gender dominates in many
cultures, a handful allow for the inclusion of a third (non-binary, non-dichotomous) gender within their traditional conceptualizations. For example, devotees of the goddess Bahuchara Mata in India hold a valued and institutionally recognized sacred role in society—a role associated with a blend of characteristics which cannot be accurately categorized as male, female, or transgender (Nanda, 1986). Additionally, Native American tribes such as the Winnebago, Navajo, Cheyenne, Mojave, and Crow include a “two-spirit” gender identity characterized by gender ambivalence or gender identities/presentations which are neither exclusively male nor female. Often, two-spirit individuals hold distinct cultural and social roles (Jacobs, Thomas, & Lang, 1997; Walters, Evans-Campbell, Simoni, Ronquillo, & Bhuyan, 1996).

In Thailand, a community of individuals who were assigned male at birth and who live according to local female gender norms are referred to as “kathoeys” or “ladyboys” (Doussantousse & Keovongchith, 2005). While research indicates that gender identity formation among kathoeys follows a developmental trajectory similar to common conceptualizations of Transgender MTF individuals, kathoeys face limited peer pressure or social stigma surrounding their identities (Doussantousse & Keovongchith, 2005). A similar community, the “Muxe” exists within Mexican culture wherein biological males identify as females and embody feminine cultural norms (Lacey, 2008). While Muxe face less social stigma and pressure to conform compared to modern American society, these individuals occasionally face some cultural backlash even within a larger milieu which often attributes unique characteristics of intellect and creativity to their identities (Keeps, 2009).

The Samoan Fa'afafine, another case of biological males embodying feminine traits to characterize a third non-binary gender category, are perhaps the most researched of such cultural
groups. Similar to characterizations of kathoeys and Muxes, Fa'aafafine represents an identity category at the intersection of gender and sexual orientation, and as such is often associated with biological males who are sexually and/or romantically attracted to other biological males (Bartlett and Vasey 2006). Also similar to kathoeys and Muxes, Fa'aafafine live within societies of not only tolerance but also acceptance of their identities and presentations with regard to gender and gender roles. As such, researchers have explored Fa'aafafine experiences and identities in order to shed light upon the inaccuracies of the (now defunct) diagnosis of Gender Identity Disorder (Vasey & Bartlett, 2007).

**Defining Identity**

When investigating gender identity, it is necessary to not only define the complex construct of gender, but also to explicitly explore the meaning of “identity” within a psychological framework from both historical and modern perspectives. Pfafflin (2011) defined identity as “the connectedness of the general and the individual” and stated that “we usually only have to think about identity when it is no longer assumed, but questioned” (p. 15). Historically, identity was first intensively investigated by developmental psychologists Erik Erikson and James Marcia. Erikson (1959) conceptualized identity development as a hierarchical process of experiencing conflicts in learned experiences and internal associations and subsequently progressing through a number of distinct stages. Each stage contains a specific conflict between old and new (perceptions, ideals, methods of coping, etc.) which must be resolved before an individual can progress to the next, cumulatively more advanced stage of identity development. Marcia (1980) built upon this model to define identity as “an internal, self-constructed, dynamic organization of drives, abilities, beliefs, and individual history” (p. 159). Both Erikson and Marcia emphasized the developmental (rather than static) nature of identity as well as the
importance of multiple intersecting influences including inter and intra-personal factors to this process of identity development.

More recently, Ashmore, Deaux, & McLaughlin-Volpe (2004) constructed a multi-dimensional model for understanding the construct of identity. These authors maintain that self-categorization, evaluation, importance, attachment/independence, social embeddedness, behavioral involvement, and content/meaning are all important themes which feed into an individual’s identity development. It is therefore important to consider all of these dimensions in conducting and evaluating identity research. While few empirical investigations have sought to identify the processes by which transgender identities develop, a great deal of research has evaluated identity development in general, and the general consensus posits that transgender identity development will follow a similar trend: characterized by both nature and nurture and consisting of multiple developmental pathways (Kaufman, 2008).

Once identity as a general construct had been defined historically and theoretically, researchers and theoreticians began contemplating more specific sub-categories of identity, such as gender identity. Pfafflin (2011) posits that “as long as they are not asked about it, [people] are sure of their gender identity” (p. 17). This highlights the idea that identity, and gender identity specifically is something possessed by all, but acknowledged, explored, and understood by few. Pfafflin describes the historical process of conceptualizing gender identity which began with assumed maleness or femaleness (considered opposite and mutually exclusive categories), to an eventual acknowledgment of transgender identities, to the more modern rejection of binary and assumed gender categories to instead include a spectrum of possibilities. Pfafflin calls this a process of “Identity Pluralization”, of gradually splitting general identity categories off into
countless sub-categories of self-identification representative of an increasing focus on individuality with regard to gender identity and gender expression.

**Identity “stages” versus “statuses”**.

Identity developmental models typically exist in two easily confounded formats: stages and statuses. Identity stage models, such as Erikson’s (1959) stages of psychosocial development consist of a chronological outline of discrete categories of experience through which individuals theoretically progress in a step-wise fashion. Developmental stage models assume that each stage contains progressively more advanced abilities and tasks unique to that particular stage. Additional assumptions of stage models include that all individuals progress through stages in the same order and manifest the same behaviors, experiences, and abilities in the same stages despite individual differences and the assumption that various stages are distinctly qualitatively distinct from one another (White, Hayes, & Livesy, 2010).

Identity statuses, on the other hand, are conceptualized more as flexible phases than as discrete and concrete stages. Marcia’s Ego Identity Status Model (1980) for example, posits that individuals exist in one of four qualitatively distinct identity statuses at various points in their development with regard to various aspects of identity (e.g., politics, religion, sexual orientation, gender). While stage models of identity development contain chronologically organized and qualitatively discrete stages through which individuals must progressively advance, status or phase models contain more flexibility. Status models allow for regression and progression between the four statuses in a fluid manner such that a combination of internal and external experiences may lead an individual to question their gender identity, for example, at a later point in life despite the fact that they might have experienced and reported stability in a different gender identity years prior. Status models therefore allow for a greater degree of fluidity and
accommodate individual differences more effectively than stage models. The majority of modern identity developmental models, discussed in greater detail below, tend to integrate aspects of both stage and phase models such that they propose a series of loosely chronological stages while still allowing for individual differences in the order and pace at which individuals transition through the various phases (Adams & Fitch, 1982). The model proposed within the present investigation will utilize the term “phase” rather than “status” or “stage” for two reasons. First, this allows the proposed model to occupy a related but distinct place within the larger pool of gender identity formation literature. Second, this facilitates the understanding of the proposed model as a flexible, non-linear, dynamic, multi-dimensional, summary of a series of lifelong developmental processes.

**Multicultural Identity Development Models**

In addition to the theoretical model proposed by Pfafflin (2011), a number of different developmental models have arisen out of earlier general models of identity development (such as those of Erikson and Marcia). Some of the earliest and most extensive examples pertain to racial and ethnic identity (Cross, 1971; Kim, 1981; Helms, 1995). Similar to the ego identity development models they were founded upon, racial and ethnic identity models generally indicate a gradual, stage-like progression. Cross’ model of black identity development, for example, consists of six sectors or phases of life differentiated by age category. The first four sectors of Cross’ model involve socio-cultural influences such as family and peer environments which facilitate the initial development of a black identity. The fifth sector of this model, pertaining to adult identity, is comprised of four stages: pre-encounter, encounter, immersion-emersion, and internalization/internalization-commitment. As individuals progress through these phases, identity is said to become more salient and more integrated. Similar models have been
created pertaining to white identity development (Helms, 1995), Latino identity (Ferdman & Gallego, 2001), Asian-American identity (Kim, 1981), and American-Indian identity (Horse, 2001).

A model of feminist identity development (McNamara & Rickard, 1989) follows a similar trend from increasing levels of exploration, to forming new social ties, to synthesis and commitment. McNamara and Rickard’s (1989) model consists of five stages: passive acceptance, revelation, embeddedness-emanation, synthesis, and active commitment. Similar to aforementioned models of racial/ethnic identity development, this model of feminist identity development accounts for a gradual progression through stages of increasing awareness of group differences in society (based on race/ethnicity, gender, etc.) leading to a pivotal moment of awareness of one’s own identity as a product of those societal group differences and then eventually integrating that sense of the feminist self into the overall sense of self (for example the self as a mother, a sister, a worker, a basketball player) and concluding with a sense of commitment to one’s sense of self as a feminist. As identity becomes increasingly salient and integrated, individual’s become more effective at navigating a sense of the dynamic self where being a feminist may represent part but not the entirety of the sense of self. Together these models of racial/ethnic and feminist identity development are all similar in that they indicate a gradual progression through a number of conceptual stages increasing in cognitive complexity and existing at the intersection of internal, interpersonal, and societal-level influences.

Most closely related to transgender identity development are models which delineate the process of developing a lesbian, gay, bisexual (LGB) sexual orientation identity. Research on LGB identity development continues the line of thinking begun by Erikson (1959) and Marcia (1980) and maintains the trend of stage models of identity development. One of the most
prevalent of these models was proposed by Cass (1984) who, similarly to Erikson, proposed the process as a hierarchical stage model in which varying levels of conflict, negotiation, change, and acceptance are necessary for progression to higher stages. While there is some variation regarding the number of proposed stages, authors of various models tend to agree that the development of an LGB identity begins with a sense of majority group identification (defined as abiding by heteronormative ideals), progressing to a state of internal and/or external conflicts which challenge an individual’s sense of comfort with that initial identification, and ultimately progressing toward exploration and acceptance of a new identity, (e.g. lesbian, gay, bisexual, queer, or transgender) and ideally gradually integrating that identity into existing identity structures (Cass, 1984; Fassinger & Miller, 1996; Mohr & Fassinger, 2000; Johns & Probst, 2004). Research on the development of LGBQ identities also generally agrees that such a development involves a lifelong process of self-discovery and a perpetual sense of conflict with majority culture (e.g. cisgender and heterosexual society), and many believe these conclusions are likely to generalize to transgender identity development (See Greenfield, 2008 for a review).

Bilodeau and Renn (2005) conducted a review of the history of LGB identity developmental models with implications for clinical work with LGB clients, and noted a number of the disparities still present in this vein of research. The history of LGB identity research includes both stage models (such as Cass, 1984) and lifespan developmental models (such as D’Augelli, 1994). The authors note that despite the apparent heterogeneity in the composition of these models, the majority indicate a gradual progression from ambiguity of identity to specificity, pride, and ownership. Additionally the authors note that the development of LGB identity formation models faces a number of obstacles relating to societal (and researcher)
assumptions about gender and sexual orientation which must ideally be explored and meaningfully integrated into the theoretical considerations of the models.

**History of Gender Identity Research**

Historically, Ellis (1945) embarked on one of the earliest attempts to investigate individuals who experienced a gap between their assigned and experienced genders. Ellis utilized the unique population of “hermaphrodites”, a term which is now understood to be stigmatizing and has been replaced by the term “intersex” (Kaufman, 2008). This population is unique in that it is comprised of individuals who possess both male and female secondary sex characteristics. At birth, doctors and parents often decide to raise the child as one gender or the other, and research indicates that intersex individuals are more likely than any other group to experience gender dysphoria, or a sense of discomfort regarding their assigned gender (Kaufman, 2008; Meyer-Bahlburg, 2005). Given that these infants were often assigned a gender at birth according to physical characteristics, this early investigation exemplifies the importance of internal experiences compared to physical characteristics in determining gender identity. Even as early as 1945, Ellis highlighted the importance of both internal/psychological and external/environmental factors in the development of a sense of oneself as a gendered individual.

In 1968, Robert Stoller published a book entitled “Sex and Gender: The Development of Masculinity and Femininity” which was to begin the field of gender identity research as we know it today. In this book, Stoller coined the term “gender identity”, although he stakes no claim to copyright the term (Stoller, 1968, p. vi). Stoller notes that gender identity results from the intersection of three primary domains: biological factors (including hormones), sex (as it was assigned at birth), and environmental and psychological influences. Furthermore, Stoller posits that threats to an individual’s gender identity are experienced as threats to the individual overall.
Stoller therefore sheds light on the imperative nature of accurately describing an individual’s gender (i.e. using appropriate pronouns such as “she”, “he”, “her”, and “his) given that failure to do so may be experienced by said individual as an assault to their overall identity. Green (2010) conducted an updated review of Stoller’s theory and found that his description of gender identity development remains relevant and valid even within more modern contexts. Fagot and Leinbach (1985) and Frable (1997) conducted historical overviews and reflections upon theoretical approaches to gender identity development and provide a more comprehensive breakdown of the historical literature approaching this topic.

More modern investigations of gender identity development initially paralleled the historical developmental models of general identity proposed by Erikson and Marcia. For example, Adams and Marshall (1996) reflected on the developmental processes of general identity formation, emphasizing the role of incongruence or identity conflict in facilitating self-awareness of that identity. While these authors focused on identity in general, they highlighted the importance of socialization, reference points, and gender roles to the development of overall identity, thus implicating the importance of gender identity to the formation of overall identity and self-perceptions. Kroger (1997) worked from Marcia’s framework of a stage model of gradual identity development over time to compare gender identity among male and female cisgender individuals. Kroger hypothesized that cisgender women and men would differ in identity structures, content, and context. While Kroger found no significant differences between the identity structures of cisgender men and women, it does represent an initial attempt to parse out gender-related identity issues.

Egan and Perry (2001) built upon the aforementioned body of literature to investigate gender identity as a complex, multi-dimensional construct with potential implications for
psychological well-being. The authors operationalized gender identity using three primary domains: a sense of compatibility (or incompatibility) of one’s sex and gender, social-environmental pressures toward gender role conformity, and a sense of one’s own gender as being superior to others. It was found that individuals who experienced higher levels of compatibility between their sex and gender identity were more psychologically adjusted and that social-environmental pressures toward conformity and a sense of gender superiority were both related to lower levels of psychological adjustment. Individuals who reported sensing less societal pressure regarding their gender identity also reported higher levels of psychosocial adjustment, thus indicating that both aspects of gender identity (internal and external) can potentially impact relationships between an individual’s identity and psychological well-being.

**Intersections of gender identity and sex assigned at birth.**

While many models of gender identity development serve the primary purpose of condensing the experiences of a diverse cluster of individuals overlapping in one substantial domain (i.e., gender identification which differs from sex assigned at birth), it should be noted that not all gender identities develop alike. Many intersectional characteristics can influence the means and processes by which an individual’s gender identity develop. One such intersection exists between gender identity and birth sex. For example, an individual assigned male at birth who later comes to identify with a gender other than male does not necessarily experience their gender identity or its development the same as an individual assigned female at birth. Similarly, (though notably more difficult to study due to low population base rates), individuals assigned Intersex at birth may have experiences which differ from natal males, natal females, or both. Worthen (2013) highlighted the necessity of group-specific investigations and analyses, stating that “efforts to combat prejudices are likely to be most successful if they are based in research
that explores how attitudes are both similar and different across specified targets of prejudice” (p. 703).

Unfortunately, such research as encouraged by Worthen (2013) remains rare. In one example, Grossman et al. (2005) found that MtF youth (transgender individuals who identify as female and were assigned male at birth) experienced gender identity/presentation-related oppression at younger ages than FtM youth, and also faced prejudicial attitudes and non-therapeutic responses from their parents upon disclosure of their gender identities. Some studies which have specifically investigated differences in experiences based upon sex assigned at birth have found no significant differences, thus highlighting the need for additional research in this domain. For example, Gerhardstein and Anderson (2010) conducted an investigation of discriminatory attitudes toward “transsexuals” (a term the authors used interchangeably with “transgender” in a strictly binary sense) based upon undergraduate student responses to facial features. The authors found that conformity to expectations regarding masculinity or femininity (as related to the gender identity rather than the birth sex represented by each stimulus face) significantly influenced participant demonstrations of bias, whereas no significant differences emerged between MtF and FtM stimuli.

In one investigation which explicitly included non-binary gender identities (genderqueer) in their analyses in addition to the binary categories of MtF and FtM, Factor and Rothblum (2008), interesting differences emerged between MtF and FtM participants. For example, while all groups reported no significant differences in the age at which they first experienced their gender identity as different from their sex assigned at birth, MtF participants first identified as TGNC earlier, but claimed gender presentations congruent with their identities later than FtM individuals.
Though empirical research remains scant (and that which exists remains contradictory), several authors have proposed strong theoretical foundations for differences in TGNC gender identity experiences based upon birth sex. Judith Butler (1988), a well-known scholar on the construction of gender (specifically related to feminism), conceptualized gender as “the stylized repetition of acts through time, and not a seemingly seamless identity” (p. 520). As such, Butler viewed gender as a continuous process of perception and performance wherein social attitudes and norms regarding gender are internalized and integrated in varying degrees into the lifelong dynamic process of gender performance. To demonstrate this conceptualization, Butler highlights unnatural, but historical precedential beliefs in the predominance of binary gender and, relatedly, of heterosexuality. Insofar as gender identity (from Butler’s perspective of perpetual multidimensional development) is influenced by social milieu, so might differences in social attitudes toward biological males and biological females contribute to differences in the experiences of TGNC individuals based upon their birth sex. Connell and Messerschmidt (2005) has produced a similarly influential body of theoretical literature pertaining to men and masculinities emphasizing social milieu and zeitgeist.

While a comprehensive examination of the narrative and empirical history of differing social attitudes toward men and women is beyond the scope of this review, such differences in the experiences of boys/men and girls/women has long been established. For example, Eagly and Mladinic (1989) investigated the relationship between social attitudes and gender stereotypes in a (cisgender) sample of 203 college students. Results indicated that attitudes toward natal women (individual assigned female at birth) were significantly more positive compared to attitudes toward natal males. Consistent with prior research, traits stereotypically attributed to natal males ("masculine traits") included agency and instrumental qualities) whereas “feminine traits”
included communality and expressive qualities. In addition, a simple Google Scholar search of 
the literature reveals extensive meta-analyses regarding gender differences in leadership style, 
mathematics performance, personality, ADHD, verbal ability, sexuality, self-esteem, leadership 
effectiveness, aggression, cognition (and the list continues exponentially).

Similar to the preponderance of research on (binary) gender differences, a large pool of 
research has investigated differences in social attitudes pertaining to gender role flexibility. 
Connell (2010) compared workplace experiences among individuals who identify as MtF, FtM, 
and genderqueer through qualitative interviews (N = 19). Most FtM participants reported 
working “stealth”, a performance of binary gendered masculinity consistent with their gender 
identity, though characterized by simultaneous non-disclosure of transgender identity and/or 
gender history. Whereas many MtF participants also reported working stealth to negotiate 
workplace attitudes toward gender and gender identity, female-identified participants reported a 
higher degree of effort and struggle with regard to working stealth via femininity. Individuals 
across all three gender identity categories (FtM, MtF, and genderqueer) described increased 
experiences of discrimination and social friction during periods of transition (or those otherwise 
characterized by gender non-conformity). As such, and similarly to the findings of Gerhardstein 
and Anderson (2010), physiological and perceptual conformity to gender role expectations and 
norms contributed to differences in experiences more so than sex assigned at birth. However, it 
should be noted that physiological transitions and resultant conformity tend to be obtained more 
readily when individuals physically transition earlier (note: Factor & Rothblum, 2008 found that 
FtM individuals transition earlier than MtF) and that FtM transitions are less complex than MtF 
transitions (Berg & Gustafsson, 2009).
TGNC Identity Development

Gender identity, as previously mentioned, refers to an individual’s felt or experienced gender. An individual’s gender identity can fall into any of the aforementioned gender categories such as male, female, transgender, genderqueer, agender, genderfluid, or bi-gender, among others. Gender identity may or may not align with an individual’s sex assigned at birth (Kaufman, 2008). The construct of gender identity refers to the internal experience of an individual as they seek to relate (or not to relate) to various gender categories. Many authors have also argued that gender identity is not a static construct, but rather one which adapts to changing experiences and self-perceptions over time (Davis, 2009; Monro, 2000; Steensma, 2011). A small number of researchers have attempted to develop models to represent the process by which TGNC individuals formulate their gender identity in order to investigate this argument.

In 1996, Mason-Shrock embarked on a qualitative investigation of the personal narratives of transgender individuals who were preparing to undergo gender confirmation surgery (surgical procedures to attain the physical characteristics of their experienced gender). This early investigation into the ways gender minority individuals navigate identity developmental processes seized on the unique opportunity to speak with individuals who were preparing to undergo a drastic shift in their identity. Mason-Shrock concluded that individuals sought a great deal of community resources in preparation for this identity shift. Most notably, dominant gender ideologies provided a frame of reference in these initial identity constructions, and then contacts with other transgender individuals reinforced the fledgling identity as it developed. Transitioning individuals sought support from the larger transgender community (whether in person or by technological means) not only for reference points in the development of their new identity, but also as a source of periodic reinforcement of that identity as it developed. For example,
transgender individuals in transition may ask post-transition individuals about the stages or process of transitioning (physically internally and externally as well as psychologically) and may ask for advice regarding this process. While Mason-Shrock’s early investigation did not empirically investigate transgender identity formation, it did set the foundation for future research by highlighting the importance of interactions between social and interpersonal variables in the construction of gender identity.

One of the first comprehensive investigations of transgender identity development was conducted by Hill (1997). Hill investigated the precursors, motivational factors, developmental processes, and implications of transgender lives and the development of transgender identities. Hill’s qualitative investigation yielded results which fundamentally contradict existing assumptions about what gender is and how gender identity develops. Hill found that the vast majority of participants in his study did not identify on the gender binary system (male/female), but rather that they frequently felt as though they were caught between two worlds, an identity comprised both of some femaleness (femininity) and some maleness (masculinity), but that they felt compelled by society to claim a single box to check: male or female. Participants constructed narratives relating to their sense of identity and retrospective sense of how that identity developed, and most reported feeling that their experiences were fundamentally different from men, women, and from other transgender individuals. This highlights the inherent sense of heterogeneity within the transgender community which has been colloquially implied, but rarely empirically investigated.

Hill concludes his paper by urging the psychomedical (i.e., psychological and medical) communities to expand their horizons, acknowledge the possibility of non-binary genders, and to acknowledge the potentially oppressive implications of exclusively using the term “transgender”
to identify all individuals who are not cisgender-identified. Experiences within the transgender community appear to be quite heterogeneous and if the psychomedical community continues to ignore that heterogeneity then it is in effect perpetuating the pathologizing of anyone who does not fit pre-existing models of gender identity. A vast community may thus remain excluded from gender identity-affirmative medical and mental health services, potentially further marginalizing an already marginalized population of individuals.

Roen (2002) began to examine this within-group heterogeneity in her series of interviews intended to uncover and explore the complexities within the process of developing and maintaining a transgender identity. Roen conceptualized non-binary gender as manifesting in the conflict between “either/or” and “both/and” identifications. An “either/or” identification indicates that an individual identifies either as male or as female (or potentially as either transgender male or transgender female) on a binary, two-gender system. The “both/and” identification indicates that individuals do not identify with exclusively male nor exclusively female identities, but rather sense themselves as a mixture of the two. Similar to Hill’s findings above, Roen found that the vast majority of participants preferred the “both/and” identification, reporting feeling that it more accurately described their experiences with gender identity. Roen indicates that personality variables may account for differences in preferences between these two identity categories, as “either/or” identified individuals tend to hold more traditional or conservative views regarding gender and gender roles while “both/and” individuals tend to harbor more liberal perceptions of gender and many also tend to be more politically oriented toward advocacy, whereas “either/or” individuals tend to be more preoccupied with obtaining a “passing” status, and then continuing with their lives shedding the transgender identification entirely. A book entitled “GenderQueer: Voices From Beyond the Sexual Binary” (Nestle,
Howell, & Wilchins, 2002) provides further anecdotal support for the relevance of non-binary conceptions of gender in a vein quite similar to that provided by Hill (1997) and Roen (2002).

Devor (2004) developed the most recent model of transgender gender identity development. Devor developed his model through a series of interviews with transsexual individuals (he utilized the term “transsexual” as broadly synonymous with current conceptualizations of the term “transgender”), and based his investigation upon previous models of sexual identity development (e.g. Cass, 1984). Devor uses the term “transsexual” to indicate an individual who falls under the umbrella term of “transgender”, or one who identifies with a gender that does not align with the sex they were assigned at birth. Devor’s 14-stage model consists of the following chronological stages: (1) Abiding anxiety, (2) Identity confusion about originally assigned gender and sex, (3) Identity comparisons about originally assigned gender and sex, (4) Discovery of transsexualism, (5) Identity confusion about transsexualism, (6) Identity comparisons about transsexualism, (7) Tolerance of transsexual identity, (8) Delay before acceptance of transsexual identity, (9) Acceptance of transsexual identity, (10) Delay before transition, (11) Transition, (12) Acceptance of post-transition gender and sex identities, (13) Integration, and (14) pride.

Devor’s model of transsexual (and transgender) identity development was formulated based on years of personal and professional qualitative experiences, therefore its foundations are theoretical rather than empirical. Regardless, Devor’s model represents one of few modern attempts to study, categorize, and chronologically sequence the developmental processes behind the formation of a transgender identity. Devor also openly states that this model may not apply to all individuals and that no particular stage description is intended to depict any ideal lifestyle or identity state. Rather, the stages depict a generally followed process reported by a number of
transgender-identified individuals. Two themes drive Devor’s understanding of transgender identity development: witnessing and mirroring. The author posits that identity development is simply an ongoing process of witnessing oneself, witnessing characteristics exhibited by others, and mirroring those characteristics witnessed which one finds to be desirable. Additionally, the theme of witnessing encompasses the overarching desire for others to bear witness to one’s accurate self or identity—to be seen for who they feel they truly are. According to Devor, individuals who feel “unwitnessed” (those who don’t feel as though the world perceives their identity accurately) are more prone to psychological distress, although he does not empirically test this hypothesis.

While Devor’s model represents a critical step toward empirically investigating the processes by which individuals come to terms with their gender identities, his model has a number of weaknesses. First and foremost, his model is purely qualitative, non-empirical, and based on personal experiences and dialogues. The sample from which he derived his conclusions, therefore, may be heavily skewed with regard to experiences and identity development. For example, Devor’s model assumes that most transgender individuals will seek surgical modifications, and as previously mentioned this is not always the case. This ‘trapped in my body’ assumption posits that transgender individuals unanimously experience such profound discomfort with their physical form (primarily with secondary sex characteristics) that they seek to alleviate this dysphoria by changing their physical presentations to more closely align with societal expectations for their experienced gender identity. Not all individuals experience this body dysphoria, however, and thus it may be overly exclusive to place such emphasis physical transition in the absence of additional, more solid, empirical evidence.
While the majority of Devor’s model and stages appear to align with other research on the topic, the culminating stages of his model may be problematic and should be critically examined. Many models of identity implicate a sense of integration and pride as indications of successful or ideal identity development (Johns & Probst, 2004; Cass, 1984; Mohr & Fassinger, 2000; McCarn & Fassinger, 1996; Reynolds & Pope, 1991; Horowitz & Newcomb, 2001; Jones & McEwen, 2000; Pedersen & Kristiansen, 2008) and this sentiment is also reflected in Devor’s (2004) model; however it is possible that the ideal culminating state of a gender minority identity may manifest differently. For example, an individual who identified as transgender in the past may currently identify as male (rather than as “transgender”, “FTM”, etc.) Given that this individual no longer identifies with a transgender identity, he may not exhibit the identity pride present in the final stage of many models of identity development. Not all cisgender males or cisgender females exhibit pride in their gender identity, yet their gender identities are not viewed as incomplete or maladaptive as a result of this. Transgender identities (past or present) may fit similarly within this paradigm.

Pardo (2008) conducted an empirical evaluation of Devor’s (2004) model within a sample of 170 self-identified transgender or gender non-conforming adults who were assigned a female sex at birth. Pardo’s study complements the earlier research on Devor’s model as it included not only participants who identified with the term “transgender” but also those who identified as gender non-conforming, or who chose not to identify with any particular label but who self-identified as under the TGNC umbrella. Furthermore, Pardo’s model allowed for the selection of a number of non-binary terms as well as binary. Binary options in Pardo’s study included Butch, Diesel Dyke, Dyke Fem, Female, and Girl (feminine-spectrum identifications) as well as Boy, Fem Male, Male, and Sissy Male (masculine-spectrum identifications) in
addition to a number of non-binary labels labeled as either “Gender-Transitional” (e.g. Cross-dresser, FTM, Transsexual, and TrannyBoi) or “Gender Fluid” (e.g. Androgynist, Boi, Gender Queer, and Intersex).

While Pardo’s study represents a crucial step toward the acknowledgement of non-binary self-identifications for gender identity and of multiplicity in the developmental pathways of gender identity development, the categorization of gender identity categories remains problematic. For example, “neutral” gender identity terms were limited to either “Sex Radical” or “I do not prefer labels”, thus excluding a number of popular identifications such as “agender” or “pangender” which may fit into this category of neutrality. Furthermore, the difference between Gender Transitional and Gender Fluid categories remains vague, and may represent unwarranted dichotomization even within an attempt to challenge binary conceptualizations of gender. Regardless, Pardo still acknowledges multiplicity in self-identifications in reporting participant’s responses to an open-ended question regarding how they would describe their gender identity. This question yielded 343 unique terms in participant responses, 343 individualized self-identifications all represented somewhere on a non-binary spectrum of gender non-conformity. The vast scope of these self-identifications should be considered and accounted for in future investigations regarding gender identity.

Pollock and Eyre (2012) conducted a more recent investigation of transgender identity development utilizing a grounded theory approach. These authors conducted interviews with 13 self-identified female-to-male transgender individuals, and concluded three primary stages of identity development from analysis of the interview narratives: 1) A growing sense of gender (which was characterized by self exploration and beginning to notice one’s differences), 2) Recognition of a transgender identity, and 3) Social adjustment (pertaining to one’s newly
discovered transgender identity). The third stage of social adjustment often included sub-categories of social transition (e.g. beginning to live in the role of one’s gender identity such as dressing according to social norms for that identity) and physical transition (e.g. bodily changes involving surgical procedures and/or the use of hormones). Interestingly, many participants reported the intersection of gender and sexuality as being central to their progression from Stage one onward. For example, one participant felt that his first sexual encounter with a female re-affirmed his maleness: “I think the first time I really kissed a girl was the first time I felt that I was male, truly” (Pollock & Eyre, 2012, p. 214). This finding empirically echoes the earlier conclusions of Devor (2002) who theoretically proposed that gender and sexuality, while independent of one another, are also inextricably linked with regard to their development and influences. While a great deal of research broadly indicates a separation of gender and sexuality, it may be more effective for future explorations to explore their intersections rather than their independence, however these findings remain preliminary and should be expanded upon by future research.

The aforementioned body of research collectively indicates that “passing”, or being readily perceived in society as one’s experienced gender identity rather than as a transgender individual or as one’s assigned birth sex, may not be fundamental to all, or even most transgender individuals. This means that while some individuals who identify as transgender may place a great deal of importance upon physically presenting according to social expectations for their gender identity, this desire and importance does not unanimously characterize the transgender community. For example, a 2010 survey conducted by the LGBT Task Force regarding transgender concerns and experiences with healthcare found that the majority of transgender participants accessed healthcare for counseling or hormone replacement treatment,
whereas very few reported accessing healthcare resources for surgical transitions. Of the sample of over 7,000 participants, more than 70% reported receiving counseling relating to their gender identity, and almost 15% stated that they hoped to receive this form of counseling at some point in the future (Grant, Motett, Tanis, Herman, Harrison, & Keisling, 2010). Much of the emphasis among the transgender population therefore appears to center on the formation and coming to terms with a specific gender identity, and less to do with societal perceptions and physical presentation. It is difficult to determine whether the culminating phase of gender identity development would be characterized by this state of passing, by a state of psychological stability and equilibrium, or by both or neither of those things. While physical transition is represented by a stage on Devor’s model, the author does acknowledge that identity development is a highly individualistic process and that his model is merely a gesture toward generalizing experiences in a useful way. It is critical to take these concepts and statistics into account both in developing future investigations and interventions as well as in reading past literature on transgender identity development.

**Alternative Models of TGNC Identity Development**

A small handful of studies have also investigated less conventional conceptualizations of transgender identity development. For example, one study explored gender identity as self-identification or self-chosen labels for one’s gender identity in relation to identity developmental processes, community involvement, and gender identity self-disclosure (Factor & Rothblum, 2008). These authors compared individuals who identified as completely male (female to male transgender), completely female (male to female transgender), and those who identified as genderqueer (neither completely male nor completely female). This investigation provides initial insight into the complexities of self-identification within the transgender community, as these
authors were among the first to compare binary (MTF and FTM) and non-binary (genderqueer) identified individuals with regard to clinically relevant variables such as congruency of gender presentation, disclosure of gender identity, and sense of connection to the overall transgender community. Interestingly, all three groups (binary and non-binary) reported first experiencing themselves as being different from others within the same age range in early childhood, thus suggesting that gender identity development for both groups begins around the same time frame. From that point, however, the categories of self-identification diverge. MTF participants self-identified as transgender earlier than FTM participants, but MTF participants did not begin presenting themselves as their experienced gender identity until later than FTM participants. Additionally, genderqueer participants only significantly differed in that they felt more connected to the larger LGBT community than MTF or FTM participants. While these findings represent only one preliminary study, they highlight the necessity of further investigating subdivisions under the umbrella label of transgender, particularly in the form of comparisons between binary and non-binary self-identifications of gender identity.

Alternative models of transgender identity development have also focused more on developmental narratives than developmental stages in identity formation. Wilson (2002) explores the concept of liminal identities, or identities which are transitional in nature rather than existing as discrete and permanent categories. This conceptualization of gender identity development proposes that a transgender gender identity can take on a number of forms even across the lifespan of one individual, each manifesting with unique characteristics and resulting from a unique set of inter and intra-personal influences. Wilson examines this conceptualization through the lens of a “third gender”, or an alternative space of possibility with regard to self-identifications. The concept of a third gender (or a set of third genders) challenges binary
conCEPTUALIZATIONS OF GENDER. A LIMINAL CONCEPTUALIZATION OF GENDER WOULD APPROACH THIRD-GENDER IDENTIFICATIONS (SUCH AS AGENDER, BI-GENDER, OR GENDER FLUID) AS BLURRING THE LINES OF GENDER CATEGORIES, BUT IN A POTENTIALLY TEMPORARY WAY AS MANY OF WILSON’S PARTICIPANTS INDICATED FEELING SOCIETAL PRESSURES TO EVENTUALLY CONFORM TO TRADITIONAL EXPECTATIONS OF GENDER PERFORMANCE (WHETHER MALE, FEMALE, OR TRANSGENDER).

THIS PROCESS OF BLURRING THE LINES OF GENDER WAS FURTHER INVESTIGATED BY HIESTAND AND LEVITT (2005); HOWEVER, THESE AUTHORS CONDUCTED A NUMBER OF INTERVIEWS WITH A SAMPLE WHO BLURRED THE LINES NOT ONLY BETWEEN BINARY CONCEPTUALIZATIONS OF GENDER BUT ALSO BETWEEN GENDER IDENTITY AND SEXUAL ORIENTATION. HIESTAND AND LEVITT INVESTIGATED THE DEVELOPMENT OF A BUTCH IDENTITY, OR AN IDENTITY SIMULTANEOUSLY CHARACTERIZED BY TRANS-MASCULINE GENDER CHARACTERISTICS AND A LESBIAN SEXUAL ORIENTATION SELF-IDENTIFICATION. THIS IDENTIFICATION REPRESENTS A BLURRING OF TRADITIONAL UNDERTSTANDINGS OF BOTH GENDER AND SEXUAL ORIENTATION AS BUTCH AS A GENDER IDENTITY REPRESENTS A FEMALE WHO SIMULTANEOUSLY SELF-IDENTIFIES WITH MASCLINE CHARACTERISTICS, YET ALSO AS A LESBIAN (THUS SOME PORTION OF THE GENDER IDENTITY RETAINS SOME INDICATION OF FEMALE IDENTIFICATION). PARTICIPANTS REPORTED THIS SENSE OF CONFLICT THROUGH EXPERIENCES OF BALANCING TWO SEEMINGLY DISPARATE WORLDS—MALE AND FEMALE—WHILE FEELING LINKED TO BOTH SIMULTANEOUSLY. THESE INDIVIDUALS ALSO REPORTED HAVING TO COME TO TERMS WITH MULTIPLE “COMING OUT” EXPERIENCES—DISCLOSING THEIR IDENTITIES AS BUTCH (LESBIAN) AND BUTCH (GENDER IDENTITY) DIFFERENTIALLY. THIS INVESTIGATION, ONE OF RARE INDIVIDUALISTIC FOCUS, HIGHLIGHTS THE IMPORTANCE OF ACKNOWLEDGING AND EXPLORING THE DEVELOPMENTAL PROCESSES BEHIND NON-BINARY AND OTHERWISE UNCONVENTIONAL IDENTIFICATIONS.

A NUMBER OF OTHER NARRATIVE-BASED INVESTIGATIONS OF TRANSGENDER IDENTITY DEVELOPMENT HAVE BEEN CONDUCTED (SEE PHIBBS, 2008, FOR A SUMMARY OF SOCIOLOGICAL LITERATURE ON THIS TOPIC),
however few of these investigations utilize the lens of clinical or counseling psychology, thus their relevance to clinical work with transgender patients/clients has yet to be determined. Regardless, Hansbury (2005) conducted an investigation which highlights the ability of narrative explorations to uncover clinically meaningful information about the intricacies of gender identity development, thus providing preliminary support for a bridge between the work of these two disciplines. While initially based in personal experiences, Hansbury’s investigation of sub-groups of the trans-masculine community (transgender-identified, on the masculine side of the feminine-masculine spectrum) offers a great deal of insight into heterogeneity and provides the foundation for his recommendation for individualized clinical interventions supportive of this heterogeneity of identity and experiences. Hansbury describes the conceptualization of non-binary, heterogeneous gender identifications as a transition from a linear system (e.g. dichotomous male and female options), to a matrix system (e.g. tangentially related boundaries of masculinity and femininity on a spectrum across various domains such as public and private), to his proposed “cluster of bubbles, each trans identity connected to others, touching at multiple vertices” (p. 244).

**Departing the Binary**

While much of the aforementioned research either focuses on cisgender male or female identities or upon transgender identities resulting in the eventual assumption of either a transgender male or transgender female identity, a small pool of researchers have argued for investigations into non-binary gender identities. An individual who adopts a non-binary identification is someone who does not identify with the common dichotomous presentation of gender which assumes only male or female options, and that those categories are both static and mutually exclusive (Kaufman, 2008). A non-binary individual may identify as *gender non-
conforming (GNC) or by other similar terms such as genderqueer, pan-gender, or gender fluid (these and other related terms are defined in Appendix B).

Gagne, Tewksbury, and McGaughey (1997) further investigated the concept of identity development within the context of a “coming out” process, in which individuals not only psychologically navigate and come to terms with their gender identity but also implicates a process of disclosing said identity in one’s social environment. Similar to Mason-Shrock (1996), Gagne and colleagues highlight the important role that social contexts play in the process of gender identity development, and similarly to Hill (1997), Roen, (1992), and Nestle, Howell, & Wilchins (2002), Gagne and colleagues acknowledged the existence of non-binary identifications among the transgender community; however, they utilized a different approach than Hill, Roen, or Nestle and colleagues. Gagne et al. conceptualized a transgender identity (used as an umbrella term) as non-binary in and of itself, whereas other researchers generally conceptualized transgender males and transgender females as binary representations of male and female respectively. Using this individual conceptualization, these researchers found that while the majority of transgender-identified participants reported wanting to challenge binary conceptualizations of gender, that their lived experiences and observed behaviors actually tended to reinforce the binary system rather than challenge it. For example, transgender males (FTM) tended to place a lot of personal emphasis on adherence to societal gender norms pertaining to masculinity, and likewise with transgender females (MTF) and societal norms regarding femininity. Given the conceptualization and findings of Gagne and colleagues, it is unsurprising that more modern researchers have conceptualized traditional MTF or FTM transgender identities as variations on the existing gender binary (and as remaining part of that binary) and
have grown to conceptualize non-binary gender identities as those not encompassed by male, female, or transgender categories.

Bilodeau (2005) examined and critiqued the accuracy of binary conceptualizations of gender in his investigation of the identity development of two transgender-identified students. This author challenged binary conceptualizations of gender and also highlighted critical connections between the possibility of non-binary identities which have thus far remained unaddressed and the psychological consequences of that identity. Bilodeau’s participants described themselves as self-identifying as “transgender”, but they also used a number of additional terms under the transgender umbrella to describe their gender identities. These additional terms included “dyke”, “non-operational female to male”, and “genderqueer”. One participant described her affiliation for the term transgender in the following powerful quote: “I identify as transgender because I transgress gender and I refuse to be limited by gender” (Bilodeau, 2005, p. 33). Another of Bilodeau’s participants echoes this sentiment: “I’ve tried with my identity to not reinforce the gender binary system…the only option is, if you’re male, to become female, or vise-versa. Transgender youth have felt that binary gender system is not for them. We want to increase the number of genders” (Bilodeau, 2005, p. 33-34). While Bilodeau’s study included only two participants and therefore has substantial limitations for generalizability, his qualitative data provides a foundation for future empirical investigations into the sentiments regarding binary gender demonstrated by his participants.

This trend away from exclusively binary conceptualizations of gender has also been referred to as “postgenderism” (Hughes & Dvorsky, 2008). Postgenderist theorists maintain that binary conceptualizations of gender (those which exclusively limit gender categories to male or female—often also including transgender as a binary category) exist to the detriment of both the
individual and society as a whole. Binary gender is posited as an unnecessarily restrictive construct, limiting the potential of individuals thus limiting the extent to which they may contribute to society overall. The clash of binary and non-binary gender conceptualizations essentially epitomizes the age-old philosophical debate between essentialism and constructionism. Essentialism maintains that humans are, at their core and from birth, one way or another. Relevant to the gender question, essentialism maintains that humans are born either male or female and can only be just that throughout their lifespan. The constructionist view, on the other hand, maintains that gender is constructed via an ongoing process influenced by inter and intra-personal factors as well as overarching societal influences (Hughes & Dvorsky, 2008).

Dvorsky and Hughes (2008) describe historical transgender identity movements as taking on two waves. The first wave epitomized binary gender norms, with MTF individuals adopting socially constructed norms of femininity to the extreme, and FTM adopting masculine norms to the extreme. This first wave echoes the findings of Gagne, Tewksbury, and McGaughey (1997). Dvorsky and Hughes propose that a second wave has emerged more recently, characterized by a tapering off of these extremes. What remains appears to be an infinite spectrum of possibility with regard to masculinity, femininity, and anything in between. A number of additional authors similarly support a perspective of multiplicity regarding gender. For example, Benson (2005) discussed the clinical relevance of non-binary conceptualizations in gender in her critique of the pathologizing history of clinical work with transgender clients (e.g. the formulation and diagnosis of Gender Identity Disorder, an overt pathologizing of transgender identities). Benson argues furthermore for increased understanding of the differences between gender dysphoria (a sense of unease or mis-alignment regarding one’s assigned gender) and gender non-conformity (possessing a gender identity and presenting as a gender identity which does not align with
societal expectations for one’s assigned birth sex). Not all individuals who present their gender identity in a way that challenges social norms will experience gender dysphoria, nor do all individuals who experience gender dysphoria portray their gender in socially unconventional ways. Other authors have arrived at similar conclusions regarding the multiplicity of gender in public spaces (Linstead, 2006), negotiating gender identity in fields of education and technology (Stepulevage, 2001), and gay-straight alliances and social activism movements (Schindel, 2008).

**Gender non-conforming children.**

Gender presentation variance and gender non-conformity in children is often interpreted as pathological development (Langer & Martin, 2004) and/or as indication of minority sexual orientation (Gottschalk, 2003). Langer and Martin (2004) describe gender non-conformity in children as being frequently characterized by clothing (e.g., biological males wearing dresses or biological females refusing to wear them) and by play activities and chosen toys (e.g., dolls versus trucks). These authors argue that Gender Identity Disorder (the diagnosis in the DSM-IV pertaining to gender non-conformity in children which preceded the current diagnosis of “Gender Dysphoria” discussed later in this review) stems from socially constructed biases. For example, the authors note that while biologically female children are more likely to engage in gender non-conforming behavior, parents of gender non-conforming biologically male children are six times more likely to seek treatment at a gender identity clinic for their child. Parents of biologically male children referred for gender-related treatment frequently cite concerns about homosexuality as motivations for referring their child to treatment (Kane, 2006). Additionally, research indicates that children diagnosed with Gender Identity Disorder (GID) are more likely to experience social isolation, lower self-esteem, depression, suicidal ideation and suicide attempts and more likely to drop out of school and engage in prostitution; however, these correlational
relationships appear to be the result of repeated victimization experiences resulting in socially-imposed distress (For a review see Langer & Martin, 2004).

One frequently asked question in relation to gender non-conforming (GNC) children regards long-term outcomes: Do GNC children grow up to be gender non-conforming adults? Steensma, Biemond, Boer, and Cohen-Kittenis (2008) longitudinally investigated this question in a sample of 20 adolescents diagnosed with GID during childhood. Prior to conducting their own study, Steensma and colleagues (2008) summarized past literature which indicates that gender dysphoria (discomfort with one’s assigned sex at birth) during childhood does not necessarily predict gender dysphoria in adulthood. For example, across ten investigations including a total of 246 children who expressed gender dysphoria, only 15.8% continued to express gender dysphoria into adolescence (p. 500). In order to build upon this body of literature, Steensma et al. (2008) sought to uncover individual characteristics to distinguish “persisters” (individuals whose gender dysphoria persisted from childhood into adolescence and adulthood) from “desisters” (individuals whose gender dysphoria remitted before or during adolescence). Persisters reported an increase in gender dysphoria when approaching adolescence as a result of three factors: changes to their social environments, anticipation and anxiety surrounding the onset of puberty, and experiences of romantic relationships and explorations of sexual orientation. Desisters reported a decrease in gender dysphoria during the same period persisters experienced an increase.

Desisters reported that their GNC behaviors and interests did not necessarily decrease, but that gender conforming behaviors increased such that gender non-conformity became integrated into a predominantly conforming overall gender identity and presentation. While persisters described puberty as a source of intense anxiety and heightened dysphoria, desisters
reported puberty as the source for their decrease in gender dysphoria. Both persisters and desisters reported the period between ages 10 and 13 as critical in their gender identity development. Desisters frequently reported a heterosexual orientation as substantially impacting their gender identity and gender dysphoria in adolescence whereas the sexual orientation of persisters varied. Overall, social environment, puberty, and romantic experiences proved important for both groups of adolescents; however there were no substantial differences in the experiences of either group across these three domains. Rather, the two groups seemed to intrinsically respond differently to the same circumstances over time, therefore additional research should be conducted to investigate relative social influences on gender identity development and gender dysphoria.

It should be noted that the sample utilized by Steensma and colleagues (2008) consisted of adolescents raised in families which supported their gender identities, gender role exploration, and gender presentation. Additionally, the adolescents reported comparatively low rates of teasing, bullying, and discrimination from peers both in childhood and adolescence. As such, this sample represents somewhat of an idealistic investigation that may be limited in its generalizability to samples of adolescents or young adults from less supportive family and peer social environments. Childhood gender non-conformity has been found to predict suicidality (both ideation and attempts) among adults when coupled with experiences of gender-related victimization and discrimination (Plöderl & Fartacek, 2007). The effect of gender non-conformity and victimization was particularly strong among participants who also identified with a minority sexual orientation (e.g., lesbian, gay, or bisexual) thus indicating the importance of investigating intersecting factors relevant to gender conformity and mental health outcomes.
Dummond, Bradley, Peterson-Badali, and Zucker (2008) conducted an investigation similar to Steensma et al. (2008), assessing whether gender dysphoria in childhood predicts gender dysphoria in adolescence/early adulthood. In a sample of 25 adolescent and young adult biological females (17 years of age and older), the researchers found that only 12% of participants reported clinically significant gender dysphoria at follow-up. Interestingly, the data revealed a “dosage” effect wherein participants who exhibited a greater magnitude of gender non-conformity in childhood were more likely to report gender dysphoria in adulthood. While these data remain preliminary, they offer useful insight into the experiences of GNC children and the outcomes of childhood gender non-conformity in adults.

**Gender non-conforming adolescents and adults.**

Gender non-conforming behaviors and presentations such as dressing in attire typically associated with another sex and primarily associating with peer groups of another sex regularly result in harassment and victimization experiences among adolescents. For example, a biological male who engages in primarily female non-romantic peer relationships and feels just as comfortable one day in a dress as in jeans and a sports jersey the next day may be subject to teasing, bullying, or other forms of physical or verbal violence (Toomey, Ryan, Diaz, Card, & Russell, 2010). Toomey et al. (2010) investigated relationships between gender non-conformity, victimization, and psychosocial adjustment in a sample of 245 LGBT young adults. Results indicated that gender non-conformity coupled with experiences of victimization relate to lower levels of psychosocial adjustment including lower overall ratings of life satisfaction and higher reports of depression. Similar to gender non-conformity in children, GNC young adults face increasing peer pressure with regard to gender presentation as gender roles become increasingly defined and delineated during adolescence and early adulthood. This social environment
facilitates potential for victimization experiences among GNC adolescents (Grossman & D’Augielli, 2006; Toomey et al., 2010).

GNC adults have similarly negative experiences with discrimination, victimization, and negative psychosocial outcomes, following the trend of gender non-conformity among children and adolescents. For example, Skidmore, Linsenmeier, and Bailey (2006) investigated relationships between gender non-conformity and psychological distress in a sample of 44 lesbians and 50 gay men. Childhood and current (adult) gender non-conformity (including both self-report and observer-ratings) were assessed in relation to depression and both state and trait anxiety. Attitudes toward gender non-conformity were also assessed. Results indicated that for both lesbians and gay men, adult gender non-conformity significantly related to a composite measure of global psychological distress. Gay men scored significantly higher on psychological distress than lesbian women, aligning with research on GNC children which indicates a higher degree of stigma for GNC biological males than for GNC biological females.

**Prevailing Assumptions**

While it has been noted that society, both its lay and scientific communities, have begun to increasingly recognize and seek to understand the transgender community and that existing research on general identity models make the assumption that their findings will generalize to transgender identities, research on these identities specifically remains rare. A number of barriers have hindered the development, process, and dissemination of such research, many of which pertain to assumptions about gender which prevail not only among laypersons but also among researchers and the scientific community. Norton and Herek (2013) noted that many of the pitfalls which plague gender identity research are very similar to those which previously plagued research into LGBQ identifications. These hindrances include aspects of social resistance
relating to prevailing beliefs (such as the prevailing belief that same-sex marriage is immoral or that gender exists exclusively as a binary), the persistence of negative attitudes toward individuals who challenge traditional gender roles (e.g. homophobia and transphobia), and a prevailing general lack of contact among the majority of the population with gender minority individuals thus facilitating the perpetuation of misunderstandings and fear of the unknown (Norton & Herek, 2013).

Commissioned by the New York State Department of Health, the Rainbow Access Initiative also researched and compiled a list of commonly prevailing assumptions regarding gender minority individuals: 1) common confounding of the constructs of sex and gender, 2) assumption of an exclusively binary representation of gender (male/female), and 3) the two-pronged assumption that gender and sexuality are either inextricably linked or entirely unrelated (Rainbow Access Initiative, 2009). Other authors have also pointed out the problematic assumption of a universal transgender experience, primarily the assumption that all individuals who express discontent with their natal gender will desire gender confirmation surgery (also known by a more stigmatized term, “sexual reassignment surgery” or “SRS”; Randell, 1971; Kockott & Fahrner, 1971).

It is likely that the inherently difficult nature of defining the constructs of gender and identity both separately and together as previously indicated, coupled with the aforementioned prevailing assumptions about gender and gender identity have hindered the progression of research into this domain thus far. However, as indicated by the social, clinical, and empirical spotlight which has come to focus on gender minorities within the last few years, improved understanding of transgender identities and their development has the potential to vastly benefit
not only the transgender community but also the doctors (psychological and physiological), communities, organizations, and researchers with whom the transgender population interacts.

Paxton, Guentzel, and Trombacco (2006) investigated challenges associated with conducting research relevant to the transgender community and proposed that the development of a research partnership (rather than repeatedly proposing hierarchical relationships of researcher-participant) with this community represents one promising avenue for facilitating future research. Tasked with identifying the needs/desires of the transgender community as well as research gaps regarding those needs, Paxton and colleagues identified a number of primary challenges facing researchers: 1) Transgender-identified participants may view cisgender researchers as outsiders and/or may mistrust researcher intentions, 2) Factors such as race and class influence interactions between researchers and transgender participants, 3) Some sub-sets of the transgender community may harbor animosity regarding perceptions of inequity of representation (e.g. research studies disproportionately displaying the voices of transgender males or binary-identified individuals), and 4) Transgender individuals may not approve of the term “transgender community”, feeling that this overgeneralizes and assumes homogeneity of transgender experiences. Future research should further investigate barriers to effective, respectful, and culturally competent research with transgender-identified and gender non-conforming populations, and may consider integrating the work of Paxton and colleagues as this knowledge base continues to expand.

Gender, Diagnostics and Stigmatization

Historically psychomedical communities (including social work, psychology, and the medical fields) have perpetuated many of the aforementioned assumptions within their approach to the transgender community, potentially quite to the detriment of the community they seek to
help. The first mention of gender-related psychopathology occurred in the third edition of the Diagnostic and Statistical Manual in 1980 (DSM-III; American Psychiatric Association, 1980). This edition of the manual included a diagnostic option for children (Gender Identity Disorder of Childhood) and for adolescents/adults (Transsexualism). The revised version of the manual, the DSM-III-R, added an additional diagnosis of “Gender Identity Disorder of Adolescence and Adulthood” to indicate individuals who experienced gender dysphoria but who could not be accurately categorized as transsexual (APA, 1987). The DSM-IV then collapsed these different diagnoses into a single diagnosis: “Gender Identity Disorder (GID)”, with separate criteria for children and adolescents and for adults (APA, 1994, 2000). The DSM-V then replaced the GID diagnosis with the less stigmatized option of “Gender Dysphoria”, also with separate criteria for children and for adolescents and for adults (APA, 2013).

As diagnostic approaches to individuals experiencing gender dysphoria have emerged and changed over time, the psychological community has engaged in significant debates regarding possible stigmatization surrounding diagnostic categories (Ault & Brzuzy, 2009; Ehrbar, 2010; Meyer-Bahlburg, 2011; Zucker & Bradley, 1997). Some authors have even argued that the initial inclusion of a diagnostic category of GID was linked to anti-homosexual attitudes and opposition to diagnosing children and adolescents as homosexual (For a summary see Zucker & Spitzer, 2010). In addition to the expansive debate over the potentially stigmatizing nature of categorizing transgender identities as pathological, a growing pool of medical literature has emerged to challenge these pathological conceptualizations of gender identity, stating that gender dysphoria results more from biological than from psychological characteristics (Coolidge, Thede, & Young, 2002; Berglund, Lindström, Dhejne-Helmy, & Savic, 2008; Meyer-Bahlburg, 2010).
Vitale (2001) proposed an alternative approach to psychopathology and the transgender community. She proposed that the diagnosis of GID (the primary diagnosis at the time, prior to the introduction of Gender Dysphoria as a diagnosis in the DSM-V) be replaced by a new diagnostic term: Gender Expression Deprivation Anxiety Disorder (GEDAD). Vitale posits that the gender dysphoria experienced by many transgender and gender non-conforming individuals results not from the gender identity itself, but instead from suppressed expression of that identity. Vitale describes five stages (corresponding to lifespan developmental stages set forth by developmental psychologists) of gender identity development for individuals experiencing what she described as GEDAD: Childhood (confusion and rebellion), Adolescence (false hopes and disappointment), Early adulthood (hesitant compliance), Middle age (feelings of self-induced entrapment), and Older adult (depression and resignation). These stages paint a rather melancholic image of the identity development of individual experiencing gender dysphoria and the stifling of identity expression described by Vitale as GEDAD. While this disorder was never accepted into the DSM as a diagnostic category, the theory leading to its formulation represents an interesting hypothesis regarding the potential origins or precipitating factors of gender dysphoria.

Vitale’s model also accounts for the fact that not all transgender-identified or gender non-conforming individuals report experiencing gender dysphoria through the division of three general categories of transgender identity: natal (biological) males who identify and present as female (“G1”), natal females who identify and present as male (“G2”), and natal males who identify as female but present largely as male (“G3”). Vitale reports a great deal of similarity between the experiences of G1 and G2-identified individuals, and that these two groups tend to experience very low levels of gender identity-based anxiety and gender dysphoria. G3
individuals, on the other hand, tend to experience gender dysphoria, at times quite significantly. The author hypothesizes that increased experiences of gender dysphoria stem from identifying someplace off the gender binary, as neither completely male nor completely female thus necessitating a more complex gender identity developmental process. While Vitale’s model is largely based in anecdotal evidence from years of clinical practice with transgender and gender non-conforming clients, it has not yet been empirically validated. Regardless, the concept of a third, vaguer category of gender identity (perhaps a generalized representation of non-binary gender identifications) that reports experiencing increased levels of gender dysphoria and psychological distress surrounding gender identity concerns represents a worthwhile exploration for future investigations. While Vidale’s theory remains preliminary, future empirical investigations building upon her foundation may offer some insight into the unique experiences of non-binary identified individuals and perhaps also into the mental health disparities experienced by the transgender community overall.

Fraser (2009) provided a summary of the history of clinical approaches to transgender clients, including the historical pathways of the Transgender Standards of Care (SOC) and of psychological diagnoses relevant to gender identity. Fraser notes a number of complications within the diagnostic nomenclature which have persisted across the decades, even as research and perceptions of transgender identities continually emerge and expand. For example, Fraser notes that the term “transgender” appears across the mental health discipline to characterize a vastly heterogeneous population. This term may be applied to any individual who experiences gender identity questioning or dysphoria as well as to individuals who self-identify as transgender and seek treatment relevant to dysphoria and/or physical transition. Developing transgender guidelines for care becomes increasingly complicated with such a variety of
definitions remain in use. Second, Fraser notes that applying diagnostic codes to specific gender identities serves to pathologize those identities. To address both of these issues, the author argues for a specified and non-pathologizing nomenclature where the term “transgender” is specifically defined within relevant contexts and where the definition does not serve to pathologize the gender identity itself.

Drescher (2010) conducted a similar investigation of historical debates regarding the diagnosis of gender identity-related concerns in the wake of the public comment prior to the release of the DSM-V (APA, 2014). Upon analyzing narratives within this debate, Drescher uncovered five primary themes of discontent and opposition regarding the diagnosis of Gender Identity Disorder (GID) as it appeared up until the DSM-IV-TR: (1) labeling gender variance as psychopathology stigmatizes an already stigmatized population, (2) eliminating GID from the DSM might lead insurance and other third-party payers to deny access to healthcare for transgender individuals, (3) retaining the GID diagnosis may lead to the re-introduction of homosexuality as a psychological disorder, (4) allowing for a diagnosis during childhood/adolescence may perpetuate unethical treatment interventions during vulnerable age categories, and (5) many argued that the work groups tasked with debating and drafting the DSM-V held disproportionately trans-negative attitudes, thus creating the possibility that any revised guidelines may be more (rather than less) pathologizing. These concerns were largely alleviated through the removal of GID as a diagnosis and the creation of a “Gender Dysphoria” diagnosis instead which presents the identity conflict and emotional distress as foci of treatment, rather than the gender identity itself; however it is unlikely that this debate will end with the DSM-V and the entrance of the Gender Dysphoria diagnosis.
Misdiagnosis and the prevalence of stigmatizing diagnoses such as GID over the years have perpetuated a sense of discrimination, mistrust, and hesitance among the transgender community to seek out mental health services (Benson, 2013; Danoff, 2009; McCann & Sharek, 2014; McIntyre, Daley, Rutherford, & Ross, 2011; Shipherd, Green, & Abramovitz, 2010). While the diagnosis of Gender Dysphoria appears less stigmatizing than the previous diagnosis of GID through its emphasis on the dysphoria and psychological distress rather than on the pathologizing of transgender and gender non-conforming identities, this diagnosis is relatively recent and should be rigorously investigated on a number of fronts moving forward. For example, prevalence rates, precipitants, antecedents, and mental health correlates of Gender Dysphoria diagnoses would provide a wealth of information regarding whether the newer diagnosis is less stigmatizing/pathologizing than its predecessor. This form of research is imperative moving forward in order to minimize iatrogenic effects of treatment and diagnosis with clients who identify under the transgender umbrella. Such ongoing research and frequent re-evaluation of diagnostic systems relating to gender identity may help to combat the lingering stigma which leads mental health providers to avoid working with transgender clients (whether due to personal biases or fears of being unwittingly discriminatory) and which leads transgender individuals to avoid seeking mental health services due to fear of stigma, discrimination, misdiagnosis, or inappropriate treatment. Moving the psychological community in this direction requires input and cultural competence from both researchers and clinicians alike.

Gender Variance and Clinical Cultural Competence

A great deal of research and models for clinical competence have failed to address the possibility of a heterogeneous population which may not necessarily fit into the categories of “male”, “female”, and/or “transgender”. Regardless, a strong body of qualitative and theoretical
evidence is mounting in support of a non-binary conceptualization of gender. Non-binary conceptualizations of gender posit that the construct falls on (or even off) a flexible spectrum rather than into discrete and mutually exclusive categories. For example, community education websites regarding the transgender community (such as GLAAD, 2014; Lesbian and Gay Community Services Center, 2013) emphasize that the term “transgender” is an umbrella term used generally to encompass a vast variety of individual identifications, and that some individuals may not self-identify with the umbrella term “transgender” at all. These resources also emphasize the concept of gender as a fluid construct within the transgender community, and gender identity as an even more fluid construct as individuals may adopt different self-labels for their gender identities at different stages in their lifespan and identity development. Colloquially the term “TGNC” (specifically with an asterisk) has emerged as an alternative to the use of “transgender”. “TGNC” has emerged as a more explicit reference to the fact that “transgender” is simply an umbrella term, not an all-inclusive term pertaining to all individuals who do not identify as male or female according to their sex at birth (Killermann, 2011). While a simple Google search will return hundreds of blogs and informative webpages providing similar content regarding non-binary gender and the linguistics of self-identification, empirical investigations have not yet followed suit.

Allowing for consideration of rarely or entirely unaddressed non-binary gender identifications, it becomes clear that such individuals may then struggle not only with existing as a marginalized identity individual but also with the fact that this marginality remains unnoticed and unaddressed not only within society, but also within mental health disciplines. For example, individuals who identify as transgender yet do not wish to physically transition to a gender role other than their assigned sex (whether via hormone replacement treatment, gender confirmation
surgery, or otherwise) may have difficulty accessing treatment for mental health concerns resulting from their identity because the diagnosis of Gender Dysphoria relies almost entirely on potentially archaic gender norms (e.g. preferences for alternate-gender roles) and physiological features (e.g. dislike of sexual anatomy) (APA, 2013). For example, an individual who identifies as gender-fluid may self-identify with different gender identities from one day to the next. This individual may experience gender dysphoria throughout this process, but they may not. Such an individual may seek therapy to better understand the nature of their complex identity, but struggle to receive treatment without the existence of other clinically relevant symptoms (e.g. depression, anxiety) as insurance providers require diagnoses for reimbursement.

Fortunately, the importance of exploring, understanding, and gearing interventions and competency training toward these concerns has not gone unnoticed by the psychological community. Carroll, Gilroy, and Ryan (2002) describe the history of perceptions of the transgender community and particularly emphasize describing unique characteristics and issues which bear relevance upon counseling and mental health scenarios. The authors urge counselors to be particularly aware of the intense negative stigma that society places upon transgender individuals, and that counselors working with transgender clients should seek diversity training relevant to these experiences in order to uncover any biases they may possess. Most notably, the authors emphasize that counselors should seek to better understand the transgender community through reading case studies and autobiographies first and foremost, and by approaching empirical articles and more structured research programs only after an initial foundation of understanding has been established.

Current guidelines.
In recent years, formal organizations have taken up the torch of advocating for counseling competencies directed toward transgender and gender non-conforming clients. In 2009 the Association of Lesbian, Gay, Bisexual, and Transgender Issues in Counseling (ALGBTIC) published a series of competency guidelines theoretically rooted in multiculturalism, social advocacy, and feminism. The authors also based their recommendations for best practices in past research on guidelines for working with lesbian, gay, and bisexual (LGB) clients as well as in the vast body of research pertaining to therapeutic work with marginalized populations in general.

The authors highlight eight primary domains which competent counselors will be aware of and will address in their work with transgender clients. The first domain pertains to Human Growth and Development. This domain requires counselors to acknowledge the developmental nature both of transgender identity and of issues pertaining to that identity. Social stigma, family and environmental factors, and negotiations in intimate relationships should be examined from a life-span developmental framework. The second domain, Social and Cultural Foundations, requires counselors to use appropriate and non-stigmatizing language with transgender clients and to acknowledge social forces of oppression and discrimination with particular attention to any intersectionality that may occur with race/ethnicity, ability, class, religion, etc. The third domain, Helping Relationships, requires counselors to understand that their role is to be supportive in helping clients explore their identities and navigate their lives in those identities, not to change the identity itself. Counselors should also recognize that historically healthcare has been a scarce resource for the transgender community and this history may influence client-therapist interactions. The fourth domain, Professional Orientation, requires counselors to recognize the history of psychology as it pertains to transgender individuals including the development of the DSM and the stigmatizing and/or exclusive nature of some diagnoses.
Counselors should seek consultation and supervision whenever possible. The fifth domain, Career and Lifestyle Development Competencies, requires counselors to recognize stereotypes regarding occupations for transgender individuals, and obstacles this population may face in seeking employment. The domain of Appraisal requires counselors to carefully examine the nature of the referral of the client and the goals of treatment. Lastly, the Research domain requires counselors to understand the strengths and weaknesses of research on transgender issues to date and to remain up to date in reading this literature (ALBGTIC, 2010).

In addition to the American Counseling Association, the World Professional Organization for Transgender Health (WPATH) proposed a document detailing the Standards of Care (SOC) for the health of transsexual, transgender, and gender non-conforming individuals. These standards, supported by the American Psychological Association, are intended to help mental healthcare providers (and other healthcare providers) provide gender-affirming care to patients and clients who identify under the transgender umbrella. Four sections of the standards of care bear particular relevance to the mental healthcare community: The difference between non-conformity and gender dysphoria (III), Overview of therapeutic approaches for Gender Dysphoria (V), Assessment and treatment of children and adolescents with Gender Dysphoria (VI), and Mental Health (VII). Section III highlights the difference between diversity (gender non-conformity) and pathology (gender dysphoria). While gender non-conformity represents a pattern of gender expression that differs from cultural norms, gender dysphoria represents distress caused by a discrepancy between a person’s experienced gender identity and the sex they were assigned at birth. Treatments exist to facilitate the exploration of gender identity to alleviate gender dysphoria, but the SOC highlight the importance of not pathologizing gender non-conformity, as not all gender non-conforming individuals experience gender dysphoria, nor do
all individuals who experience gender dysphoria present their gender in a non-conforming manner (Coleman et al., 2012).

Section V of the WPATH guidelines details a non-exhaustive list of potential treatment avenues for the alleviation of gender dysphoria. These include psychological options such as therapeutic exploration of gender identity, in vivo (in real life) exploration of gender roles, coping with stressors related to gender identity and experiences of discrimination and stigma, developing positive body image, building up social support systems, and encouraging resilience. Section V also includes a number of physiological interventions such as hormone replacement therapy (HRT) or gender confirmation surgery (GCS). Section VI builds upon this information to describe the assessment of Gender Dysphoria among children and adolescents, emphasizing the importance of discriminating between gender role exploration typical of childhood and true gender dysphoria in children or adolescents. Additionally, gender non-conformity in children must not be confused with Gender Dysphoria. Misdiagnosis has the potential to vastly stigmatize children when the research largely indicates that Gender Dysphoria diagnosed during early childhood persists into adulthood in less than half of known cases (for a review of this literature see WPATH, 2011, p. 11).

Lev (2009) proposed that while the SOC set forth by WPATH represent a step in the right direction toward gender-affirmative care for transgender and gender-nonconforming clients and patients, these standards could benefit from revision. For example, Lev argued for a decrease in the role of “Gate-keeping” for clinicians, advocating instead for an increase in personal gender-identity specialization and training and increased procedures of informed consent and harm reduction in work with transgender-identified clients. Second, Lev highlights the importance of increased focus on family and peer support systems in the SOC, as well as occupational
environments. Third, Lev argues for increased accommodation of gender diversity within the transgender and gender non-conforming communities, allowing for a variety of gender identity self-identifications as well as for the lifespan nature of this developmental process. Lastly, Lev encourages WPATH to enlist the training of gender specialists, clinicians who would receive specific and advanced training related to gender, gender identity, discrimination, victimization, and clinical issues relevant to transgender and gender non-conforming clients. While Lev’s recommendations have not yet been heeded by WPATH, they do indicate that the state of culturally competent care for transgender clients remains in a state of transformation, and that consistent re-evaluation of current models and conceptualizations may represent the most beneficial path toward gender-affirmative care.

A number of other models of clinical competency have been developed over the years which contain similar recommendations to those mentioned above (For examples see: Singh, Hays, & Watson, 2011; O’Hara, Dispenza, Brack, & Blood, 2013; Smith, Shin, & Officer, 2012). However, existing models for clinical competency address the diverse community of gender variant individuals under the general term of “transgender”, implying an assumption of a common transgender experience which may or may not exist in reality. Burge (2007) proposed an earlier framework for approaching clinical work with transgender clients which allows for the presence of non-binary identities among individuals who may not identify particularly strongly with the term “transgender”. The authors maintain that the over-use of the term transgender to describe a diverse and heterogeneous population of clients can be just as detrimental to those clients as society’s overemphasis on a perceived exclusivity of dichotomous gender identifications. Most notably, the authors argue that social workers and other individuals in helping professions who may work with transgender clients should adopt an affirming stance
regarding the gender of their clients, validating the individual identification of the client rather than imposing the umbrella label of transgender upon them.

In 2008, the American Psychological Association (APA) convened a two-year task force to re-assess standards relating to “Gender Identity and Gender Variance” (APA, 2008). This task force reviewed the literature summarized above and created recommendations pertaining to vocabulary and gender variance, similar to Appendix B below. Following the release of this report, the Task Force shifted its attention toward the formation of treatment guidelines in alignment with report conclusions. The “Guidelines for Psychological Practice with Transgender and Gender Non-Conforming People1”, adopted as APA policy in August 2015, include 16 recommendations for culturally competent psychological work with TGNC clients (APA, 2015b). These guidelines address the shortcomings of previous models and recommendations—particularly in their explicit inclusivity of both binary and non-binary gender identifications. For example, they define “Gender Identity” as “a person’s deeply felt, inherent sense of being a girl, woman or female; a boy, man, or male; a blend of male or female; or an alternative gender” (APA, 2015b, p. 4).

The TGNC Practice Guidelines include five over-arching domains: Foundational Knowledge and Awareness (1), Stigma, Discrimination, and Barriers to Care (2), Lifespan Development (3), Assessment, Therapy, and Intervention (4), and Research, Education, and Training (5). The first domain includes four guidelines tasking clinicians with understanding that: 1) Gender exists on a non-binary spectrum and is not synonymous with sex assigned at birth; 2) Gender identity and sexual orientation are separate, but related; 3) Intersectional identities such as race/ethnicity, socio-economic status, immigration status, and religion/spirituality (among others) influence TGNC people and require clinical awareness; and

1 Henceforth referred to as “The TGNC Practice Guidelines” for brevity.
4) Personal implicit biases, attitudes, and beliefs regarding an individual’s gender identity or gender expression can influence care quality provided by clinicians.

The second domain includes three guidelines tasking clinicians with understanding the unique experiences of TGNC individuals with regard to stigma and discrimination and the barriers to care experienced by TGNC individuals due to their (perceived or actual) gender identity/presentation. This domain asks clinicians to maintain awareness of increased experiences of stigma, prejudice, discrimination, and violence among TGNC people and the impacts these experiences can have upon well-being—physiological and psychological. Second, this domain encourages psychologists to acknowledge systems-level barriers to care faced by TGNC people. For example, widespread lack of gender-inclusive restrooms and experiences of Pathologization and/or repeated victimization from healthcare providers or the criminal justice system. Lastly, this domain highlights the need for psychologists as agents of social change to reduce the negative impacts of stigma, discrimination, and institutional barriers upon the well-being of TGNC people.

The third domain includes two guidelines encouraging psychologists to become aware of differential manifestations and challenges related to gender identity at various lifespan stages including childhood, adolescence, early adulthood, adulthood, and among the elderly. For example, childhood gender dysphoria or TGNC identifications among youth may or may not persist into adulthood. Additionally, a paucity of research includes elderly TGNC-identified participants thus excluding elderly cohorts from current understanding of TGNC experiences. Psychologists are encouraged to maintain awareness of how age may influence gender role socialization, the manifestation of intersectional identities with regard to gender
identity/expression and mental health, identity disclosure, and transitions (social and physiological).

Domain four pertains to assessment, therapy, and intervention with TGNC people. These five guidelines begin by stressing the understanding that a TGNC client’s mental health concerns may or may not relate to their gender identity or presentation and that research increasingly indicates a correlation between social support and/or receipt of trans-affirmative care and improvements in well-being. Examples of trans-affirmative care provided include understanding of: 1) How gender identity/expression might impact romantic and sexual relationships for TGNC people; 2) Differential manifestations of parenting and family formation among TGNC people; and 3) The importance of interdisciplinary collaboration in work with TGNC clients.

The fifth and final domain of The TGNC Practice Guidelines pertains to research, education, and training. One guideline encourages psychologists to respect the rights and well-being of TGNC research participants both in terms of research methodology and integrity of reported results. Last but not least, Guideline 16 requests that psychologists aspire to prepare trainees to work competently with TGNC people in accordance with the aforementioned guidelines. The TGNC Practice Guidelines were adopted as APA policy during the APA 2015 Convention in Toronto, Ontario. In a panel session at this convention, the authors of the TGNC Practice Guidelines discussed the process of formulating the guidelines and emphasized guideline dissemination and implementation as critical next steps in competent psychological work with TGNC clients (Haldeman, Mattu, dickey, Singh, Anderson, & Sickle, 2015).

Despite the existence of the aforementioned recommendations for culturally competent clinical work with transgender-identified patients and clients, there remains a marked absence of opportunities for formal training on this topic and dissemination of guidelines and
recommendations remains limited. Rutherford, McIntyre, Daley, and Ross (2012) interviewed actively practicing mental healthcare providers (including psychiatry, social work, psychotherapy, and general psychology disciplines) with at least two years’ experience working with LGBTQ clients. All eight of these providers also self-identified as members of the LGBTQ community; however they described this group membership as beneficial but not sufficient to cultivate culturally competent practice, and still reported sensing a general lack of opportunities for more formal training in clinical work with LGBTQ clients. Participants overall described the following four themes as central to developing cultural competence within mental health providers working with the LGBTQ population: LGBT self-identity, need for LGBT-sensitive services, developing a practice focus on LGBT mental health, correcting the inadequacy of currently available training, and developing specific training programs relevant to LGBTQ mental health. Together, formal training along these themes would facilitate the development of culturally competent expertise in working with this population.

While many of the aforementioned models of clinical competency have emphasized the importance of understanding, open-mindedness, affirmation, and individual experiences, the general trend appears to still dichotomize gender which may be problematic or even iatrogenic (Burge, 2007). Dichotomization is dichotomization, and rendering individual identities into either “transgender male” or “transgender female”, while a notable improvement upon the archaic approach of forced identifications based upon sex assigned at birth, is scarcely different than imposing the cis-normative labels of “male” and “female” upon individuals. As the aforementioned body of research continues to grow, approaches to clinical competency and future investigations must expand likewise. Research repeatedly indicates a great deal of heterogeneity in the experiences, desires, and identifications of what has previously been referred
to as a single population of transgender individuals, and yet very few have sought to parse out those intra-group individualities in order to better inform future empirical investigations and clinical interventions.

**Gender Dysphoria Treatment**

While the earliest attempts at treating individuals who expressed identifying as transgender focused primarily on “restoring” that individual’s gender identity such that it would eventually align with the sex they were assigned at birth, such methods quickly fell out of favor and were replaced by treatments geared toward sex reassignment (altering the physical form of an individual to more closely align with societal expectations for their experienced gender identity, whether through the use of hormones, surgical procedures, or both). Bockting (2008) provides a summary of this history while indicating that most recently an individualistic, client-centered approach has become the chosen avenue of treatment for individuals presenting in therapy with Gender Dysphoria or gender identity concerns. This support for an individualized approach has arisen out of a gradual history of unfolding understanding regarding the vast heterogeneity present among transgender-identified populations. For example, not all individuals seek HRT nor do all individuals seek GCS, nor do all individuals who seek to explore their gender identity experience Gender Dysphoria. Experiences with gender identity appear to be highly individualized, thus modern treatment protocols following both APA guidelines and WPATH Standards of Care support individualistic treatment approaches.

While the current state of knowledge supports individualized therapeutic approaches to transgender-identified and gender non-conforming clients, this does not mean that treatments cannot proceed following empirically supported trends in psychology. A number of models have already emerged as attempts to categorize and streamline even these individualized approaches.
For example, Bockting (2008) described a therapeutic approach which emphasizes gender role exploration (e.g. living full-time in the role of one’s experienced gender identity), facilitating the development of coping skills for navigating stressors such as stigma (both external and internalized) and discrimination, treating co-existing or previously existing mental health concerns (e.g. anxiety or depression which may or may not be inextricably linked to experiences of Gender Dysphoria), and managing the gate-keeping role (i.e. referrals from licensed therapists are often required before clients can proceed with HRT or GCS, therefore the therapist may help the client negotiate this immense decision and ensure that the client proceeds only after thorough exploration of identity-related concerns at hand).

Chen-Hayes (2001) proposed an additional clinical model for work with transgender clients which could potentially supplement that proposed by Bockting (2008). Chen-Hayes emphasizes a strength-based model (as opposed to a pathology-based model) which focuses on developing characteristics of strength and resiliency within transgender clients, and then utilizing those characteristics to enact positive change in self-perceptions and self-identification. The author proposes a number of guidelines to facilitate clinicians’ ability to follow this model including awareness of personal (clinician) preconceptions and biases regarding gender, the diligent use of correct gender pronouns (specifically the self-identified preferred gender pronoun or PGP of a client), awareness and coaching of clients regarding issues of gender identity self-disclosure (e.g. planning or even modeling dialogues involving affirming, factual, non-confrontational disclosures of gender identity), and focusing on multiple oppressions and intersectional minority stress (e.g. an African American, elderly, MTF Transgender-identified individual may face discrimination and biases daily based not only on gender identity but also on racial/ethnic identity, age, or other factors).
Hendricks and Testa (2012) further investigated the concept of multiple oppressions and intersecting minority identity-related stressors among transgender-identified clients. These authors developed a conceptual framework for work with Transgender clients which focuses not on gender identity exploration or Gender Dysphoria, but which instead addresses clinical approaches to helping clients cope with experiences of victimization and discrimination related to their gender identity. This framework was based on Minority Stress Theory which states that due to minority status (identifying as transgender or gender non-conforming), individuals face a greater amount of societal and interpersonal stress (e.g. victimization and discrimination) which places them at higher risk for mental health disorders (Meyer, 2003). See the section later in this review labeled “Theoretical Approaches to Disparity Origins” for additional information on this theoretical approach. Hendricks and Testa’s recommendations for a culturally competent conceptual framework for work with transgender clients appears relatively simple compared to previous models, at face value, however its two concise prongs largely encompass and supplement recommendations from aforementioned models.

Hendricks and Testa provide two recommendations for clinicians: 1) Increase understanding of trans identities and experiences and 2) Provide culturally competent assessment and treatment. Recommendation one involves elements of both personal exploration (on the part of the clinician) as well as formal training whereas recommendation two involves consideration of factors that may not appear relevant to therapeutic work at face value (e.g. mistrust of clinicians among the transgender community, trauma history, or discontent regarding the history of psychological approaches to the transgender community such as stigmatized diagnoses and treatments).
Given the aforementioned body of research regarding clinical work and therapeutic treatment with transgender and gender non-conforming clients, a number of overarching themes emerge. While authors vary in the number of recommendations, the phrasing of their recommendations and the framework from which they develop their models (e.g. counseling, psychology, psychodynamic orientations, emotion-focused orientations, or cognitive-behavioral orientations), models for clinical approaches also overlap significantly. For example, most researchers and theorists agree that culturally competent work with transgender clients involves both personal reflections on the part of the client as well as consideration of social and political influences on the lives of transgender and gender non-conforming individuals. Most also agree that individualized treatment has the highest potential to benefit those who identify as transgender, given the vast heterogeneity evident among transgender and gender non-conforming populations. Unfortunately, these concepts remain theoretical as they have not yet been empirically tested, nor have the perspectives and desires of transgender-identified individuals themselves been explored with regard to psychological treatments. Future research should further investigate these critical avenues of understanding.

**TGNC Mental Health Disparities**

Improving clinical cultural competency for psychological and medical professionals working with transgender clients/patients is paramount to beginning to address the mental health disparities faced by this population. While little research has specifically investigated health disparities among the transgender population, a substantial body of research indicates significant mental health disparities among lesbian, gay, and bisexual populations. Frost, Levahot, and Meyer (2013) found that gay men and lesbians (compared to heterosexually-identified peers) experience higher rates of substance abuse disorders, mood disorders, and higher rates of suicide.
attempts and completed suicides. Additionally, Cochran, Sullivan, and Mays (2003) surveyed a sample of almost 3,000 LGB adults and found increased rates of depression, panic attacks, and overall psychological distress among gay men compared to straight men, and increased rates of generalized anxiety disorder among lesbian women compared to straight women. These results were later replicated by Mustanski, Garofalo, and Emerson (2010) who found increased rates of conduct disorder, major depression, post-traumatic stress disorder, and more frequent reports of lifetime suicide attempts among LGB participants compared to heterosexual rates. Interestingly, these researchers found similar rates of mental illness among their LGB sample compared to other representative samples of urban, racial/ethnic minority youth, thus lending additional support to potential comparisons of the burgeoning field of LGBTQ health research to past research on disparities among other marginalized groups.

One study, conducted by Bockting, Miner, Romine, Hamilton, and Coleman (2013) among 1,093 transgender adults found high rates of clinical depression (44%), anxiety (33%), and somatization (28%). These researchers found higher rates of psychological distress related to higher rates of discriminatory experiences, and lower overall distress related to increasing levels of social support from within the transgender community. Increased rates of substance abuse were also found by Benotsch et al. (2013) in their investigation of non-medical use of prescription drugs among a sample of 155 transgender adults. Additionally, Simons, Schrager, Clark, Belzer, and Olson (2013) found that parental support protects against many mental health risks experienced by transgender youth. This suggests not only that the transgender community may experience disproportionately high rates of psychological distress, but that a number of malleable influences have the potential to moderate the degree of distress experienced.
The few existing studies investigating transgender mental health disparities appear to indicate a trend similar to past research on health disparities among marginalized populations: transgender individuals appear to experience higher levels of both overall psychological distress and diagnosable mental illnesses compared to cisgender peers. Unfortunately, in a survey of National Institutes of Health (NIH)-funded projects investigating LGBT health issues, only 6.8% of studies between 1989 and 2011 specifically highlighted transgender health concerns (Coulter, Kenst, Bowen, & Scout, 2014). This immense disparity in studies specifically pertaining to the transgender population highlights the imperative nature of future research into these issues, as it is difficult to assume that factors relevant to lesbian, gay, bisexual, and queer individuals are identical to those relevant to transgender individuals without a strong empirical foundation for such an assumption.

Other Disparities Contributing to Mental Health

In addition to the aforementioned mental health disparities faced by transgender and GNC populations, disparities exist with regard to homelessness, HIV/AIDS, educational attainment, and interactions with the criminal justice system (Grant, Mottet, Tanis, Harrison, Herman, & Kiesling, 2011). For example, Cochran, Stewart, Ginzler, and Cauce (2002) conducted a comparison of LGBTQ to non-LGBTQ homeless youth and found that homeless youth who also identified as LGBTQ were at significantly higher risk of leaving home at an earlier age and leaving home more frequently than non-LGBTQ peers. Additionally, the researchers found that homeless LGBTQ youth reported increased rates of victimization (both physical and sexual), substance abuse, depressive symptoms, and behavioral pathology compared to non-LGBTQ peers. One potential factor to attribute for these homelessness disparities is the nature of homeless shelters in the United States as typically segregated by
gender. This makes it difficult for transgender-identified individuals to find safe and identity-affirming shelters (Mottet & Ohle, 2006).

Transgender and GNC individuals also face increased prevalence rates of HIV/AIDS compared to cisgender individuals (for a meta-analysis of this literature see Herbst, Jacobs, Finlayson, McKleroy, Neumann, & Crepaz, 2008). While the 29 studies included in the meta-analysis conducted by Herbst and colleagues (2008) included only transgender male and transgender female-identified participants thus excluding or incorrectly categorizing GNC participants, the data offer insight into some degree of intersectionality with regard to HIV/AIDS risk among transgender populations. For example, the researchers identified higher rates of infection among African-American MtF (male to female) individuals compared to other racial/ethnic identifications. Additionally, MtF participants had higher rates of infection and engaged in more risky behaviors (e.g., unprotected intercourse, sex work, and having multiple casual partners) than FtM participants. The authors note that factors such as unmet healthcare needs, distrust of healthcare systems, physical and sexual victimization experiences, lower socio-economic status, and social isolation may contribute to these HIV/AIDS-related disparities.

Homelessness and HIV/AIDS disparities among transgender and GNC populations may be related to one another, as some research has indicated that behaviors that place individuals at higher risk for contracting HIV/AIDS have higher prevalence among homeless and marginally-housed transgender individuals (Fletcher, Kisler, & Reback, 2014). Furthermore, additional analyses revealed that housing status moderated the relationship between risky behaviors and HIV status thus highlighting the importance of conducting additional research into the nature of these disparities which can have immense implications in the lives of transgender and GNC individuals. Some researchers, for example, have highlighted the role of stigma, socio-economic
status, hyper-sexualization, lack of identity-affirming outreach services, and experiences of a second puberty due to cross-hormone treatment as factors contributing to increased rates of risk-taking behavior and HIV/AIDS among transgender and GNC populations (Kosenko, 2011).

Transgender and GNC individuals also face heightened disparities regarding involvement with the criminal justice system. The National Center for Transgender Equality and the National Gay and Lesbian Task Force produced a detailed report on Transgender and GNC disparities (Grant et al., 2011). This report which utilized a sample of 6,436 self-identified TGNC participants found that of the participants who reported interactions with the police, 22% stated that they experienced harassment by the police due to gender identity-related police bias during these interactions. Of those who reported experiencing harassment by the police, 6% reported physical assault and 2% reported sexual assault as a result of their gender identity or gender presentation (p. 158). Of those participants who did not report experiencing outright harassment by police, 20% reported receiving unequal services as a result of their gender identity/gender presentation, and a total of 7% reported being placed in a holding cell in jail exclusively due to their gender identity or gender presentation. Intersectionality again emerged as a factor contributing to these disparities as 41% of black and 21% of Latina/o participants reported being placed in a holding cell exclusively due to their gender identity/presentation.

The results of the Task Force (Grant et al., 2011) highlight the importance of investigating factors contributing to disparities experienced by transgender and GNC individuals as a result of their gender identity or gender presentation. Despite the fact that the aforementioned body of literature indicates heightened rates of victimization experiences among transgender and GNC individuals, these same individuals often face additional harassment, victimization, and discrimination from the police if they seek assistance. It is therefore
unsurprising that 46% of participants stated that they would not feel comfortable seeking police assistance if they were the victim of a crime. The presence of such prominent biases within the criminal justice system resulting in harm caused to individuals this system exists to protect provide evidence for the pervasive nature of minority stress, microaggressions, and other discriminatory experiences faced by transgender and GNC individuals daily.

Theoretical Approaches to Disparity Origins

**Minority Stress Theory.**

One theory regarding the origins of these aforementioned mental health disparities is Minority Stress Theory (Meyer, 1995). Minority Stress Theory posits that living with the daily stigma of a minority identity (that of an LGBTQ individual) causes increased chronic stress for LGBTQ individuals and places them at higher risk for experiencing psychological ailments. Furthermore, limited social supports may restrict the resiliency of LGBTQ individuals in light of those increased stressors. For example, LGBTQ individuals must not only come to terms with their own LGBTQ identities and decide the extent to which they will disclose that identity to others in infinite social scenarios, but they must also do so in a world which confronts them frequently with homophobia. Some LGBTQ individuals may internalize this homophobia during their struggle to come to terms with their sexual orientation identity, thus adopting homophobic beliefs such as that homophobia is immoral, and then directing this hostility and negativity inward toward that portion of their identities or toward themselves as wholes. Meyer (1995) also describes perceived social stigma regarding LGBTQ identities and prejudice events (discrimination and violence) as stressors in addition to internalized homophobia which LGBTQ individuals must confront. Meyer tested the minority stress hypothesis in a sample of 741 gay
men in 1995, and has replicated these results in a number of additional follow-up studies since that time (Meyer, 1995, 2003; Dean, Meyer, Robinson, Sell, Sember, Silenzio, & Scout, 2000).

Minority stress theory has been theoretically implicated as potentially contributing to the mental health disparities experienced by the LGBQ and, particularly, by the transgender (T) population. Experiences of perceived discrimination have been found to negatively impact mental health service utilization among LGBT individuals (Burgess, Lee, Tran, & Ryn, 2008). Not only did Burgess and colleagues (2008) find that LGBT participants had higher rates of psychological distress including depression, anxiety, and substance use, but that these individuals were more likely to report that they had unmet mental health needs. This indicates that this population might objectively benefit from mental health services (based on their increased reports of psychological distress compared to heterosexuals), and also that they subjectively report the desire to receive additional services currently unavailable to them. Additionally, while LGBT participants reported a greater degree of psychological distress than heterosexual participants, they also reported that they would be significantly less likely to seek out mental health resources to help address their distress. While adjusting for discrimination did not appear to significantly reduce mental health disparities between LGBT and heterosexual participants, it was significantly related to mental health service utilization. This indicates that while discrimination did not fully account for mental health disparities themselves, it does appear to contribute to the ways LGBT individuals seek to cope with mental health disparities once they arise. Specifically, LGBT individuals report being more likely to cope using substances (alcohol or various drugs) or avoidance, and significantly less likely to seek professional help with navigating these complex situations.
While Minority Stress Theory was initially conceptualized in relation to minority sexual orientations (e.g., lesbian, gay, bisexual) its premises can readily adapt to the experiences of transgender and GNC populations. For example, Meyer (1995) described three categories of minority stress: internalized homophobia (adopting society’s negative attitudes regarding the minority identity and directing these attitudes toward the self), stigma (chronic expectations of rejection and discrimination from society), and overt experiences of discrimination and violence. The concept of internalized homophobia adapted for transgender and GNC populations includes both transphobia (fears and negative societal attitudes toward transgender identities and the individuals who hold them) and cissexism (pervasive systematic societal biases in favor of cisgender individuals). Concepts of stigma and overt experiences of discrimination/violence apply in their original form to transgender and GNC populations (Hendricks & Testa, 2012).

Hendricks and Testa (2012) summarized past research with regard to health (physiological and psychological) and occupational disparities among transgender and GNC populations within the context of Minority Stress Theory. These disparities are hypothesized as resulting from chronic minority stress experiences and not from the minority identities themselves; therefore this model does not pathologize transgender or GNC identifications. Overall, the research supports Minority Stress Theory as an explanatory (though not causal) factor in the disparities discussed earlier in this review. For example, Testa, Sciacca, Wang, Hendricks, Goldblum, Bradford, and Bongar (2012) investigated relationships between violence (physical and sexual) and suicidality (ideation and attempts) and substance use. Utilizing a sample of 179 transgender women and 92 transgender men, the authors found that both transgender men and women who had experienced either sexual or physical violence were significantly more likely to report a history of multiple suicide attempts and of alcohol abuse.
Despite the increased prevalence of victimization experiences and the negative health implications of such experiences, the authors also found that transgender participants reported predominant hesitation and avoidance of reporting gender-motivated crimes to police. These findings highlight the importance of investigating transgender and GNC victimization and discrimination experiences within a greater theoretical context such as through Microaggression Theory or Minority Stress Theory, as the experiences of these populations are embedded within greater societal contexts.

**Social Justice Theory.**

A second theory posits that inadequate or even unavailable mental healthcare opportunities allow for the perpetuation of mental health disparities among the transgender population. Social Justice Theory (Rawls, 1971) conceptualizes justice in terms of fairness, or of equal distribution across various social groups (e.g., race, class, gender). Rawls primarily advocated that the ideal social state consisted of equal opportunities and resources for all, but allowed for inequality in instances of providing additional resources and opportunities to individuals in social positions that afforded them fewer assets and opportunities compared to other social groups (e.g., additional resources for racial/ethnic or gender minorities). Bankston (2010) noted that Rawls’ division of individuals into social categories based on social position and relative advantages/disadvantages “lends itself to understanding these categories as defined by victimization or oppression (that is, as matters of race, class, gender)” (p. 175). As a result, Social Justice Theory as conceptualized by Rawls (1971) and those who built upon his foundational writings offers a useful lens for observing and interpreting disparities experienced by transgender and GNC individuals.
Evidence in support of Social Justice Theory abounds in modern experiences of transgender and GNC individuals who frequently experience disproportionately low access to adequate resources and opportunities compared to cisgender and other majority social groups. For example, in a study of 101 transgender participants in New York City, Sanchez, Sanchez, and Danoff (2009) found that while the majority of the sample (77%) had medical insurance, participants perceived a number of other factors acting as barriers to effective health interventions. These perceived barriers largely revolved around uninformed or mis-informed healthcare providers. For example, participants reported perceiving a profound lack of providers who were either open/amicable toward transgender identities or knowledgeable regarding those identities. While locating a healthcare provider who is both open and knowledgeable regarding heterosexual identities and health concerns generally does not appear as a barrier to care, this search proves significantly more difficult for the transgender population.

McCann and Sharek (2013) found similar results in a sample of 125 LGBT participants via a mixed-methods design including both quantitative questionnaires and qualitative interviews specifically assessing perceptions of mental health care providers. The majority of participants (63%) reported feeling as though they could not disclose their LGBT identity to mental healthcare providers and felt that providers lack knowledge about LGBT-specific needs and issues (64%). Additionally, 43% of participants felt that mental health practitioners were unresponsive to their needs as an LGBT client thus making it more difficult and less likely for these clients to benefit from work with such providers.

Benson (2013) further investigated identity-specific experiences with mental health providers in their qualitative investigation of transgender client experiences with mental health care. Benson highlights the general, yet gradual, societal trend toward increased understanding
and openness toward the transgender community alongside a paradoxical lack of formal training for mental healthcare providers regarding transgender issues and concerns. Benson describes identity affirmative therapy as “a therapeutic approach that adopts a positive view of transgender clients by respecting their self-defined identities and addresses the impact of a normative gender society on their lives” (Benson, 2013, p. 23). Affirmative therapy must therefore not only accept transgender identities as valid, non-pathological senses of self, but it must also recognize the detrimental of societal assumptions upon not only self-views but also psychological well-being. Furthermore, Benson argues that affirmative therapy should recognize that not all transgender-identified clients will identify with the construct of binary (exclusively male versus female) gender, and that non-binary gender identities are just as valid as binary identities.

Utilizing the aforementioned framework of gender-affirmative therapy for transgender clients, Benson interviewed transgender-identified individuals and uncovered detailed information regarding motivations for seeking mental health services, barriers to care, and perceptions of mental health providers overall. Participants reported seeking therapy for two primary reasons: to improve their overall quality of life and/or to explore their gender identity (and/or seek gender confirmation surgery or hormone replacement treatment). Unfortunately, participants’ reported experiences with mental health providers appear less-than-ideal, as even the most well-intentioned therapists may unwittingly endorse biases during their work with transgender clients. For example, one participant claimed that a therapist appeared to have no understanding of transgender identities nor a desire to understand: “I just had therapists who had crazy off-the-wall ideas and just not really understood who I was or really taken the time to understand” (Benson, 2013, p. 29). Participants expressed concerns regarding formal training for therapists regarding transgender identities and issues and misunderstanding and conflation of sex
and gender. Notably, many participants expressed substantial concerns regarding the motives of therapists and their competence or abilities to provide help through therapy, stating that “most of them don’t have any idea what to do” and “I think most of them listen to the transgendered clients so that they can learn something about the issue” (Benson, 2013, p. 30).

Shipherd, Green, and Abramovitz (2010) surveyed 130 transgender participants and found similar sentiments and concerns. While only approximately 1/3 of the sample reported seeking mental health services for issues such as anxiety, depression, and relationship problems, over half the sample demonstrated symptoms of overall psychological distress, indicating that a much larger proportion of the sample may benefit from mental health interventions. Unfortunately, these participants reported avoidance of seeking mental health services due to financial constraints, negative past experiences with therapists, fears of what treatment will entail (e.g. treatment to change one’s gender identity), and stigma concerns. Additionally, many participants reported experiencing gender dysphoria, but seeking mental health services for presenting problems other than the dysphoria (e.g. depression or anxiety). While research specifically focusing on gender dysphoria is therefore clearly still warranted during mental health provider training programs, understanding gender dysphoria is insufficient to provide competent clinical services to transgender clients. Similarly, extensive expertise regarding the treatment of presenting problems such as depression and anxiety appear insufficient to work with transgender clients in a culturally competent manner given that exclusively focusing on such treatments may invalidate the daily experiences with stigma, discrimination, and identity conflict which may plague some transgender individuals. Culturally competent care, and the research which seeks to modify and produce it, should take into account not only transgender-specific issues, but also should account for intersectionality in the needs of transgender clients who also experience
depression (whether related to their gender dysphoria or not). Regardless of even the best intentions, disproportionate emphasis on (or avoidance of) a client’s transgender identity during therapy may have iatrogenic effects.

Given the concerns voiced by the aforementioned transgender participants, increased knowledge of the prevailing assumptions regarding transgender identities, societal stigma, and mistrust of the competence and motives of mental health providers, these issues must be acknowledged and explored by both researchers and clinicians in order to begin to address the mental health disparities experienced by the transgender community. Many participants reported finding therapists through word-of-mouth, with members of the transgender community exploring a variety of mental health providers and then sharing information regarding competency across therapists. While this method may facilitate mental health interventions for transgender individuals who are members of a stable and mutually beneficial community of other transgender-identified individuals, the word-of-mouth method is insufficient for transgender individuals who may still need time to explore their potential transgender identities or those who live in regions where a sense of community among transgender individuals is scarce. For this reason, additional research should seek to facilitate not only the understanding of transgender identities and mental health disparities among the transgender population, but it must also seek to disseminate this knowledge in a way which may positively benefit the ways therapists interact with transgender clients and the means by which transgender clients can locate gender identity-affirmative therapists within their financial and geographical restrictions.

The burden for creating systems for culturally competent clinical work with transgender clients does not fall entirely upon the shoulders of therapists and other mental health providers, though. A number of systemic variables exist which influence (and at times restrict) the abilities
of mental health providers to expand their studies and practice to meet specific client needs.

McIntyre, Daley, Rutherford, and Ross (2011) conducted an investigation of these systems-level barriers to culturally competent practice with LGBTQ clients. One barrier to treatment discussed by participants was the stifling of individuality seemingly inherent to a medical model of mental health care. Providers reported concerns that a medical model based upon the needs of the human population in general may overlook a number of factors specifically relevant to LGBTQ individuals. Inherent in this concern as well was the expressed idea that training programs in counseling and psychology lack sufficient focus on LGBTQ issues, thus perpetuating overgeneralizations across the discipline. Second, providers described lack of access to supportive mental health services as a barrier to receiving culturally competent care. A marked lack of organizations providing services specifically for the LGBTQ population has created extensive wait-lists for LGBTQ clients, thus resulting in sometimes profound delays between the onset of a presenting problem and the time when an individual begins to receive treatment for that issue. This delay may not only exacerbate psychological distress as conditions may worsen over time without treatment, but it may also unwittingly engender distrust of the mental healthcare system.

One additional barrier described by McIntyre and colleagues’ (2011) participants involve disincentives for LGBT-affirming providers. Tangential to the aforementioned barrier of a lack of LGBT-specific organizations providing services, a lack of providers within these few organizations places a great deal of stress and an extensive workload upon those few providers present across the mental health disciplines. Such practitioners experience alarmingly high case-loads which may impair their ability to provide culturally competent care to their clients, despite them seeking out specific training and catering their clinical work to this purpose. This difficulty may then be exacerbated by perceptions of mental health providers by clients, an additional
barrier to creating rapport with LGBTQ clients. It is therefore clear that LGBTQ-affirmative mental healthcare providers are few and far-stretched, and that those who exist face their own set of barriers to providing culturally competent care, even as they intend to alleviate the barriers faced by their clients.

**Microaggression Theory.**

While formal training in cultural competence for mental health providers working with LGBTQ clients represents one step toward addressing the mental health disparities experienced by the transgender population, subtle forms of discrimination and implicit biases may still interfere in the work of even the most highly trained clinician. Microaggressions represent one such form of subtle discrimination. Microaggressions are “brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative slights and insults toward members of oppressed groups” (Nadal, 2008, p. 23). Sue, Capodilupo, Tornio, Bucceri, Holder, Nadal, and Esquilin (2007) described three categories of microaggressions: microassaults, microinsults, and microinvalidations. Microassaults are conscious and explicit forms of discrimination, such as shouting a derogatory term. Microinsults are more subtle, and less intentional such as a brief expression of disgust/disapproval when passing an LGBTQ couple on the street. Microinvalidations are statements which undermine the legitimacy of an individual’s experiences, such as telling an LGBTQ person that other groups have it worse and that they should “get over it”. Research on experiences of discrimination against transgender individuals indicates a variety of negative implications including increased risk for suicide attempts, substance use, depression, anxiety, post-traumatic stress, lower self-esteem, and fears of rejection (See Nadal, Skolnik, & Wong, 2012 for a review).
Nadal, Skolnik, and Wong (2012) conducted a qualitative investigation of the types of microaggressions experienced by transgender-identified individuals. This investigation built upon the theoretical taxonomy of microaggressions experienced by the LGBTQ community developed by Nadal, Rivera, and Corpus (2010). Interviews with nine self-identified transgender participants facilitated the discovery of 12 primary manifestations of transgender microaggressions: (1) the use of transphobic or incorrectly gendered terms (e.g. calling a transgender female by masculine pronouns such as “he”), (2) assumption of a universal transgender experience (e.g. asking one transgender individual to speak for the entire transgender population or assuming that all transgender individuals will seek gender confirmation surgery), (3) exoticization (e.g. saying “I’ve always wanted a transgender friend!”), (4) discomfort/disapproval of the transgender experience, (5) endorsement of gender-normative or binary ideals (e.g. telling someone who identifies as “gender fluid” or whose gender presentation may vary from day to day that they should “pick a side”), (6) denial of the existence of transphobia (e.g. telling a transgender individual that the discrimination they experience is not valid), (7) assumption of sexual pathology/abnormality (e.g. assuming all transgender women are sex workers or that transgender individuals are pedophiles), (8) physical threat/harassment, (9) denial of individual transphobia (e.g. saying “I’m not prejudiced, I get along with my transgender coworker!”), (10) denial of bodily privacy (e.g. asking an individual to describe their genitalia or staring at someone extensively in an attempt to discern their gender based on appearances), (11) familial microaggressions (e.g. a father telling his transgender daughter that wanted a son and not a daughter or refusing to use appropriate pronouns when communicating with a transgender child), and (12) systemic/environmental microaggressions (e.g. laws which either allow discrimination based on gender identity or gender presentation, laws which fail to
Individuals who identify as transgender experience these 12 primary themes of microaggressions as chronic life stressors, and these perpetual experiences of discrimination (whether subtle or overt) can take a toll on their well-being. Nadal, Davidoff, Davis, and Wong (2014) qualitatively investigated the ways nine transgender participants reacted to microaggressive experiences. Reactions were sorted into three categories: emotional, behavioral, and cognitive. Emotional reactions in response to experiencing a microaggression included anger, betrayal, distress, hopelessness/exhaustion, and feeling invalidated/misunderstood. Cognitive reactions included rationalization (e.g. thinking “that person is uneducated, that’s why they discriminated against me”), experiencing a double-bind (e.g. cognitively negotiating how much to disclose in social arenas regarding gender identity and personal experiences), vigilance and self-preservation (e.g. thinking about safety as a primary concern following experiences of microaggressions), and resiliency and empowerment (e.g. participants described themselves as “holding my head up high” in response to discrimination). Behavioral reactions included direct confrontation (physical or verbal), indirect confrontation (e.g. contacting authorities), and passive coping (e.g. departing from the situation and avoiding similar situations in the future).

While Nadal and colleagues (2014) utilized a small sample for their study, the results indicate some homogeneity in coping responses to microaggressions among transgender individuals. Most notably, these results indicate a spectrum of adaptivity in coping methods, with discrimination leading to avoidance and shame in some cases, but resilience and pride in others. Additional research should further investigate the nature and manifestation of coping strategies among transgender individuals faced with discrimination whether overt, or covert in the form of...
subtle microaggressions. Given the demonstrated discriminatory experiences of transgender individuals, the demonstrated negative mental health correlates of those experiences, the possibility for even the most empathetic and highly trained clinician to unwittingly micro-aggress against a transgender client, and initial data indicating a spectrum of adaptivity of coping in response to transgender microaggressions, additional research regarding clinical cultural competency for work with transgender clients/patients should take all of these facets into account.

**Gender Identity, Discrimination and Mental Health**

Bridging gaps between the mental health experiences of transgender and gender non-conforming individuals compared to heterosexual and cisgender populations is of paramount importance as past research demonstrates a clear relationship between experiences of discrimination and negative mental health correlates. A great deal of extant research indicates that experiences of discrimination are associated with poorer overall well-being (see Schmitt, Branscombe, Postmes, & Garcia, 2014 for two meta-analyses). Notably, this relationship between discrimination and health outcomes is stronger for individuals from disadvantaged groups, such as individuals identifying as transgender or gender non-conforming compared to individuals from dominant groups (e.g. heterosexuals and cisgender individuals) who experience discrimination. Schmitt and colleagues (2014) conducted two meta-analyses exploring relationships between discrimination and well-being, and found that perceived discrimination significantly related to negative mental health correlates (e.g. anxiety, depression, and overall negative affect). These relationships were stronger for members of disadvantaged groups (e.g. members of the LGBT community). These authors also investigated a number of potential moderators to the relationship between discrimination and well-being, revealing that the negative
relationship between discrimination and well-being held true even when controlling for well-being prior to experiencing discrimination, thus indicating that discrimination negatively impacts well-being in spite of previously existing resiliency factors (Schmitt et al., 2014).

Past research on the general topics of gender discrimination, microaggressions, and psychological well-being indicates that discrimination bears heavily on mental health with largely negative consequences (for a review, see Sue, 2010). Mays and Cochran (2001) explored mental health correlates of perceived discrimination comparing a sample of 73 LGB participants to 2,844 heterosexual participants. These authors found that LGB-identified participants not only reported experiencing more daily experiences of discrimination than their heterosexual counterparts, but that LGB participants also reported higher levels of depression, anxiety, substance abuse, and overall psychological distress and lower levels of self-rated overall mental health. While the body of extant research appears to indicate a strong relationship between experiences of discrimination and negative mental health correlates, Bostwick, Boyd, Hughes, West, and McCabe (2014) re-evaluated these relationships in a national probability sample of 577 self-identified LGB adults and reached conclusions which complicate understanding of these variable relationships. Bostwick et al. (2014) found that identifying as LGB alone did not significantly relate to negative mental health correlates, but that simultaneously identifying as LGB and another marginalized identity (e.g. racial/ethnic minority as well) did significantly relate to negative mental health symptoms such as depression, anxiety, and substance abuse. This relatively recent finding indicates that our understanding of the relationships between discrimination and well-being are as yet imperfect, thus these relationships should be further investigated by future studies.
Victimization and the TGNC Community

While microaggressions and general perceived discrimination represent subtle forms of discrimination experienced by marginalized groups such as the transgender community, other factors relevant to discrimination still hold the potential to profoundly impact the perceptions, well-being, and identities of individuals who identify as transgender or gender non-conforming. Victimization is one such factor. Victimization is the process of becoming a victim (of being victimized). Transgender and gender non-conforming individuals may become victims of overt (e.g. physical or verbal assaults or confrontation) or covert (e.g. microaggressions) forms of discrimination, both of which can negatively impact their psychological well-being. For example, Clements-Nolle, Marx, and Katz (2006) conducted an investigation into the independent predictors of suicide risk among transgender and gender non-conforming individuals and found that gender-based discrimination and gender-based victimization both significantly predicted suicidal behaviors (e.g. attempted suicide). These findings indicate that experiences of gender-based victimization do not only impact cognitive aspects of suicidality (such as suicidal thoughts or dysphoric emotional states) but also behaviors leading to actual suicide attempts.

Additional research relevant to transgender identity and suicidality conducted by Mathy (2002) found that while sexual orientation did not discriminate between whether or not an individual had a history of suicidal ideation or attempts, identifying as transgender did significantly discriminate between these two groups. Given this predictive ability based only on a transgender identification coupled with higher rates of suicidal ideation and attempts among transgender-identified individuals, it is important to further investigate variable which may be contributing to this disparity—such as victimization. Additionally, Goldblum, Testa, Pflum,
Hendricks, Bradford, and Bongar (2012) explored relationships between gender-based victimization and suicide attempts in a sample of 290 self-identified transgender participants. Goldblum et al. found that participants who reported experiencing gender-based victimization were four times more likely to have attempted suicide in the past than participants who had not experienced victimization. This relationship held true for frequency as well. Not only did more participants who had experienced victimization than not report past suicide attempts, but those who had experienced victimization reported a higher number of past suicide attempts as well.

Victimization has also been linked to a number of other indicators of psychological well-being. While this body of literature is rather small when considering only the transgender population, the literature on victimization and well-being among lesbian, gay, and bisexual individuals is vast in scope. For example, Herek, Gillis, and Cogan (1999) found that compared to heterosexual crime survivors, lesbian and gay survivors reported increased symptoms of depression, anxiety, post-traumatic stress, crime-related fears and beliefs, and lower sense of mastery. Similarly, Russell, Ryan, Toomey, Diaz, and Sanchez (2011) found increased rates of suicidality, depression, anxiety, and increased high-risk sexual behaviors among LGBT-identified participants who reported experiencing victimization based on their LGBT identity. A number of additional authors arrived at similar conclusions (For examples see Burton, Marshal, Chisolm, Sucato, & Friedman, 2013; Dragowski, Halkitis, Grossman, & D’Augelli, 2011; Hughes, Johnson, Steffen, Wilsnack, & Everett, 2014; Toomey, Ryan, Diaz, Card, & Russell, 2013).

transgender youth. Developmental milestones included: feeling different from others, being told they were different from others, being called “sissy” by peers (for MTF individuals), told to stop acting like a “sissy” by parents, referred to counseling for gender or sexual orientation related issues by parents, considered self transgender, and first told someone else they identified as transgender. Analyses indicated that participant youth who had reached these milestones (at any level) were significantly more likely to have experienced verbal victimization, verbal abuse from both peers and parents, and childhood physical and psychological abuse. While no additional studies to date have investigated this potential link between transgender identity development and victimization experiences, it is a worthwhile exploration with potentially vast implications given the increased rates of suicidality among transgender-identified individuals.

“Victims” versus “survivors”.

When discussing victimization among marginalized populations, a debate frequently emerges regarding the use of the term “victim” versus “survivor”. Research on trauma and victimization often locates these two terms along a linear spectrum where “victim” denotes an individual who has experienced a discrimination-based crime but who has not yet taken steps to cope with this crime. For example, the individual may not have disclosed or reported their experience and may not have employed effective individual coping strategies in order to integrate the experience into their greater life story. The “survivor” space on this spectrum commences as the individual begins “a gradual process of recapitulating and reconstructing the traumatic facets of the catastrophe” (Figley, 1985, p. 404).

Though empirical research on the correlates, predictors, or outcomes of these two terms remains scant, a vast body of research has indicated the theoretical underpinnings of this spectrum in titles such as “From Victim to Survivor…” Such titles imply that individuals who
experience victimization undergo a process gradually transforming them from victims to survivors (for examples see Brosi & Rolling, 2010; Danzer, 2011). Furthermore, Ovenden (2012) conducted a qualitative investigation of victim/survivor narratives among five female self-identified survivors of childhood sexual abuse. Ovenden’s interviews with those five women revealed a critical pattern in the victim/survivor debate: the term “victim” was unanimously discarded by participants due to its negative connotations and stigma, whereas the term “survivor” was often adopted as it provided participants with a sense of empowerment and carried the connotation of well-being and stability. Given the paucity of empirical data on the topics of “victims” versus “survivors”, the present narrative will utilize neither term, instead implementing statements such as “individuals who have experienced victimization” to minimize biases introduced via terminology.

**Beyond the Deficit Skew in TGNC Research**

As demonstrated by the preponderance of extant literature focusing on mental health disparities, discrimination, and victimization, psychological investigations of TGNC experiences comprise a noteworthy deficit skew. While not necessary reflective of author or researcher intentions, this deficit skew contributes to the perpetuation of pessimistic conceptualizations of TGNC individuals and communities. To state that TGNC individuals face increased negative life experiences (e.g., discrimination, unequal allocation of opportunities or resources) compared to cisgender individuals, TGNC individuals also demonstrate extensive resilience, perseverance, and strength both at the individual and group levels.

Riggle, Rostansky, McCants, and Pascale-Hague (2011) surveyed 61 transgender-identified participants regarding positive aspects of their gender identities and experiences. While 10% of participants initially stated that identifying as transgender had no positives, all but
one of those participants later went on to describe positive aspects of their gender identity-related experiences. Qualitative analyses of participant responses revealed eight themes of positive identity: 1) Congruency of Self; 2) Enhanced Interpersonal Relationships; 3) Personal Growth and Resiliency; 4) Increased Empathy; 5) A Unique Perspective on Both Sexes; 6) Living Beyond the Sex Binary; 7) Increased Activism; and 8) Connection to the GLBTQ Communities. The authors elaborated on these positive outcomes of “claiming a transgender identity” (p. 150) as facilitated expressions of unity and truth (Congruency), increased strength, self-confidence, and self-awareness (Personal Growth/Resiliency), increased awareness and new perspectives on stereotyping (Empathy), and “self disclosure…with sensitivity toward the person you are sharing with” (Interpersonal Relationships; p. 151). The most common theme produced by participants was the development of a “unique perspective” strengthened by insights into the strengths, challenges, and oppression of both sexes. Theme Eight, Connection to GLBTQ Communities, bears particular relevance upon the well-being of TGNC individuals in light of aforementioned findings that social support mediates the relationship between adverse experiences (e.g., discrimination) and well-being (Beals, Peplau, & Gable, 2009; Budge, Adelson, & Howard, 2013).

Unfortunately, despite research such as that produced by Riggle and colleagues (2011), the deficit skew remains predominant in psychological investigations of TGNC experiences. While research teams affiliated with Riggle have also produced empirical investigations of positive experiences among lesbians and gay men (Riggle et al., 2008) and bisexual-identified individuals (Rostosky, Riggle, Pascale-Hague, & McCants, 2010), other research teams have yet to take up the torch of explicitly positive lenses. A review of extant literature produces no additional examples of explicit examinations of positive aspects of TGNC identities and/or
experiences; However, a small pool of researchers has investigated positive characteristics associated with negotiating chronic states of oppression and discrimination. The most common positive characteristic examined is “resilience”.

**Resilience and the TGNC community.**

While the majority of extant research on transgender identities relates to topics such as discrimination, victimization, and mental health disparities as previously outlined, a small pool of research has also emerged investigating resiliency among this population. Nadal, Davidoff, Davis, and Wong (2014) qualitatively investigated cognitive, emotional, and behavioral methods of coping with experiences of discrimination among the transgender community and found that not all reactions were negative. For example, while participants reported responses such as anger and psychological distress they also reported feeling a sense of solidarity with the larger transgender or LGBT communities and a sense of identity pride and re-affirmation in response to experiences of discrimination. Similarly, Meyer, Oulette, Haile, and McFarlane (2011) found that LGB individuals who experienced discrimination not only reported feeling an increased sense of communality with the LGB community, but also demonstrated more positive LGB identity characteristics and reported having more positive self-perceptions. Branscombe, Schmitt, and Harvey (1999) also obtained similar results, but from a sample of racial/ethnic minority-identified participants who indicated that while discriminatory experiences negatively related to overall well-being, they also related positively to group identification and a sense of belongingness which may serve as a resiliency factor to help members of marginalized groups cope with stressors related to discrimination and victimization. This hypothesis of identity pride as a mediating factor between discriminatory experiences and psychological well-being has found support in investigations of Korean-American college students (Lee, 2005), a longitudinal
investigation of discriminatory experiences of Latino/a students (Cronin, Levin, Branscombe, Laar, & Tropp, 2011), and a small sample of transgender individuals (Singh, Hays, & Watson, 2011).

Studies of positive psychological traits among other populations frequently utilize constructs such as social support and GRIT. Social support generally incorporates both quantity (i.e., number of individuals from which a person can draw social support) and quality (i.e., that individual’s subjective satisfaction with that level of support; Sarason, Levine, & Basham, 1996). Thus, social support is not conceptualized as an objective or universal construct, but rather varies from one person to another. For example, while one individual may be entirely satisfied with having one close individual from which to derive social support, another individual may experience great distress and dissatisfaction if they do not have multiple others from which to derive this support. Further, Shumaker and Brownell (1984) highlight the importance of distinguishing between the content of social support (i.e., the behaviors which comprise support) and the functions of social support (i.e., to enhance well-being in the absence of stress or to facilitate well-being in the presence of stress). This dichotomy, described by the authors in terms of “health-sustaining” (i.e., facilitating in the absence of stress) and “health-compensating” (i.e., in the presence of stress) bears particular relevance when applying the concept of social support to marginalized populations. Specifically, given the extensive and chronic marginalization (and even victimization) faced by marginalized groups such as TGNC populations, the functions of social support are likely to be skewed more toward health-compensating rather than health-sustaining. Thus, it is crucial that researchers and clinicians maintain a critical eye when applying the concept of social support to marginalized groups, particularly by acknowledging
openly (as in the present document) the potential limitations and unique applications of the construct within context.

Similarly, the concept of GRIT (Duckworth & Quinn, 2009) refers to the positive-psychological characteristic of perseverance toward long-term goals in the face of adversity. While it has been argued at length above that TGNC populations face disproportionate adverse experiences compared to cisgender populations, it is important to note that the concept of GRIT was normalized on cisgender samples and thus its applicability outside of that norm may be limited. Specifically, it is important to note that an absence of GRIT may be misconstrued as victim-blaming, in that some may interpret the absence of this perseverance as an absence of the will rather than limited ability given current resources (Crawford, 1977). Lytle, Vaughan, Rodriguez, and Shmerler (2014) argue for the clinical application of the GRIT Scale (Duckworth & Quinn, 2009) in a strengths-based assessment of LGBT (and also specifically for transgender-identified) clients, however the the construct has not yet been empirically applied or evaluated via this application.

**Summary and the Present Investigation**

The body of literature described in previous sections outlines a sub-discipline of diversity psychology which has been growing exponentially in recent years. First, researchers sought to better understand concerns relevant to specific racial and ethnic groups, and later discovered and sought to understand and remedy mental health disparities among those groups. In time, this pattern continued with the exploration of concerns and disparities relevant to sexual orientation minorities including individuals who identify as lesbian, gay, bisexual, or queer (LGBQ). While the vast majority of this latter pool of research claims to focus on the LGBTQ community as a whole, the T is often unintentionally excluded from specific investigation and analysis, despite
the fact that a small pool of research indicates that the transgender community has concerns, experiences, and needs which while they overlap significantly with those of the larger LGBQ community, also remain distinct in many ways. For example, while LGBQ and transgender individuals alike must both struggle with internal identity states, navigation of social identities, and coping with societal stigma, discrimination, and systemic forms of oppression, individuals who identify as transgender face a separate host of challenges.

The most readily studied of these additional challenges is gender dysphoria, or a sense of disconnect and disease regarding one’s assigned gender. Individuals who identify as transgender may experience profound dysphoria regarding their physical presentation (whether in the form of social expectations, secondary sex characteristics, or a combination of the two). These individuals may also identify as LGBQ, thus compounding the difficulties they face with regard to their self-identifications. Similarly, an African American transgender woman may face compound challenges of stigma related to identifying as transgender, as a woman, and as African American. The permutations on this complexity are infinite. As yet, the body of research regarding transgender concerns has brushed the surface of our potential understanding, offering general ideas about what it means to be transgender, how it feels, how it impacts individuals, how social influences impact transgender individuals, and what mental health disparities exist, but to date the complexities of intersectionality and separation from the larger LGBQ community have rarely been addressed.

In addition, the extant body of research and empirical investigations in particular, focus disproportionately upon binary conceptualizations of gender and gender identity. A binary conceptualization of gender is limited to the categories of male and female, or to transgender male and transgender female. Regardless of whether the identity in question is cisgender or
transgender, the existence of only two categories for identification render the construct dichotomous, and forcing human identities into a binary conceptualization has proven to be inefficient, inaccurate, but most of all, iatrogenic. For example, as evidenced by the aforementioned body of research, individuals who identify as gender non-conforming (GNC) but do not identify with the term “transgender” are frequently excluded not only from empirical investigations but also from social services, identity-affirming interactions, and other facets of life afforded by identification with a well-known category. Past research indicates that lack of access to identity-affirming services and resources create and amplify health disparities among individuals who identify as transgender. Logic dictates that gender non-conforming individuals who receive a great deal less support and recognition than even transgender individuals may be subject to similar negative consequences due to invalidation—a systematic societal lack of recognition of their gender identities as valid experiences.

While very little research has specifically investigated the development of a transgender gender identity, research which exists currently tends to point toward a very heterogeneous developmental process culminating in identity states which are malleable across time, place, and person. An individual assigned female at birth may spend half her life in the lived role of a female, and may do so with great content, but may at some point in her life come to find that she identifies more as transgender. Another individual may feel torn between genders their whole life, feeling male some days and female others, without having a framework of understanding in which to situate and organize this experience. A third individual may not identify with any construct of gender, finding the idea of socially constructed gender to be irrelevant. This person may identify as “agender” or potentially “pan-gender”. Other individuals may identify with none of these terms, yet it is clear that the number of permutations for gender identity, if limited to
only two options, leave a vast proportion of the population unaccounted for, and ultimately invisible.

This sense of invisibility, if unaddressed, has the potential to perpetuate systemic and interpersonal methods of discrimination, whether overt or in the form of microaggressions. By silencing a population of individuals who don’t identify with the gender they were assigned at birth, and those who do not identify with the currently prevailing binary conceptualization of gender, stereotypes and discrimination are being perpetuated, even within the system of mental health interventions which seeks to alleviate psychological suffering. A great deal of additional research regarding these topics is necessary before the mental health disciplines can truly reach a standard of culturally competent care with transgender and gender non-conforming patients/clients, but extant research at this time provides a solid foundation from which to springboard future investigations.

A number of issues have complicated the progress of gender identity research to date. First and as previously mentioned, prevailing assumptions about the definitions and roles of gender and gender identity have restricted not only research itself, but also the ideas by which it is generated. For example, society to date has generally understood gender as being inextricably linked to sex assigned at birth, and binary in nature. From this foundational understanding, social conceptions of gender roles attributed to male and female, masculinity and femininity have emerged and become increasingly solidified over time. In order to begin to dissect this socially constructed understanding of gender, gender identity, and gender roles, researchers first had to recognize, identify, and define these constructs. They then sought to situate transgender and transsexual identities into this framework. Now, the field is in the process of further expanding
its scope and understanding to investigate non-binary conceptualizations of gender, and to investigate intersectionality among transgender and gender-non-conforming individuals.

Unfortunately this expansion faces a great deal of resistance from both societal pressures and from the population it seeks to understand. Thus the second primary complicating factor for the growth of gender identity research is distrust of researchers from within the transgender and gender non-conforming communities. The vast majority of research on transgender identities has been conducted by cisgender researchers with little foundation in the transgender community itself. This has led to a general sentiment of distrust of researchers, where research participants or non-participating transgender-identified individuals may feel exoticized by researchers, their identities potentially framed as a research fad or empirical bandwagon. This may occur when researchers conduct their studies simply for the production of empirical data, yet do not put the information they discover to use for the transgender community in the way of social or political activism, cultural calls to action, or acquisition and provision of funding to transgender-serving organizations which are few and far-stretched.

A third challenge to the progress of spectrum-inclusive gender identity research is the time old battle between idiographic (or individualistic) and nomothetic (aggregate or group-level) conceptualizations. Some researchers fear that by conducting research on an ever expanding spectrum of potential gender identities, research on gender identity overall will begin to lack cohesion and meaningfulness. While it is undoubtedly true that conducting research on 50 or more gender identifications requires more complicated analyses compared to simply comparing male/female, this does not inherently invalidate the utility of conducting spectrum-inclusive research in addition to the extant body of literature and data focusing on binary conceptualizations of gender and of transgender identities as extensions of that binary.
The aforementioned research challenges of social convention and opposition as well as distrust of researchers are not new to the field of gender identity research, nor will they end with this subject. Rather, these challenges can be approached head-on, through the conduct of mindful, inclusive, purposeful mixed-methods investigations yielding data-driven interpretations. The present investigation seeks to approach these challenges in this way, exploring gender identity development in a large, demographically diverse sample of transgender-identified participants. This sample will include both binary and non-binary identified individuals, will allow for individualistic self-identifications of gender identity, will accommodate change in identification and perceptions over time, and will do so with the intention of benefitting the transgender community as a whole through the generation of clinically relevant knowledge and an action plan for more effective clinical work with transgender-identified patients/clients.

In recent years, psychological research has begun to increasingly investigate the unique struggles, strengths, and characteristics of marginalized groups. One of these groups, the lesbian, gay, bisexual, and transgender (LGBT) community, has garnered a great deal of recent focus; however the “T” is rarely investigated as a stand-alone identity. This frequent confounding of sexuality (LGB) and gender (T) has allowed a gap to form in existing knowledge about the developmental processes, perceptions, experiences, and physical and psychological health of the transgender population. The present study sought to fill this gap by providing critical information regarding the unique developmental processes of transgender identities. Furthermore, the present investigation seeks to provide not only substantive knowledge regarding the experiences, perceptions, and health of this population but also to highlight clinical implications and propose a model of clinical competency to be utilized by healthcare professionals working with the transgender population. Non-binary conceptualizations of gender (as well as binary) will be
considered, as will intersectionality of various group identifications such as race/ethnicity, age, religious preference, geographic region, and other demographic variables.

To address the aforementioned gaps in previous research, the following hypotheses were investigated: 1) Participant narratives will indicate a greater degree of heterogeneity in later phases of identity development than previously considered; 2) Narratives will reveal common themes of risk (e.g., internalized or environmental stigma) and resiliency (e.g., social support, community connectedness) within developmental processes; 3) Victimization will positively predict depression, anxiety, gender dysphoria, and grit; 4) Victimization will negatively predict flourishing; 5) Social support will mediate the relationship between victimization and psychological well-being; 6) TGNC community connectedness will mediate the relationship between victimization and psychological well-being; 7) Victimization will relate to decreased help-seeking (mental health or criminal justice services).
Chapter 3: Methods

Participants

Because canonical correlation was the chosen method of statistical hypothesis-testing for quantitative hypotheses, power was estimated a-priori based on the correlation model using G*Power 3.1 (Faul, Erdfelder, Buchner, & Lang, 2009). This power analysis indicated that a sample size of 82 would be sufficient to detect significant correlation effects of moderate magnitude at .30 with a power of .80 and an alpha of .05.

Participants included 357 adults (at least 18 years of age) who self-identified as TGNC. Of these 357 participants, 15 comprised Study 1 including the qualitative identity interview, a demographic questionnaire, and measures of psychological well-being (depression, anxiety, gender dysphoria, flourishing, and grit). The remaining 342 participants comprised Study 2, including the demographic questionnaire, a multi-dimensional assessment of gender identity, a victimization survey, and measures of psychological well-being (as above). Participants self-selected for participation and were recruited through a series of emails sent to university Listservs with which the primary investigator (PI) and PI’s dissertation advisor were affiliated. Additionally, participants were recruited through various Facebook groups centered on topics of gender identity. From each of these initial contact points, individuals were encouraged to share study information with their professional and peer groups. Participants under the age of 18, who identified as cisgender, or who did not speak English were excluded from the study due to its focus on TGNC identity and the materials (presented in English). Study 1 participants received $50 cash upon interview completion. Study 2 participants did not receive monetary compensation, but were informed of the potential benefits of participation at social, empirical, and policy levels.
Participants represented a wide variety of socio-demographic identities across both studies. This section will provide a summary of Study 2 (online survey) participants, as they comprised 96% of the total dissertation sample. For a detailed breakdown of socio-demographic characteristics for Study 1 see Table 1. For socio-demographic characteristics of Study 2 see Tables 2 and 3.

Study 2 participants \((N = 342)\) reported an average age of 30.02 years \((SD = 11.78)\) and ranged in age from 18-78. Notably, 58.1% of the sample was aged 26 or below. In terms of geographic location, most participants reported living in major cities (56.7%), followed by medium-sized towns or villages (29.5%), whereas 13.8% reported living in rural areas including small towns or villages.

Participants largely reported being assigned binary (male or female) sex at birth, with 32.5% \((N = 111)\) assigned male at birth and 67% \((N = 229)\) assigned female at birth. Two participants \(0.6\%) were assigned intersex at birth. At the time of data collection, 22.8% of participants identified simply as “Male” (9.9%) or “Female” (12.9%), 21.3% identified as binary transgender (11.1% MtF and 10.2% FtM), and 41.6% identified as non-binary (20.8% each as “Transgender non-binary” and as “genderqueer”). Lastly, 14.3% \((N = 49)\) participants did not identify with any of the abovementioned gender identities and wrote in their own personal gender identification (e.g., “agenderflux”, “gender = no”, “two-spirit”, “androfemme”). At the time of data collection, most participants (66.5%) reported that they were not currently undergoing hormone therapy of any kind (i.e., hormone blockers or hormone replacement therapy/HRT). Of remaining participants, 4.4% were taking hormone blockers, 20.9% were taking cross-sex hormones (HRT), and 8.2% received both blockers and HRT. Most participants described their sexual orientation as “Queer” \((N = 98, 28.7\%)\), followed by pansexual (16.1%),
bisexual (12.9%), heterosexual (12.1%), gay/lesbian (10.5%), asexual (9.4%), and polysexual (3.5%).

In terms of racial/ethnic identifications, the sample was largely White (79.4%), followed by Hispanic/Latina/o/x (8%), mixed race/ethnicity (6.2%), Asian/Asian American (2.9%), American Indian or Alaskan Native (2.1%) and Black/African American (1.5%). Tables 2 and 3 provide detailed depiction of participant socio-demographic characteristics noted above, including “identity not listed, please explain____” responses (Table 3) as well as other socio-demographic information such as religion/spirituality, educational attainment, income, and residential status (Table 2). Additionally, 7% of participants (N = 24) did not identify with any of the above sexual orientations and wrote in their own personal sexual orientation identities (e.g., “hard to describe”, “demi-pansexual”, “gay but not ‘homosexual’”, “androsexual”, “queer asexual” and “prefer not to label”).

Measures

**Demographic Questionnaire.** This questionnaire included 15 items assessing socio-demographic characteristics such as age, birth sex, gender identity, race/ethnicity, sexual orientation, location and population density (rural/urban/suburban/small versus large city/town) of residence, religion/spirituality, housing status, employment status, and socio-economic status (income). One item asked whether individuals are currently undergoing current hormone treatment (estrogen or testosterone—including hormone blocking therapy and/or hormone replacement therapy/HRT).

**Help-Seeking Behaviors.** Four exploratory questions assessed likelihood of seeking mental health services, physiological health services, or criminal justice services. These final
four items were measured on a seven-point Likert scale. This questionnaire appears in Appendix C.

**Gender Identity Semi-Structured Interview.** The Gender Identity Interview was created by the author for the purposes of this investigation and was utilized only for Study 1. Adapted from previous identity research (Sophie, 1985; Savin-Williams & Diamond, 2000; Jamil, Harper, & Fernandez, 2009; Shapiro, Rios, & Stewart, 2010), this interview investigated factors and processes relevant to gender identity development. It contained 21 items investigating the process of gender identity development in qualitative terms, including retrospective accounts of the processes of self-discovery and self-disclosure, factors of risk and resiliency related to gender identity development, influences of societal perceptions regarding participant gender identities, and the potential influences of romantic and sexual partners, sexuality, and sexual orientation in gender identity development. Two questions explored experiences with the mental healthcare system: “What is one particularly positive experience you have had in therapy?” and “What is one particularly negative experience you have had in therapy?” Lastly, a clinically relevant exploratory question attempted to tap into participants’ overall identity configurations and the salience of gender identity therein: “What is one thing you wish the world knew about you as an individual?” Appendix D highlights the 21 questions utilized in this interview.

**Victimization Survey.** The Victimization Survey was based upon the work of Grossman, D’Augelli, and Salter (2006) investigating victimization experiences among transgender individuals. This survey includes three items assessing whether participants have experienced physical, verbal, or sexual victimization related to their actual or perceived gender identity/presentation. Each of these three items includes six follow-up questions which gather
specific information about any victimization experiences endorsed (e.g., how many times participants experienced each category of victimization—lifetime and past year incidence, participant’s age at time of first victimization, perpetrator’s gender from most memorable event, relationship to the perpetrator, and degree of emotional upset in response to this/these event/s). For a detailed breakdown of participant victimization experiences, see Table 5. The full Victimization Survey appears in Appendix E.

**Gender Expression/Experiences/Identity Questionnaire.** The Gender Expression/Experiences/Identity Questionnaire (GEEIQ; Factor & Rothblum, 2008) was collaboratively developed with both transgender researchers and the transgender community to assess gender expression, experiences, and identity in a culturally competent manner. The GEEIQ consists of nine domains of gender expression, experiences, and identity. The 14 items included in this questionnaire investigate fluidity of identity; pronoun preferences and pronoun fluidity; public restroom preference/usage; milestones in identity (first experiencing self, first presenting self, first disclosure to others, first self-identification); and connection to the larger TGNC community (e.g., TGNC event attendance, peer group composition, and subjective connection).

The items within this questionnaire underwent a rigorous selection process by their author (Factor, 2002) before comprising the scale in its current form. Data from transgender-specific conferences, Listservs, community members, and other researchers were integrated into an initial item pool. A panel of experts in the fields of transgender research and gender identity research evaluated the item pool to ensure clarity and increase validity. Factor (2002) provided an in-depth description of the theoretical and practical underpinnings and implications of the questionnaire. This instrument appears in Appendix F.
Gender Dysphoria Questionnaire. The Gender Dysphoria Questionnaire was formulated based upon the Gender Identity/Gender Dysphoria Questionnaire for Adolescents and Adults (GIDQY-AA; Deogracias, Johnson, Meyer-Bahlburg, Kessler, Schober, & Zucker, 2007). The GIDQY-AA is a 27-item dimensional measure of dysphoria associated with gender identity in adolescents and adults. For the purposes of this study, the original version was modified to decrease emphasis upon binary conceptualizations of gender and to measure Gender Dysphoria across the gender spectrum. For example, items previously separated by gender such as “In the past 12 months, have you felt satisfied being a woman?” (for a natal female) and “…have you felt satisfied being a man?” (for a natal male) were modified to inclusively incorporate the spectrum of gender identities: “In the past 12 months, have you felt satisfied with the gender you were assigned at birth?” The instrument utilized herein consists of 18 items assessing the extent to which participants experienced discomfort, conflict, and/or uncertainty regarding their gender identity.

Psychometric analyses indicate strong discriminant validity with high degrees of sensitivity and specificity for the GIDQY (Deogracias et al., 2007). Additionally, past studies have demonstrated high reliability of this instrument with Cronbach’s alphas ranging from .88 (Singh, McMain, & Zucker, 2011) to .97 (Deogracias, Johnson, Meyer-Bahlburg, Kessler, Schober, & Zucker, 2007). For the current study, the Gender Dysphoria Questionnaire yielded a Cronbach’s alpha of .72. Item analysis indicated that all 18 items contributed similarly to the scales internal consistency (alphas if item deleted ranged from .69 to .74). This questionnaire appears in Appendix G.

Patient Health Questionnaire. The Patient Health Questionnaire (PHQ-9; Spitzer, 1999) screens for depression, has high convergent validity with DSM diagnoses, and accounts for
symptoms as well as participant-reported level of impairment. The PHQ-9 consists of nine primary items and a final item assessing level of distress or impairment caused by any endorsed items. Sample items responding to the prompt “Over the last 2 weeks how often have you been bothered by…” included: “Little interest or pleasure in doing things?”, “Poor appetite or overeating?”, and “Thoughts that you would be better off dead or of hurting yourself in some way?” Endorsement of this last sample item indicated potential risk to self of the participant, therefore all participants endorsing this item were immediately redirected during the survey to a list of community resources (both in-person and online) as well as suicide prevention resources. Participants not endorsing this item received these same resources at the conclusion of participation.

Data from two large-scale validation studies support the criterion and construct validity of the PHQ-9 with regard to its use both as a diagnostic measure and as a measure of severity. Preliminary data also supports sensitivity to change within the PHQ-9, thus substantiating its use in repeated assessments over time such as in the measure of treatment progress (Kroenke & Spitzer, 2002). Previous research has found high internal consistency (.85) and test-retest reliability (.87) for the PHQ-9 (Zhang et al., 2013). In the present study, the PHQ-9 yielded a Cronbach’s alpha of .90. This questionnaire appears in Appendix H.

**Generalized Anxiety Disorder Scale.** The Generalized Anxiety Disorder Scale (GAD-7; Spitzer, Kroenke, & Williams, 2006) screens for general anxiety symptoms that may warrant further assessment to substantiate a diagnosis of GAD. The GAD-7 consists of eight items, seven assessing anxiety symptoms and one assessing level of distress or impairment caused by any endorsed items. This scale, developed to complement the PHQ-9 (above), has demonstrated high convergent validity with DSM anxiety disorder diagnoses and accounts for both symptom profile
and degree of associated distress or impairment. The prompt for this screener is “In the past 2 weeks, how often have you been bothered by the following problems?” Sample items include: “feeling nervous, anxious, or on edge”, “not being able to stop or control worrying”, and “being so restless that it’s hard to sit still”. These items therefore encompass both physiological and psychological manifestations of anxiety.

Research on the GAD-7 reliability and validity supports its use in both primary care (Spitzer, Kroenke, Williams, & Löwe, 2006) as well as in the general population (Löwe, Decker, Müller, Brähler, Ellmar, Schellberg, Dieter, Herzog, & Herzberg, 2008). Spitzer et al. (2006) investigated the psychometric properties of the GAD-7 and found high reliability including internal consistency ($\alpha = .92$) and test-retest reliability ($r = .83$). In addition, they found high criterion, construct, factorial, convergent, and procedural validity. High sensitivity (89%) and specificity (82%) were also demonstrated. Löwe et al. (2008) later developed population norms for use in interpreting GAD-7 scores, however these norms were developed based on an exclusively binary conceptualization of gender (male/female) therefore the present investigation will not utilize these norms as comparisons but will compare score variance across participants exclusively. The GAD-7 yielded a Cronbach’s alpha of .91 in the present study. This questionnaire appears in Appendix I.

**Social Support Questionnaire.** The Social Support Questionnaire-Shortened Version (SSQ-6; Sarason, Sarason, Shearin, & Pierce, 1987) is a 6-item measure of the extent to which individuals feel supported within their social environment. The SSQ-6 contains a sub-set of questions from the original 27-item SSQ. This instrument contains two segments: first asking participants to describe their perceived level of support and the second asking them to rate their satisfaction with that level of support. For the purposes of the present investigation and to
maintain brevity of the questionnaire, only the first segment will be utilized herein. Items include “To what extent do you feel there is someone in your life who you can count on to...distract you from your worries when you feel under stress?” or “…to console you when you are very upset?” Participants rank each item on a 6-point Likert scale from “Very Dissatisfied” to “Very Satisfied”.

The SSQ-6 has demonstrated sufficient test-retest reliability and internal reliability as well as construct validity through high correlations with related personality variables such as loneliness and social competence. The instrument authors describe a number of additional studies in which the SSQ demonstrated high reliability and validity—for example, it has been found to yield results equivalent to those of a lengthy structured interview. Previous studies using the SSQ-6 have yielded Cronbach’s alphas ranging from .75 to .97 (Sarason, Sarason, Shearin, & Pierce, 1987). In the present study, the SSQ yielded a Cronbach’s alpha of .90. This questionnaire appears in Appendix J.

Flourishing Scale. The Flourishing Scale (FS; Diener, Tov, Kim-Prieto, Choi, Oishi, & Biswas-Diener, 2010) is an 8-item measure designed to assess psychological well-being including dimensions of relationships, self-esteem, purpose, and optimism. Responses are measured on a 7-point Likert scale where participants indicate their agreement/disagreement with survey items where “1” indicates “Strongly Disagree” and “7” indicates “Strongly Agree”. Examples of items include: “I lead a purposeful and meaningful life” and “I actively contribute to the happiness and well-being of others” (α = .94). Each participant’s flourishing score was calculated as the average of their responses to the eight scale items. Previous studies utilizing the Flouring Scale yielded Cronbach’s alphas of .83 to .94 (Hone, Jarden, & Schofield, 2013;
Whitman & Nadal, 2015). For the current sample the Flourishing Scale yielded a Cronbach’s alpha of .89. This measure appears in Appendix K.

**Grit Scale.** The Grit Scale (GRIT; Duckworth, Peterson, Matthews, & Kelly, 2007; Duckworth & Quinn, 2009) is a 17-item measure of “grit”: non-cognitive characteristics of “perseverance and passion for long-term goals (Duckworth, Peterson, Matthews, & Kelly, 2007, p. 1087). Grit is conceptualized as an integration of interest and effort in the pursuit of long-term personal goals. This present investigation utilizes pooled items from the original Grit Scale (Grit-O; Duckworth et al., 2007) and the Short Grit Scale (Grit-S; Duckworth & Quinn, 2009), thus allowing for exploration of three sub-dimensions of grit: Consistency of Interest, Perseverance of Effort, and Ambition in accordance with the recommendations of Jarden (2011). GRIT items were measured on a 5-point Likert scale ranging from “1-Not like me at all” to “5-Very much like me” in response to questions such as “I have overcome setbacks to conquer an important challenge”, “I think achievement is overrated” (negatively scored), and “Setbacks don’t discourage me”. For a full list of GRIT items, see Appendix L.

Across six initial validation studies, the Grit Scale yielded Cronbach’s alphas ranging from .70 to .84 and demonstrated predictive and consensual validity as well as test-retest reliability (Duckworth & Quinn, 2009). The GRIT scale in this study yielded a Cronbach’s alpha of .85. Each participant’s GRIT score was calculated as the average of their responses to the 17 scale items. For a detailed depiction of scale characteristics including means, standard deviations, and Cronbach’s alphas, see Table 8.

**Procedure**

A mixed-methods design with both quantitative and qualitative components was utilized. Participants included English-speaking adults who self-identified as (a) transgender, (b) gender
non-conforming, and/or (c) with a gender identity other than the sex they were assigned at birth (e.g., transgender, genderqueer, agender). Recruitment included emails to various United States university listservs, trans-serving community organizations (local and national), as well as social media posts to transgender and ally groups on Facebook.com (e.g., “The Facebook Transgender Alliance”, “TGNCREsearch”, and “TRANSlations”). Study links were also disseminated via a website entitled “Psychological Research on the Net” (http://psych.hanover.edu/Research/exponnet.html) which chronicles current online research in psychology, arranged by topic. These recruitment avenues facilitated access to a socio-demographically diverse sample while also maximizing anonymity in participation.

The procedure consisted of two independent studies, both utilizing mixed-method designs. At the end of both studies, an identical survey item assessed participant knowledge/awareness of recent events and media surrounding TGNC individuals (e.g., Janet Mock, Caitlyn Jenner, or Laverne Cox): “Are you aware of recent increases in media and pop culture portrayals and discussions of TGNC individuals and TGNC identities? If so, please describe an instance or two which stand out in your memory?”

During the first study, participants \( (N = 15) \) completed a face-to-face semi-structured gender identity interview with the primary investigator for approximately 60-90 minutes. Study 1 participants also completed the Demographic Questionnaire, the PHQ-9, the GAD-7, the Gender Dysphoria Questionnaire, the Flourishing Scale, the Grit Scale, and the Social Support Questionnaire. These quantitative measures required approximately 10-15 minutes to complete. Interviews took place during April, June, and July of 2016.

During the second study, participants \( (N = 342) \) utilized an online survey platform to complete the Demographic Questionnaire, Victimization Survey, Gender
Experiences/Expression/Identity Questionnaire, Gender Dysphoria Questionnaire, PHQ-9, GAD-7, Flourishing Scale, Grit Scale, and Social Support Questionnaire. These instruments required approximately 20-30 minutes to complete. To minimize the influence of common survey methodology limitations, several methodological elements were implemented. First, to minimize fatigue experienced by participants progressing through the survey, question logic was implemented in which participants were presented with a minimum number of follow-up questions based on their previous responses. Second, in order to maintain the integrity of the survey instruments as provided by their authors and to counter-balance potential order effects, four levels of randomization were implemented. First, prior to randomization, some measures were always in the same order (e.g., informed consent always occurred first, demographics always occurred last, the validity check for TGNC media awareness always occurred second-to-last, and the thank you/resource page always occurred last)/ Second, Survey pages were placed into one of two groups based upon their content (gender identity or well-being)/ Third, the order of group presentation was randomized. Finally, the presentation of survey pages within the random presentation of each group was randomized, with each page containing one survey instrument. The online survey opened on November 2, 2015 and closed on July 14, 2016.

Participation was voluntary, and participants could choose to cease participating at any time without penalty. Study 1 participants received $50 cash for their time after their interviews and completing their surveys. Study 2 participation was non-incentivized, though participants were informed of potential benefits to the field and for TGNC communities. Participation was anonymous as no identifiable data was ever requested or collected at any point during the research process. Participants indicated consent with a signature on a hard copy consent form for Study 1, and by selecting an affirmative survey response at the bottom of an independent survey
Both consent procedures included identical information detailing the purpose of the study and describing the rights of participants. The consent process also provided researcher contact information to address any pre-participation questions or concerns. All participants received identical counseling resources including online, telephone, and face-to-face options (in hard copy for Study 1, and in the form of a final survey page for Study 2).

To address the potential for participant endorsement of suicidal ideation or intent via the PHQ item “Have you had thoughts that you would be better off dead or of hurting yourself in some way”, participants who select any response other than “not at all” were immediately presented with information regarding suicide prevention resources (including websites and a national hotline for LGBTQ suicide prevention). Over half (55.7%) of participants did not endorse suicidal ideation or intent; however, a sizeable portion of participants endorsed suicidal ideation (SI) at different levels over the two weeks prior to participation. Specifically, 23.5% endorsed SI “several days”, 11% endorsed SI “over half the days”, and 9.8% endorsed SI for “nearly all of the days”.

**Analysis**

Study 2 data was analyzed utilizing techniques including Pearson’s product moment correlation, linear and hierarchical regression, and analyses of group differences including T-tests and ANOVAs. Corrections for inflation of alpha and Type I error were utilized when appropriate in the form of the Bonferonni Correction. For analyses in which the outcome variables involved psychological well-being, Canonical Correlation Analyses (CCA) were run - given the likelihood of construct overlap between depression, anxiety, and gender dysphoria. CCA is appropriate due to the inter-correlation between predictors (victimization variables) and
between outcomes (well-being variables). By running CCA rather than simple linear or even hierarchical regressions, we can better understand the variance explained by predictors in relation to their latent constructs (victimization and well-being; Sherry & Henson, 2005). To test mediation hypotheses, Sobel’s test of mediation was utilized (Sobel, 1982). Mediation was also tested using the bootstrapping technique described in Hayes (2013). Bootstrapping is useful as a test of mediation as it does not rely as heavily upon statistical significance as in Sobel (1982), but rather significance is inferred more widely based upon confidence intervals (wherein a confidence interval including zero is considered non-significant whereas confidence intervals not including zero indicate significance).

Study 1 data was analyzed via the Consensual Qualitative Research (CQR; Hill, Thompson, & Williams, 1997) method. CQR is a method of qualitative data analysis which utilized open-ended questions to gather information in the form of words, which are then categorized and interpreted. CQR arises out of the trend of “grounded theory”, therefore themes and interpretations will be derived from the data, rather than attempting to fit the data into any pre-existing theoretical framework. Decisions regarding coding domains as well as which segments of data belong in which domain occurred as a result of group discussion until reaching consensus.

The coding team consisted of three individual coders and one external auditor. Because personal identities inform world views, members of the coding team anonymously reported their self-identifications and were encouraged to examine the ways in which their various identities might inform their perspectives on the data and coding process. The coding team included two current master’s students and one current doctoral student in psychology. Coders endorsed racial/ethnic identities including “mixed”, “Asian American”, and “White, Non-Hispanic”. Two
coders identified as “cisgender females” whereas the third coder identified as “gender non-conforming”. Coders identified their sexual orientations as “Queer”, “Straight/heterosexual”, and “Pansexual”. The external auditor identified as a cisgender male gay Asian American professor.

Due to the complexity of the results, this section has been divided into two chapters: Quantitative Results (Chapter 4) and Qualitative Results (Chapter 5). Chapter 4 outlines general descriptive statistics and quantitative results related to seven a-priori hypotheses. Chapter 5 outlines qualitative results from CQR analyses related to the seven a-priori hypotheses, followed by a series of ancillary analyses in addition to those initially proposed. Predictive statistical analyses were limited to Study 2 (online survey) results (N = 342) given the small sample size (N = 15) of Study 1. Descriptive and qualitative analyses were applied to both studies, though the largest degree of qualitative results arose from Study 1 (individual interviews).

**Chapter 4: Quantitative Results**

The following seven hypotheses were tested: 1) Participant narratives will indicate a greater degree of heterogeneity in later phases of identity development than previously considered; 2) Narratives will reveal common themes of risk (e.g., internalized or environmental stigma) and resiliency (e.g., social support, community connectedness) within developmental processes; 3) Victimization will positively predict depression, anxiety, gender dysphoria, and grit; 4) Victimization will negatively predict flourishing; 5) Social support will mediate the relationship between victimization and psychological well-being; 6) TGNC community connectedness will mediate the relationship between victimization and psychological well-being; 7) Victimization will relate to decreased help-seeking (mental health or criminal justice services). All hypothesis tests were run based upon the post-multiple imputation data set. For a
summary of overall hypotheses supported versus not supported, see Table 6. For a summary of overall CQR qualitative coding results, see Table 7.

**Data Cleaning**

Prior to hypothesis-testing, multiple steps were taken: 1) data were analyzed both graphically and statistically for the presence of outliers; 2) missing data analyses were undertaken; 3) data were analyzed both graphically and statistically in relation to the four assumptions for linear regression: linearity, independence, homoscedasticity, and normality; 4) construct variables were individually coded and prepared for analysis; and 5) analyses of group differences were undertaken to identify the presence of any systematic differences in construct scores based on socio-demographic variables (i.e., age, gender identity, sexual orientation, and race/ethnicity).

**Outliers.** Multiple steps were taken to assess and identify outliers within each variable distribution. First, descriptive statistics were examined for each construct variable comparing the mean to the 5% trimmed mean (i.e., the mean after the highest and lowest 5% of the data have been removed). A substantial difference between the mean and 5% trimmed mean was interpreted as an indicator of problematic skewness potentially influenced by outliers. This step indicated possible issues with victimization variables, which were then examined for outliers. Graphical depictions including histograms and box and whisker plots were then examined to identify specific outliers for victimization variables. This step further supported the abovementioned decision to code victimization categorically rather than continuously, as traditional methods of eliminating outliers were not reasonable for these variables. For example, winsorizing (Dixon, 1960), or excluding as outliers any data points beyond a certain criterion (e.g., one or two standard deviations from the mean) would have substantially restricted the data,
eliminating over 75% of data points. These results were interpreted as indicating that data points which might have been interpreted as outliers could more accurately be understood as meaningful data points, and further as an indication that victimization would be best characterized as categorical rather than continuous.

Three verbal victimization data points (.88%) were removed based upon conceptualizing a single instance of verbal victimization as lasting up to 60 minutes (thus characterizing repeated shorter instances of victimization as part of one larger episode rather than as discrete units). Based on this conceptualization, any reported frequency for experienced discrimination would be ruled out as unreasonable if it exceeded 24 per day. Based on these two decisional criteria, four data points were removed. For example, one participant reported 50505050 instances of verbal discrimination within their lifetime. Based on this participant’s age (19), this would average to approximately 7,283 daily instances of verbal discrimination (including participant’s pre-verbal years, for a conservative estimate).

Two data points were removed from two additional items, the first asking participants at what age they first self-identified as TGNC and the second asking participants at what age they first presented themselves in accordance with their gender identity, because impossible values were entered (e.g., an age of “200” or “202”).

**Missing data.** System missing data presents throughout this data set for several reasons, two of which predominate. First, participation was entirely voluntary, and participants were afforded the option of skipping and not answering any question(s) without penalty. Second, the online survey included multiple question logic algorithms such that participants would only view survey items relevant to them, based on their previous responses (e.g., if a participant stated that they have never experienced sexual discrimination in their lifetime, they would not view any
follow-up items regarding age at first sexual discrimination, perpetrator information, etc. as such participants denied having this experience outright). In addition, it is possible that participants failed to respond to an item due to inattention or other factors external to the study method.

Data which was missing due to participants voluntarily skipping questions or due to inattention or other extra-study factors could not be definitively identified, and thus received no assigned missing data value label in SPSS. Missing data which resulted from the question logic algorithm was assigned a value of “-55”, a value not contained within the range of possible values for those items. Additionally, one variable (lifetime verbal discrimination frequency) contained user missing values (three highly improbable participant self-reported values for frequency of lifetime verbal discrimination experiences, specifically participants 188, 229, and 312). These user missing variables were defined within SPSS with a value of “-99”, a value not contained within the range of possible values for lifetime verbal discrimination frequency, which cannot be negative.

In summary, this dataset includes three categories of missing data: 1) system missing data due to extra-methodological reasons which cannot be confirmed by the researcher (coded automatically in SPSS a system missing data); 2) user missing data defined based on the four values excluded by the researcher (defined as “-99”); and 3) system missing data which resulted from the survey algorithm (coded as “-55”). Missing data analyses were run to better understand the first category: extra-methodological system missing data.

First, Little’s Missing Completely at Random (MCAR; Little, 1988) test was applied (only to the extra-methodological system missing data) to determine whether system missing data occurred at random, or whether some identifiable pattern exists within this form of missing data. MCAR results indicated that missing data within the sample are random $\chi^2(11694, N =}$
342) = 11883.88, \( p = .11 \). Because data were found to be missing at random, multiple imputation analysis was deemed appropriate (Enders, 2010). This method was chosen as it maximizes the ability to accurately represent the uncertainty surrounding system missing values by combining a set of plausible values rather than simply replacing missing values with the mean, which may or may not represent the most accurate depiction of that missing data point (Yuan, 2010). The multiple imputation method implemented utilized the full range of values available to participants for each survey item (rather than restricting to the range of observed values), and required five imputations, a number deemed sufficient in past research (Graham, Olchowski, & Gilreath, 2007).

**Preliminary Analyses**

*Regression Assumptions.* Each assumption (i.e., linearity, normality, homoscedasticity, and independence of errors) was evaluated for the following predictor variables: discrimination (lifetime and past-year for verbal, physical, and sexual discrimination experiences) in relation to each of the following outcome variables: depression, anxiety, gender dysphoria, flourishing, GRIT, and help-seeking (mental health, medical, criminal justice minor, and criminal justice major). Regression assumptions were examined in relation to the data after missing data analysis (including multiple imputation), because all hypothesis-testing was based upon the imputed data set.

To test linearity, standardized residuals were plotted against predicted values. Normality was assessed both statistically (utilizing Shapiro-Wilk test wherein a significant value of \( p < .05 \) indicates non-normality) and graphically (through visual analysis of histograms). Shapiro-Wilk significance values indicated non-normality for gender dysphoria, social support, depression, flourishing, and mental health help-seeking (all with \( p < .05 \)). Thus, the following variables
demonstrated normality indicated by $p > .05$: medical help-seeking, criminal justice major and minor help-seeking, GRIT, and anxiety.

Non-normally distributed variables were transformed according to the nature of their skew. Specifically, a square root transformation was applied to positively skewed variables (i.e., depression) whereas negatively skewed data were first reflected and then transformed using both square root and log10 transformations (the most effective transformation was retained for subsequent analyses). All variables which were reflected during transformation were subsequently re-reflected for simplicity of interpreting directionality during hypothesis-testing. The square root transformation effectively increased the normality of depression but not gender dysphoria, social support, or flourishing. Thus, a log10 transformation was applied to the latter three variables, producing substantially improved normality (though still not passing the stringent Shapiro-Wilk test for statistical normality).

Lastly, homoscedasticity was tested utilizing the Variance Inflation Factor (VIF) was used wherein $1 < \text{VIF} < 10$ indicates sufficient homoscedasticity (Gelman & Hill, 2006), and independence of errors was assessed using the Durbin-Watson statistic, wherein autocorrelation is deemed non-problematic when $1 < d < 3$ and Tolerance is $< .10$ (Durbin & Watson, 1971). Results indicated that multicollinearity was not a concern (verbal victimization, Tolerance = .77, VIF = 1.30; physical victimization, Tolerance = .92, VIF = 1.09; sexual victimization, Tolerance = .63, VIF = 1.60) and that data met the assumption of independent errors (depression $d = 2.36$; anxiety $d = 1.90$; gender dysphoria $d = 2.65$; flourishing $d = 1.57$; GRIT $d = 2.09$; mental health help-seeking $d = 1.60$; medical health help-seeking $d = 1.98$; criminal justice minor help-seeking $d = 2.19$; criminal justice major help-seeking $d = 2.69$).
Construct variables. Construct variables were coded based upon the established interpretation guidelines for their associated measures when available, and based upon considerations including theory and logic regarding the variable’s distribution where established coding guidelines did not exist. For a summary of bi-variate correlations between constructs, see Table 4.

Victimization was first coded according to frequency of victimization experiences (lifetime and past-year) for verbal, physical, and sexual discrimination. These three levels of victimization (each with their two frequencies: lifetime and past-year) remain distinct throughout subsequent analyses. Initially, the author considered combining these variables into lifetime and past-year frequencies across the three sub-dimensions (verbal, physical, and sexual), however upon deeper examination of these variable distributions it was determined that to combine them into a single victimization variable would sacrifice depth of the data as well as misrepresenting variance between the three categories of verbal, physical, and sexual victimization. Further, statistical analyses of these variables indicated substantial positive skewness across all levels and graphical visual analysis indicated that these variable distributions would be best characterized categorically rather than continuously. See Table 5 for a breakdown of victimization experiences by method of measurement. Specifically, all variables were positively skewed, with frequency spikes at 2-3 separate locations in each distribution. In order to maximize statistical power and to maintain a bin size sufficient for parametric testing, each variable was categorized into two levels: “high” and “low”, divided by the median value such that approximately 50% of the distribution fell above and 50% below the cut-off—with one exception. The median value for past-year sexual discrimination was zero, thus the cut-off for high/low for this variable was set at one. See Table 9 for response ranges captured for each variable category.
Depression, anxiety, flourishing, and GRIT were each coded based on the average of participant responses to the Likert scales comprised within each respective measure. Gender dysphoria was coded based on the number of items endorsed, such that participants who endorsed a greater number of gender dysphoria symptoms would score higher on their corresponding total score.

Social support scores were calculated as the sum of endorsed items, such that scores ranged from 0-6 depending on whether participants felt they had access to social support in the six different contexts addressed by the questionnaire: distraction from worries, relaxation when under pressure, full acceptance, unconditional caring, feeling down-in-the-dumps, and feeling very upset. Participants also ranked the extent to which they are satisfied with their current level of overall social support on a scale from 0-100. The remaining variables (i.e., depression, anxiety, flourishing, and GRIT) were coded based on the average of participant responses to the Likert scales comprised in each measure.

As noted in the above section on data cleaning and preliminary analyses, the following variables underwent transformations to meet assumptions for linear regression: depression, mental health help-seeking, gender dysphoria, social support, and flourishing. All transformations performed (specifically square root and log10 transformations) maintained the integrity of the data, and any variables which required reflection during transformation were later re-reflected for ease of interpretation. Thus, all variables including those which underwent transformation may be interpreted logically (i.e., higher values indicate higher levels of depression, anxiety, etc.)

Analyses of group differences. Analyses of group differences were run to assess whether participant scores on construct variables might have varied systematically according to socio-
demographic variables. Construct variables included the six victimization variables, depression, anxiety, gender dysphoria, flourishing, GRIT, social support, community connectedness, and help-seeking including mental health, medical, criminal justice for major crimes, and criminal justice for minor crimes. Socio-demographic variables assessed included age, gender identity, and race/ethnicity.

**Age.** Pearson product-moment correlations were calculated to assess relationships between age and the abovementioned construct variables. With regard to victimization, age only significantly correlated with past-year verbal victimization ($r = -.17, p = .01$). To demonstrate systematic variation in victimization based on age, significant correlations would have been expected across multiple domains of victimization (past-year and lifetime for verbal, physical, and sexual). In particular, if variation was systematic, significant correlations between age and lifetime frequencies of verbal, physical, and sexual victimization were expected, however this effect was not observed. Thus, victimization does not appear to systematically vary with age.

Age significantly negatively correlated with depression ($r = -.26, p < .001$), anxiety ($r = -.26, p < .001$), and gender dysphoria ($r = -.21, p < .001$). These results indicate that psychological distress significantly varies according to age, such that participants who are older reported lower levels of psychological distress. Similarly, age significantly correlated with both variables of psychological well-being ($r = .20, p < .001$ and $r = .255, p < .001$ for flourishing and GRIT respectively). Despite these significant findings, $r$ scores were moderate and should be interpreted cautiously. In terms of social support and TGNC community connectedness, both demonstrated a negative correlation wherein increased age related to decreased support/connection, though only the social support correlation was significant and weak ($r = -.13, p = .02$).
Lastly, age was examined in relation to the four help-seeking variables: mental health, medical, criminal justice for minor crimes, and criminal justice for major crimes. Age significantly positively correlated with all four help-seeking variables ($r = .13, p = .01; r = .19, p = .001; r = .23, p < .001; r = .20, p < .001$ respectively). Thus, overall, the following constructs demonstrated systematic variation according to age: depression, anxiety, gender dysphoria, flourishing, GRIT, social support, and all four help-seeking variables. Though r-scores ranged from weak to moderate, hypothesis-testing analyses involving these variables will control for age.

**Gender identity.** One-way analyses of variance (ANOVAs) were run to assess whether construct scores varied as a function of gender identity. The Bonferroni adjustment was applied to all post-hoc tests to control for Type I error inflation (in this ANOVA and all subsequent ANOVAs in this section). Neither victimization nor help-seeking varied systematically according to gender identity. There was a significant effect of gender identity on gender dysphoria, depression, anxiety, flourishing, and GRIT. However, this effect was not systematic across the outcome variables. For example, participants who identified as “transgender (non-binary)” scored significantly higher on gender dysphoria than binary-identified participants, but these results were not replicated for depression, anxiety, flourishing, or GRIT.

To examine whether the above findings might have been impacted by small group sizes, gender identity was recoded into binary (i.e., male, female, MtF, or FtM) and non-binary (non-binary, genderqueer, or identity not listed) identifications and all comparisons were re-run using independent sample T-Tests. Results indicate compelling differences based on gender identity (binary versus non-binary). Specifically, binary-identified participants reported significantly higher levels of GRIT, flourishing, criminal justice major help-seeking comfort, and medical
help-seeking comfort whereas non-binary participants reported significantly higher levels of gender dysphoria and depression. Notably, these results generally indicate that binary-identified participants endorsed higher levels of psychological strengths and help-seeking orientation whereas non-binary participants endorsed higher levels of psychological distress.

**Race/ethnicity.** One-way analyses of variance (ANOVAs) were run to assess whether construct scores varied as a function of race/ethnicity. There was no significant effect of race/ethnicity on victimization or any of the help-seeking variables. There was a significant effect of race/ethnicity on depression and anxiety, but not on gender dysphoria, flourishing, or GRIT. Specifically, White and mixed-race/ethnicity participants scored significantly higher on depression compared to Hispanic/Latina/o/x. Similarly, participants of mixed race/ethnicity scored significantly higher on anxiety compared to Hispanic/Latina/o/x. Notably, these results indicate that participants of mixed race/ethnicity fare worse in terms of psychological distress (i.e., depression and anxiety, but not gender dysphoria) compared to White and Hispanic/Latina/o/x participants (who, together, comprise 87% of the sample).

To examine whether the above findings might have been impacted by small group sizes, race/ethnicity was recoded into three categories: white, POC, and mixed. All comparisons were then re-run using ANOVAs with the Bonferonni correction applied. Results indicate compelling differences based on race/ethnicity specifically in terms of mental health comfort, gender dysphoria, depression, and anxiety. In terms of comfort seeking mental health services, mixed-race participants ($M = 43.80$) scored significantly lower than white participants ($M = 64.95$), and significantly lower than POC ($M = 63.31$), $F(2,338) = 5.29, p = .01$. Regarding gender dysphoria, POC scored significantly lower than white participants, $F(2,338) = 3.81, p = .02$ ($M = 1.13$ and 1.21 respectively). Regarding depression, POC ($M = .90$) scored significantly lower than white
participants and significantly lower than mixed-race participants ($M = 1.22$), F(2,338) = 5.65, $p < .01$. Lastly, with regard to anxiety, mixed-race participants ($M = 1.88$) scored significantly higher than white ($M = 1.38$) and POC ($M = 1.08$), F(2,338) = 6.89, $p = .001$.

**Descriptive Statistics**

The following constructs were examined descriptively: help-seeking (mental health, medical health, criminal justice for minor crimes, and criminal justice for major crimes), depression, anxiety, gender dysphoria, GRIT, flourishing, social support, and TGNC community connectedness. See Table 8 for a depiction of scale means, standard deviations, and reliability statistics (i.e., Cronbach’s alpha). All construct descriptives as reported in the aforementioned tables were based upon observed data values, as these analyses were conducted prior to multiple imputation of missing data.

**Hypothesis 3: Victimization as a positive predictor.** Hypothesis three posited that victimization (verbal, physical, and/or sexual) will positively predict depression, anxiety, gender dysphoria, and grit. That is, that participants who experienced higher levels of victimization would report higher levels of psychological distress, while also demonstrating higher levels of resilience in the face of cumulative challenges (i.e., GRIT). To test this hypothesis, a canonical correlation analysis (CCA) was conducted, based upon its strengths in maintaining orthogonal relationships between variables to allow for improved understanding of unique variable contributions to overall variance in the outcomes, as well as due to its utility when working with latent constructs as it accounts for the latency rather than relying exclusively upon observed values.

To test Hypothesis 3, two sets were entered into the CCA: 1) Victimization variables (i.e., verbal, physical, and sexual both past-year and lifetime) and 2) Psychological well-being
variables (i.e., depression, anxiety, gender dysphoria, and GRIT). The CCA produced four responses (variates), the first of which demonstrated statistical significance $\lambda = .04$, $F(24, 32.61) = 2.03$, $p = .03$, $R^2_c = .76$. Thus, the model captures approximately 76\% of the variance shared by victimization and psychological well-being. Of the six victimization variables, the best predictor for Variate 1 was physical lifetime victimization ($r_s = -1.29$) whereas other forms of victimization ranged in $r_s$ from .14 to .48 (in absolute values). The second-best predictor for Variate 1 was lifetime sexual victimization ($r_s = .48$). Of the four well-being variables, the best predictor of Variate 2 was gender dysphoria ($r_s = -.81$) followed closely by anxiety ($r_s = -.78$) and depression ($r_s = .61$). GRIT was the weakest predictor for Variate 2 ($r_s = .37$). To determine the significance of these canonical correlation coefficients, their respective canonical loadings were examined, with a cut-off of .30 (absolute value) as an indicator of a moderate and significant relationship.

The following victimization (Set 1) variables significantly relate to Variate 1: verbal lifetime, verbal past-year, physical lifetime, sexual lifetime, and sexual past-year. Interestingly, while lifetime experiences of physical victimization were the strongest predictor, past-year experiences of physical victimization were non-significant. All four well-being variables (Set 2) significantly related to Variate 2. For a summary of the relationships between victimization and well-being latent variables, see Table 10.

Lastly, redundancy analysis of cross-loadings was conducted to explore the extent to which each variable (e.g., verbal victimization, depression, etc.) measures its own latent score (i.e., victimization and well-being respectively) compared to measurement of the other latent score. Canonical loadings which exceed the values of cross-loadings indicate that variables are effective predictors of their own latent scores, and that the two combined variables of victimization and well-being represent distinct latent constructs. Results supported independence
of these two latent constructs, and that variables each measure their own latent constructs better than the other latent construct. Further, cross-loadings were examined relation to proportion of variance explained also indicating that Set 1 (victimization) accounted for 33% of unique variance whereas Set 2 (well-being) accounted for 28% of unique variance in their own constructs, whereas this predictive strength was lower across constructs (24.7% and 15.7% for Set 1x2 and 2x1 respectively).

Overall, these results indicate that victimization positively predicts depression, anxiety, and gender dysphoria and negatively predicts GRIT. Thus, Hypothesis 3 was supported in relation to depression, anxiety, and gender dysphoria whereas the inverse of Hypothesis 3 was upheld for GRIT. Put simply, participants who experienced higher levels of victimization (especially increased lifetime physical victimization episodes) also experienced higher levels of depression, anxiety, and gender dysphoria and lower levels of GRIT (or perseverance in the face of adversity).

**Hypothesis 4: Victimization as a negative predictor.** Hypothesis 4 posited that victimization would negatively predict flourishing. Multiple hierarchical regression analysis was used to assess victimization as a predictor of flourishing. Flourishing only significantly correlated with sexual past-year victimization ($r = -.44, p = .002$), thus sexual past-year victimization was entered into the model on the first step, followed by all of the remaining predictors (i.e., both categories of verbal and physical victimization and sexual lifetime victimization) entered simultaneously in the second step. Results indicated non-significance for both models $F(5,12) = 2.62, p = .07, R^2 = .57$.

The researcher hypothesized that the ability to detect a significant predictive relationship may have been limited due to the range restriction after dichotomizing all six victimization
variables into high/low levels (around the median). Thus, the model was re-run with the original continuous victimization variables (i.e., past-year and lifetime frequency of verbal, physical, and sexual victimization). Of note, these variables met regression assumptions of linearity, homoscedasticity, and independence of errors, but demonstrated non-normal distributions. This non-normality was deemed non-problematic given the large sample size, thus a linear model was still deemed appropriate for analysis. Flourishing significantly correlated with past-year verbal victimization ($r = -.15, p = .008$), lifetime physical victimization ($r = -.11, p = .04$), and past-year sexual victimization ($r = -.14, p = .01$). Effect sizes of non-significant correlations were investigated to assess appropriateness for model inclusion, resulting in exclusion of verbal lifetime ($r = -.01$), physical past-year ($r = -.05$), and sexual lifetime ($r = -.08$) as these variables failed to demonstrate moderate (or even weak) effect sizes. Variables were entered into the steps based upon theoretical importance and reported frequencies among participants. Thus, past-year verbal victimization was entered in Step 1, lifetime physical victimization in Step 2, and past-year sexual victimization in Step 3.

Results partially supported Hypothesis 4, as victimization significantly (negatively) predicted flourishing across all three models, though this model is a weak predictor, predicting only 4.7% of variance in flourishing, $F(1, 331) = 5.40, p = .001$, $R^2 = .05, 95\% \text{ CI} [-.08, -.01]$. However, all forms of victimization were not significant predictors, and the time-period within which predictive victimization occurred varied across the predictors (i.e., past-year for verbal and sexual and lifetime for physical). See Table 11 for the full model.

**Hypothesis 5: Social support as a mediator.** To examine the hypothesis that social support mediates the relationship between victimization and psychological well-being (depression, anxiety, and gender dysphoria), Sobel’s Test for mediation (Sobel, 1982). First,
correlation matrices for hypothesized mediation variables were examined, to evaluate whether the bivariate relationships meet the conditions (i.e., significant bivariate linear relationships) necessary for evaluating mediation relationships. Results indicated significant correlations between social support and both categories of verbal discrimination, past-year physical discrimination, depression, anxiety, flourishing, and GRIT. Based on these results, it was decided that two separate mediation analyses would be most appropriate: 1) evaluating social support as a mediator between victimization (verbal and past-year physical) and psychological distress (depression and anxiety) and 2) evaluating social support as a mediator between victimization (verbal and past-year physical) and psychological well-being (flourishing and GRIT).

**Victimization and distress.** Raw (unstandardized) regression coefficients and their standard errors were individually computed using SPSS for the following bivariate relationships: 1) victimization predicting social support (B = -0.03, SEB = 0.06), 2) victimization and social support predicting distress (B = -0.66, SEB = 0.26). Values for victimization were calculated as the sum of values obtained for verbal (past-year and lifetime) and past-year physical. Values for distress were calculated based on the average of anxiety and depression scores. These values were then entered into Sobel’s equation to determine whether the indirect effect of victimization on distress via social support is greater than zero. The Aroian version of the Sobel test was used as per Baron and Kenny (1986). Results indicated that the Sobel test was significant (Sobel value = 0.46, p = 0.04), indicating that social support significantly mediates the relationship between victimization and distress.

The indirect (mediation) effect of social support on the relationship between victimization and distress was also examined utilizing Hayes (2013) bootstrapping technique. The direct effect of victimization on distress was estimated at 0.20 (SE = 0.09) 95% CI [0.02, 0.39],
\( t(34) = 2.22, p = .03 \). This indicates that victimization significantly (positively) predicts distress. However, the indirect effect of victimization on distress, mediated through social support was not significant, indirect effect = .02 (SE = .04), .95% CI [-.05, .12].

**Victimization and well-being.** The abovementioned steps were repeated to examine whether social support mediates the relationship between victimization and well-being. As above, well-being was calculated as the average of flourishing and GRIT scores. Raw (unstandardized) regression coefficients and their standard errors were individually computed using SPSS for the following bivariate relationships: 1) victimization predicting social support \( (B = -.03, SE = .06) \), 2) victimization and social support predicting well-being \( (B = .41, SE = .17) \). These values were then entered into Sobel’s equation to determine whether the indirect effect of victimization on distress via social support is greater than zero. The Aroian version of the Sobel test was used as per Baron and Kenny (1986). Results indicated that the Sobel test was not significant (Sobel value = -.45, \( p = .65 \)), indicating that social support does not mediate the relationship between victimization and well-being.

The indirect (mediation) effect of social support on the relationship between victimization and well-being was also examined utilizing Hayes (2013) bootstrapping technique. The direct effect of victimization on well-being was non-significant, estimated at .02 (SE = .06) 95% CI [-.10, .14], indicating that victimization alone does not significantly predict well-being. Thus, the indirect effect of victimization on well-being, mediated through social support was also not significant, indirect effect = -.01 (SE = .03), .95% CI [-.08, .03].

The researcher hypothesized that social support may differentially impact relationships between victimization and flourishing compared to victimization and GRIT (based upon the conceptualization of flourishing as a generalized measure of well-being and GRIT as a measure
of perseverance in the face of adversity). Thus, two separate mediation analyses were run separately investigating the potential for social support to mediate relationships between victimization and flourishing versus GRIT. Raw (unstandardized) regression coefficients and their standard errors were individually computed using SPSS for the following bivariate relationships: 1) victimization predicting social support (B = -0.03, SEB = 0.06), 2), victimization and social support predicting flourishing (B = 0.27, SEB = 0.09). These values were then entered into Sobel’s equation to determine whether the indirect effect of victimization on distress via social support is greater than zero. The Aroian version of the Sobel test was used as per Baron and Kenny (1986). Results indicated that the Sobel test was not significant (Sobel value = -0.47, p = 0.64), indicating that social support does not mediate the relationship between victimization and flourishing.

Lastly, raw (unstandardized) regression coefficients and their standard errors were individually computed using SPSS for the following bivariate relationships: 1) victimization predicting social support (B = -0.03, SEB = 0.06), 2), victimization and social support predicting GRIT (B = 0.56, SEB = 0.30). These values were then entered into Sobel’s equation to determine whether the indirect effect of victimization on distress via social support is greater than zero. The Aroian version of the Sobel test was used as per Baron and Kenny (1986). Results indicated that the Sobel test was not significant (Sobel value = -0.43, p = 0.67), indicating that social support does not mediate the relationship between victimization and GRIT. Thus, Hypothesis 5 was partially supported, as social support significantly mediated the relationship between victimization and distress (depression and anxiety) but not well-being (flourishing and/or GRIT). It is interesting that this mediation hypothesis was supported by Sobel’s test, but not by the bootstrapping
technique, and any interpretations of these results should carefully consider the fact that this finding was not unanimously supported by all statistical analyses.

The indirect (mediation) effect of social support on the relationship between victimization and flourishing was also examined utilizing Hayes (2013) bootstrapping technique. The direct effect of victimization on flourishing was non-significant, estimated at -.03 (SE = .03) 95% CI [-.09, .03]. This indicates that victimization alone does not significantly predict flourishing. Thus, the indirect effect of victimization on flourishing, mediated through social support was also not significant, indirect effect = -.01 (SE = .02), 95% CI [-.05, .02].

The indirect (mediation) effect of social support on the relationship between victimization and GRIT was also examined utilizing Hayes (2013) bootstrapping technique. The direct effect of victimization on GRIT was non-significant, estimated at .05 (SE = .11) 95% CI [-.17, .27]. This indicates that victimization alone does not significantly predict GRIT. Thus, the indirect effect of victimization on GRIT, mediated through social support was also not significant, indirect effect = -.02 (SE = .04), 95% CI [-.15, .02].

In summary, Hypothesis 5 was not supported in terms of social support mediating relationships between victimization and distress, between victimization and well-being, between victimization and GRIT, or between victimization and flourishing, regardless of mediation method utilized (i.e., Sobel versus bootstrapping). Additionally, the hypothesis that a moderation rather than mediation effect may be present was tested by conducting linear regressions and comparing the simple linear model to that same model with the moderator (standardized victimization * standardized social support). As with mediation, results do not support social support as a moderator between victimization and psychological distress or well-being.
Hypothesis 6: TGNC community connectedness as a mediator. To examine the hypothesis that TGNC community connectedness mediates the relationship between victimization and psychological well-being (depression, anxiety, and gender dysphoria), Sobel’s Test for mediation (Sobel, 1982). First, correlation matrices for hypothesized mediation variables were examined, to evaluate whether the bivariate relationships meet the conditions (i.e., significant bivariate linear relationships) necessary for evaluating mediation relationships. Results indicated that TGNC community connectedness only correlated significantly with flourishing \((r = .16, p = .004)\). However, TGNC community connectedness demonstrated a marginally significant correlation with gender dysphoria \((r = .11, p = .05)\). None of the victimization variables significantly correlated with TGNC community connectedness, however gender dysphoria significantly correlated with verbal past-year \((r = .14, p = .04)\) and physical lifetime \((r = .45, p = .001)\) victimization. Flourishing correlated only with past-year sexual victimization \((r = -.44, p = .002)\). Based on these results, it was decided that two separate mediation analyses would be most appropriate: 1) evaluating TGNC community connectedness as a mediator between victimization (past-year verbal, physical lifetime, and past-year sexual) and gender dysphoria and 2) evaluating TGNC community connectedness as a mediator between victimization (verbal and past-year physical) and psychological flourishing.

Victimization and gender dysphoria. Raw (unstandardized) regression coefficients and their standard errors were individually computed using SPSS for the following bivariate relationships: 1) victimization predicting TGNC community connectedness \((B = .30, SE_B = .69)\), 2), victimization and TGNC community connectedness predicting gender dysphoria \((B = .15, SE_B = .04)\). Values for victimization were calculated as the sum of values obtained for verbal past-year, physical lifetime, and sexual past-year victimization. These values were then entered
into Sobel’s equation to determine whether the indirect effect of victimization on distress via social support is greater than zero. The Aroian version of the Sobel test was used as per Baron and Kenny (1986). Results indicated that the Sobel test was not significant (Sobel value = .10, \( p = .92 \)), indicating that TGNC community connectedness does not significantly mediate the relationship between victimization and gender dysphoria.

The indirect (mediation) effect of TGNC community connectedness on the relationship between victimization and gender dysphoria was also examined utilizing Hayes (2013) bootstrapping technique. The direct effect of victimization on gender dysphoria was estimated at .15 (SE = .04) 95% CI [.08, .23], \( t(20) = 4.25, p = .001 \). This indicates that victimization significantly (positively) predicts gender dysphoria. However, the indirect effect of victimization on gender dysphoria, mediated through TGNC community connectedness was not significant, indirect effect = -.001, SE = .01, 95% CI [-.03, .01].

Victimization and flourishing. Raw (unstandardized) regression coefficients and their standard errors were individually computed using SPSS for the following bivariate relationships: 1) victimization predicting TGNC community connectedness (B = .30, SEB = .69), 2) TGNC community connectedness and victimization predicting flourishing (B = -.10, SEB = .04). Values for victimization were calculated as the sum of values obtained for verbal past-year, physical lifetime, and sexual past-year victimization. These values were then entered into Sobel’s equation to determine whether the indirect effect of victimization on distress via social support is greater than zero. The Aroian version of the Sobel test was used as per Baron and Kenny (1986). Results indicated that the Sobel test was not significant (Sobel value = -.09, \( p = .93 \)), indicating that TGNC community connectedness does not significantly mediate the relationship between victimization and flourishing.
The indirect (mediation) effect of TGNC community connectedness on the relationship between victimization and flourishing was also examined utilizing Hayes (2013) bootstrapping technique. The direct effect of victimization on flourishing was estimated at -0.10 (SE = .04) 95% CI [-0.18, -0.02], \( t(20) = -2.52, p = .02 \). This indicates that victimization significantly (negatively) predicts flourishing. However, the indirect effect of victimization on flourishing, mediated through TGNC community connectedness was not significant, indirect effect = .01 (SE = .01), 95% CI [-0.01, .04].

In summary, Hypothesis 6 was not supported in terms of TGNC community connectedness mediating relationships between victimization and gender dysphoria or between victimization and flourishing, regardless of mediation method utilized (i.e., Sobel versus bootstrapping). Additionally, the hypothesis that a moderation rather than mediation effect may be present was tested by conducting linear regressions and comparing the simple linear model to that same model with the moderator (standardized victimization * standardized TGNC community connectedness). As with mediation, results do not support TGNC community connectedness as a moderator between victimization and gender dysphoria or flourishing.

**Hypothesis 7: Victimization and help-seeking.** Hypothesis 7 posited that victimization would predict decreased help-seeking (including mental health, medical health, and criminal justice help-seeking for minor or major crimes). Due to inter-correlations between victimization variables and between help-seeking variables, CCA was selected as the method of analysis for this hypothesis. Two sets were entered into the CCA: 1) Victimization variables (verbal, physical, and sexual both past-year and lifetime) and 2) Help-seeking (mental health, medical, and both criminal justice variables). The CCA produced four variates, the first of which demonstrated statistical significance, \( \lambda = .03, F(24, 32.61) = 2.03, p = .01, R^2 = .90 \). Thus, the
model captures approximately 90% of the variance shared by victimization and help-seeking. Of the six victimization variables, the best predictor for Variate 1 was past-year verbal victimization ($r_s = .87$) whereas other forms of victimization ranged in $r_s$ from .03 to .24 (in absolute values). The second-best predictor for Variate 1 was lifetime verbal victimization ($r_s = .24$). Of the four help-seeking variables, the best predictor of Variate 2 was criminal justice comfort for minor crimes ($r_s = -1.17$) followed by criminal justice comfort for major crimes ($r_s = .67$), mental health comfort ($r_s = -.25$), and medical health comfort ($r_s = -.17$).

To determine the significance of these canonical correlation coefficients, their respective canonical loadings were examined, with a cut-off of .30 (absolute value) as an indicator of a moderate and significant relationship. The following victimization (Set 1) variables significantly relate to Variate 1: lifetime verbal, past-year verbal, lifetime physical, and lifetime sexual. Thus, past-year physical and past-year sexual victimization experiences did not significantly relate to help-seeking (though their lifetime frequency counterparts did significantly relate). All help-seeking variables (Set 2) significantly related to Variate 2. For a summary of the relationships between victimization and help-seeking latent variables, see Table 12.

Lastly, redundancy analysis of cross-loadings was conducted to explore the extent to which each variable (e.g., verbal victimization, mental health help-seeking, etc.) measures its own latent score (i.e., victimization and help-seeking respectively) compared to measurement of the other latent score. Canonical loadings which exceed the values of cross-loadings indicate that variables are effective predictors of their own latent scores, and that the two combined variables of victimization and help-seeking represent distinct latent constructs. Results supported independence of these two latent constructs, and that variables each measure their own latent constructs better than the other latent construct. Further, cross-loadings were examined relation
to proportion of variance explained also indicating that Set 1 (victimization) accounted for 33% of unique variance whereas Set 2 (well-being) accounted for 21% of unique variance in their own constructs, whereas this predictive strength was lower across constructs (29.6% and 11.3% for Set 1x2 and 2x1 respectively).

Overall, these results indicate that victimization negatively predicts all four categories of help-seeking: mental health, medical, criminal justice minor, and criminal justice major. Thus, Hypothesis 7 was supported. Put simply, participants who experienced higher levels of victimization (especially increased verbal victimization episodes both recently in the past year and overall in their lifetimes) also reported decreased comfort regarding help-seeking.

Chapter 5: Qualitative Results

Hypothesis 1: Heterogeneity in participant narratives. For a visual representation of the phases of extant literature proposed in the present investigation to be most problematic, see Figure 2 in Appendix M. It was predicted that participant narratives would indicate greater heterogeneity than indicated in extant research, particularly during later phases of identity development. Interview participants ($N = 15$) described their identity developmental trajectories in terms of four phases: childhood, adolescence, early adulthood, and adulthood. Within each phase, participants described unique challenges and realizations which influenced their identity development. It should be noted that participants often described their gender identity development chronologically, though they were not prompted to do so.

Childhood. During childhood, participants described two primary themes: 1) Early Discomfort and 2) Instinctive Identity Expression. Participants described early discomforts as centering around binary gender norms, to which children are exposed from very young ages, coupled with a lack of resources (personal or otherwise) to conceptualize or manage their
discomfort. For example, one participant stated “there was like a lot of feeling really
uncomfortable inside gender identity of male and like the societal expectations…but I didn’t
really know why or understand completely” whereas another stated “I hated having to wear
dresses, but I didn’t necessarily connect that with anything like bigger, like any kind of identity”.
In addition to this generalized sense of discomfort, participants also described discomfort
specifically regarding their anatomical characteristics (e.g., “I realized that I’m in the wrong
body”) and gender presentation (e.g., “I had dreams of being a girl, dreams of like being way
more feminine than I was”).

In addition to describing early discomfort regarding gender, gender norms, and gender
expression during childhood, participants also described somewhat of the opposite experience:
instinctively expressing their experienced gender identity regardless of social norms. For
example, a number of participants who identified along the TGNC masculine spectrum but who
were assigned female at birth described times when they removed their shirts at the beach or
summer camp, instinctively, but much to the surprise of those around them: “[my sister and I
were] playing pretend that we’re at the beach and I’m like okay, and I took my shirt off and she
was kind of like you can’t do that…boys do that and I’m like I’m at the beach shut up you know,
I have seen people at the beach who are like me you know”. Another participant stated “I did not
understand certain differences, like why I had to wear a shirt you know, umm, when it was really
hot”.

Adolescence. During adolescence, participants described experiences uniquely related to
puberty and its associated physical, hormonal, and social changes. Specifically, some
participants described the greatest degree of challenge related to physical changes and puberty:
“when I had puberty, stuff was happening and I was having like panic attacks and freaking out,
binding down my chest I had no idea what was going on with me” and “I really didn’t want my body to become muscular, I didn’t want my body to become hairy and then these things were happening”. On the other hand, participants also described challenges during adolescence specifically related to the social norms surrounding puberty and this developmental time-period: “I didn’t wanna [sic] be seen as like a guy, and I didn’t wanna be considered masculine at all. I mostly just hated the performative high fence of what’s always expected of you.”

**Early adulthood.** During early adulthood, participants described themes related to increasing autonomy, separation from parents, and beginning to individuate in terms of their own lives and identities. Many participants described this as a crucial turning point in their identity development and process of coming to terms with their own sense of self, separate from the expectations of their families and/or the environments in which they were raised (which were often quite conservative). One participant described moving away from their parents as being crucial to their development, even though their parents were supportive: “they allowed me to transition, they let me take HRT, but I felt like I could not really completely explore my transition or my gender if they were there”. Similarly, another participant stated “I think it sort of just happened naturally when I moved away from home and had more freedom to explore without feeling like my every move was being policed by my parents”.

**Adulthood.** During adulthood, participants described expanding upon the autonomy and individuation they began to experience during early adulthood, independently exploring and developing their sense of themselves in relation to gender (or without relation to gender at all, in some cases). This developmental time period also carried the greatest degree of heterogeneity in participant narratives, though for the most part adulthood was a time of physiological transition for participants. For example, one participant stated “I wanted the physiological, part of the
physiological change”. One participant described being accidentally “catapulted” into physiological transition after a battle with breast cancer: “I actually got like free top surgery and that just catapulted me into like ‘yeah wow, I never really liked my boobs’, just sort of digging a little deeper and realizing that this totally fit and this was the body I always wanted.” Lastly, some participants described a later phase of gender identity development within adulthood wherein they no longer identified with the transition process: “I feel like transitioning from one gender to another is something that I don’t identify as much with anymore…it feels like that part of the journey from one gender to another is kind of done for me, and this is more of just like exploring gender itself”.

Whereas previous models of gender identity development often necessitated physiological transition, participant narratives demonstrated that many participants (especially non-binary identified participants, though not exclusively so) did not feel motivated to pursue physiological transitions such as hormone therapy or gender-affirming surgeries. Such participants challenge the ‘stuck in the wrong body’ narrative, by claiming their bodies as their own and their genders as their own, entirely aside from societal norms and expectations regarding gender and gender expression. Additionally, while some participants described activism as a crucial component of their identity development, others explicitly stated that they choose not to take on the role of activist or educator, as do not feel those roles are important to (or even part of) their gender identities. For example one participant stated “my roommate keeps asking me what gender fluid is but I keep telling her to go to the internet. My friends and I have a phrase: ‘I don’t have time to teach old white men this stuff, you have the internet.’” Thus, participant narratives supported Hypothesis 1, as they indicated a greater degree of heterogeneity both within this study and compared to other studies within later phases of identity development,
with a greater convergence both with one another and with extant literature regarding earlier experiences of anatomical discomfort and the challenges of puberty.

**Hypothesis 2: Themes of risk and resiliency in participant narratives.** It was predicted that participant narratives would reveal not only common experiences (themes) of risk and challenges, but also common factors of resiliency or protective factors which provided some insulation against risk factors they faced. As detailed below, results from coding participant narratives supported Hypothesis 2.

**Risk factors.** Participants described three themes of risk factors (challenges): personal, interpersonal, and systemic.

**Personal.** Three sub-themes of personal risk factors emerged: lack of information/resources, internalized transphobia/trans-negativity, and learning how to perform gender. Many participants described struggling to understand their own sense of self and gender with few reference points or sources of information: “no frame of reference for what I’m going through”, “I didn’t have these kinds of words to talk about this”, “I didn’t really know that there were other options”, and “we didn’t’ have access to anything, like no internet connection, no doctors available to talk to about this problem and no therapists available, no counselors available”.

Second, and likely related to both the personal sub-theme of lack of information/resources and the theme of systemic challenges, participants described grappling with internalized transphobia and/or trans-negativity: “I’d see someone who I thought was probably trans or gender queer and I’d avert their eyes. I didn’t want to be a part of it”. Some participants literally described internalized transphobia as a challenge they face(d): “I think I have this internalized transphobia. I don’t really know what this looks like or what other people’s
experiences are” and “I got really really depressed because of internalized transphobia and all that nonsense of like okay I’m this, but this is a terrible thing to be”.

Lastly, participants described personal challenges related to learning how to perform gender: “I am also always trying to figure out like how to woman, like how to do that…and you know there is no right or wrong way but I think that like finding my own ways has been really difficult and is something that I’m still struggling with”. Similarly, another participant described facing challenges regarding learning not only the performance of gender but also the normative gendered expectations associated with that performance: “that sort of like male posturing, I feel like maybe one of the biggest challenges is that I don’t’ recognize that are socialized male. I don’t understand them”.

Interpersonal. In addition to personal (internal) challenges, participants described four themes of interpersonal challenges: 1) other-imposed identity, 2) exclusion from binary trans* communities, 3) family tolerating but not accepting, and 4) challenges specifically arising within romantic relationships with partners. With regard to other-imposed identity, participants described numerous instances in which other individuals (e.g., family, partners, strangers, etc.) would impose a gender identity upon them: “I had my family mates tell me ‘oh you know you are not a boy, you are a girl’”, “my second-to-last partner…very unapologetically saw me as like not really feminine but they saw themselves as a lesbian and therefore that meant they were dating a woman”.

Participants, particularly non-binary identified participants, described experiencing exclusion (both implicit and explicit) from binary trans* communities: “I had a lot of experiences of feeling like trans community was very binary”, “I just feel like we stopped when it comes to the ‘T’, like we have the T but our T is still binary”, and “when I go to support groups and they
go to retreats, I am actually realizing how unfortunately that space is very binary…so like even that space triggers me”.

Lastly, participants described interpersonal challenges related to family above and beyond the aforementioned sub-theme of other-imposed identity. Specifically, participants described both general concerns related to family (e.g., older family members such as parents, grandparent, uncles/aunts, etc. but also participants’ children) and specifically related to family tolerating but not fully accepting their gender identity and/or expression. One participant described concerns related to their own gender identity journey and their children: “mostly I worry about my kids particularly as I feel gender queer doesn’t really fit for me…do I actually identify as trans, as a trans guy? What in god’s name impact would that have on them?” More generally, participants also described their parents denying the validity of their gender identity: “he would rather deny everything, everything is a phase” and “[they would] periodically do things like tell my sister that she had to like teach me how to dress or something like maybe I just didn’t know how to be a girl I guess”.

Most participants described interpersonal family challenges specifically regarding tolerance but not acceptance of their gender identities and/or expressions. For example, one participant noted the distinction between tolerance and acceptance: “like oh this is the thing that you’re doing and we have to like accept this because you are old enough to do what you want for yourself but people actually saying like, wow no this is like more than okay, this is great, this is awesome and we’ll support you.” Specifically, participants described experiences where their parents hesitantly tolerated their internal sense of gender, but strictly policed their external gender presentations: “literally one of the first things she said to me was like, you can dress however you want but don’t be one of those people who like has surgery and takes hormones”
and “if I was a tomboy then like I was a tomboy, but they alos were very much about like the way things are...if there was an important event, or church, or like a wedding we had to go to”.

At times, participants described this division between tolerance and acceptance as covert discrimination (e.g., misgendering) compared to overt discrimination: “she said she was accepting, but the tone of her voice or change in speech, her body language told me otherwise”, and “I wasn’t ostracized or anything, but I don’t know that they use the pronouns I would like them to use”.

Systemic. Systemic challenges included four sub-themes: 1) systemic bias, 2) lack of media representation, 3) public spaces, and 4) overt discrimination. Systemic bias included experiences with cis-normativity and anti-TGNC beliefs and environments: “trying to deal with a cisnormative society for sure”, “the challenges are everywhere...society readily does not accept it and there is always resistance from the society”. Some participants specifically referred to challenges related to institutionalized forms and procedures: “everything is a struggle, each and every step is a struggle, everything is not that easy because there are so many barriers” and “it’s really hard to fill out forms”, especially for non-binary identified participants: “I can’t put down male because I’m not going through any of the sort of steps to taking hormone replacement therapy or you know, binding my chest every day. That’s not my everyday experience so I have to put down female because some days I am presenting as a cis female”.

Lack of media representation was particularly pervasive in that it contributed to the unavailability of role models in the media. Participants described looking around their social environments and into the media, and not seeing anyone like themselves: “I don’t have any role models, it’s not seeing images of myself” or when a similar image is projected through the media “it’s not a happy life that’s transmitted to me. My friend shae this countdown of how many
women and lesbian characters are killed on TV and it’s a lot. It’s hard to constantly see images of myself being punished”.

Public spaces posed unique challenges related to, but not entirely encompassed by more general systemic challenges. For example, participants often described the specific settings of beaches and bathrooms, both in terms of self-presentation and anatomical discomfort (e.g., “it can be difficult to find swimwear that communicates your gender to people”) and in terms of safety (e.g., “the only thing I worry about, I’ve heard instances of increased harassment in bathrooms…like queer women being targeted”.

Finally, participants described instances of verbal (e.g., “call me like a tranny, a dyke, a faggot), physical (e.g., “when it comes down to a transgender woman using a female bathroom that person will do something to them), and sexual (e.g., “if I’m dressed feminine I get sexually harassed a lot. If I’m dressed masculine I get really nasty stares”) discrimination. Participants also described instances where they felt dehumanized (e.g., “one set of messages are really like dehumanizing or degrading”) and/or exoticized (e.g., “it just reminds me of the whole like freak-show aspect…it’s like tourism that people are like oh, how fascinating”) as challenges to their self-concept, gender identity and sense of safety within the context of the latter two developmental processes.

**Resiliency and protective factors.** Participants described three primary themes of resiliency and protective factors which positively impacted their identity development: 1) social support, 2) resources, and 3) validating experiences.

**Social support.** Sources of social support described included peers (both TGNC and cisgender), family, larger communities (collections of peers, for example Queer community or TGNC community in general), and partner(s). Specifically, participants described peer social
support as helpful in two ways: 1) providing role models and/or sources of information and support from others who have already gone through the same gender-related experiences (e.g., “growing up I had a lot of friends who came out as transgender and transitioned while I knew them…I had a good queer friend support group”) and 2) having a social network which was supportive as they explored gender identity and gender presentation (e.g., “when I wanted to try out gender neutral pronouns I was like hey guys, can you try doing this for me, because I knew that they would say yes without hesitation). To a lesser extent, participants described social support from their parents both in terms of a social justice perspective and in terms of supporting exploration of gender, thus there is some indication that family played a similar role to peers for participants, though to a lesser extent.

In addition to the importance of immediate peer groups, participants emphasized the importance of remaining connected to a larger community of similarly-identified individuals (e.g., “having access to those communities has been really huge”) and of having (a) supportive romantic partner(s) (e.g., “she’s been amazing and is like ‘wherever you land is fine with me, it’s your life, your body, your gender, go for it’” and “my spouse from the beginning has been very understanding of gender being a complicated thing and bodies being really complicated things…and not making assumptions and judgments and understanding that like things are fluid and complicated”).

_Resources_. Participants described five categories of resources which benefitted them during their processes of identity exploration and development: 1) media and technology, 2) educational resources, 3) support groups, 4) exposure through travel, outreach, etc., and 5) creative outlets and self-expression. One participant’s shared experience highlights the benefits of media and technology: “I typed into google ‘I think I might be a girl’, and like thank goodness
the search results came up with just all of these wonderful transgender stories”, compounded by the experiences of other participants (e.g., “after watching all those videos [of other TGNC people describing their journeys] I was like oh my gosh, that’s me!”). However, participants noted that the internet also has the potential to become a challenge rather than a supportive resource, depending on the specific information an individual accesses: “the internet has been both really lovely and terrible”.

Educational resources described by participants included college courses in gender theory and gender roles, conferences focused on gender as a spectrum, books written about gender and author experiences with gender, and workshops regarding gender, gender identity, and gender presentation. Specifically, participants highlighted the following specific events and resources: books by Judith Butler and TGNC-specific conferences such as the Philly Trans Health Conference and Gender Odyssey: “the trans community has totally blossomed…there are different non-binary groups so like now at trans health there’s [sic] like sections that are focused on non-binary stuff so that’s very affirming to me”.

In addition to media and educational resources, participants described individualized sources of support such as support groups specific to their identities (e.g., support group for gender non-conforming people or for trans-masculine identified people), travel and activism (e.g., “I have been traveling all around the world…I have a good sense of how transgender people are in the rest of countries), and creative outlets such as writing, music, dance, and theater (e.g., “dancing has really helped me…I’m using my body creatively, it’s almost like all the stuff I think about with the masculine aspects of my body sort of like fades away and I’m not gendered in my body anymore, I’m sort of free and powerful”).
Validating experiences. Lastly, validating experiences formed a large foundation of resiliency among participants. These experiences including being read consistent with their identity (e.g., “I see you, see you for how you see yourself, I see you for how you want to be seen”), seeing societal representations of TGNC people in the media (e.g., Caitlyn Jenner, Laverne Cox in Orange is the New Black, and a YouTube series called “Her Story”)). However, participants also described validation occasionally within the context of a double-edged sword: “I knew I was passing because white women were uncomfortable around me” and “I can generally tell how well I’m passing especially in the warmer months by whether or not people street harass me”. Similarly, validation through being read consistent with one’s gender identity was often described as un-attainable for non-binary identified participants: “I think that binary trans people if/when they get to the point where they are passing well, there’s a sort of amnesia that you forget what it’s like for people who are gender non-conforming or transgender and may never experience gender affirmation”.

Ancillary Analyses

Identity development critical processes. In addition to describing phases of identity development as explored in Hypothesis 1, participants described a series of critical processes in their gender identity development which generalized across the phases. These included: 1) identity selection (for a summary of gender identities described and defined by interview participants, see Table 13), 2) navigating names, 3) reclaiming self/body, 4) navigating disclosure, 5) navigating self-presentation, 6) increased flexibility, 7) transition amnesia, and 8) activism and educating others (or not).

Identity selection. Within the critical process of identity selection, participants described locating and claiming terminology to describe their gender identities. Two sub-themes emerged:
identifying as “Not _____” and spectrum preferences. In the former process, participants described an ongoing process of trying to locate the appropriate identity descriptor for them, but narrowing the process by what they do not identify as in the meantime: “I don’t think that I’m trans, so I’m just trying to figure out something in between” and “I don’t mind using trans as like an umbrella term, but I don’t really identify with being a trans woman like I used to”. In the latter process, participants (particularly non-binary identified participants) described first identifying a portion of the gender spectrum: “I’d rather have people call me sir. If I go into a store and someone greets me as ma’am…it infuriates me” and “masculinity is something that, like, I’ve been less comfortable with than femininity”. Thus, participants overall described a process of narrowing down potential identities by first acknowledging those identities which do not apply to their experience and then further narrowing the possibilities by reflecting upon their preferences in terms of the gender spectrum (if any). As such, these results indicate that each phase of identity development, from terminology selection (and possible future changes) to expression and disclosure, each contains numerous sub-phases which participants navigated throughout their gender identity development.

**Navigating names.** Following selection of a gender identity, participants described coping with indicators of that identity, in particular the name they were assigned at birth. Participants who changed their names (whether legally or socially) to more accurately reflect their sense of self sometimes referred to their name assigned at birth as their “dead name”. While participants noted a sense of hope attached to name changes (e.g., “people who change their names do have an opportunity to wipe the slate clean”), many highlighted the challenges associated with names as identity indicators. In some cases, participants described challenges associated with name changes (e.g., “I told the barista my name and they asked ‘oh so you know
what was your name before it was _____?”) whereas other participants described a desire to change society’s perception of their name, rather than the name itself (e.g., “I wish it was gender neutral, like I like my name and I’ve had the option to change it before… it pisses me off that it’s a girl’s name but I kind of feel like it is society’s problem” and “I kind of just wanted to de-gender my birth name and just, like, take it back or something”).

Reclaiming self/body. Similarly to above, whereas some participants described a desire to reclaim their birth names as indicators of their experienced gender identities rather than as indicators to the contrary, participants also described a critical process of reclaiming themselves, their identities, and their bodies (e.g., “2014 was this shift toward gender-fluid…I reclaimed my body”, “I think it was the process of like internet culture and sort of reclaiming myself and identity away from society”).

Navigating disclosure. Once participants had settled on a gender identity and/or expression that felt authentic to them, many described a never-ending process of navigating disclosure of that identity, and described five influences upon their decisions regarding navigating disclosure: 1) comfort in relationships, 2) inconsequential contacts, 3) interview/occupational, 4) age, and 5) path of least resistance.

In the first sub-theme, participants expressed different decisions regarding identity disclosure depending on the audience, specifically friends versus strangers: “socially it’s always sort of gender queer, trans-masculine, or the thing that I like to really use with my friends is dude with a vag”, “meeting people for the first time especially if I’m going to be working with them I’m wondering how to present myself and if I should be honest with myself or if I should kind of just be a little more neutral”, and “[for example] last night I felt very masculine, but I dressed really feminine because I was meeting new people”. Participants also reported simplifying their
gender identity disclosures to time-limited or otherwise inconsequential contacts: “to the people in the grocery store I identify as male but if I’m like on a panel I identify as trans-masculine”.

Similarly, participants described particular challenges related to disclosures in the workplace: “I put up an act when I go to a job interview…I know one interview I didn’t do very well in just because the whole time I was in a dress and I wanted to cry” and “the environment at work has made it really difficult…I am particularly concerned about the backlash in part, I’m really worried about how I would be perceived at work and what sort of backlash that would have on me”.

Participants provided the highest degree of detail regarding navigating disclosures based on the age of the disclosure recipient, specifically expressing increased flexibility in terms of their own self-identification toward others who are of older ages: “it depends on the audience. With younger people, it’s much easier. With older people, it’s just something more private to me so I put it, I won’t tell people” and “maybe I need to think about the way I relate with elders, like what is the expectation that we have of elders because I think it may be unreasonable”.

While most participants described some combination of the abovementioned factors as influential upon their identity disclosure decisions, many also described simply taking the path of least resistance and identifying in the way least likely to create friction within a given context. For example, one participant stated “I just identify as a trans woman because I think it is easier for people to wrap their heads around and also I don’t want to have a one-on-one gender talk every time I talk to people”. Another participant similarly described navigating disclosure in a way that avoided lengthy gender-focused conversations: “in general I portray myself as cisgender male and I find that that way conversations don’t come up very often…the path of least resistance is to just kind of go with what people expect”. One participant very explicitly
stated “I’d just choose the one that I know they want me to say”. Overall, participant responses indicate that navigating disclosure in consequential and/or inconsequential contacts on a daily basis is no simple matter, but rather that this process is informed by a multitude of shifting influences.

*Navigating self-presentation.* Similarly to navigating identity disclosures, participants described a number of factors influential in the complex process of determining their self-presentations on a daily (or even situational) basis. The two most common influential factors were safety concerns and passing concerns. In describing safety concerns, participants shared experiences where they explicitly modified their self-presentation in order to increase or maintain their safety within a given context: “I have to be careful, especially when I’m on the bus going through Newark. If I wear eye makeup I wear shades so I don’t get called out on the bus”. One participant even described presenting according to their sex assigned at birth rather than their gender identity to maintain safety: “some days I was still incognito like dressing male as to not get beat up”.

One participant aptly summarized themes associated with passing concerns: “When it comes to passing, it’s for whom do I have to pass? Am I passing for myself or am I passing for others?” While other participants did not directly answer this question in their own narratives, they certainly expanded upon it by describing concerns related to self-validation (e.g., “I wasn’t living a lie anymore” and “as long as I’m passing within myself as myself and feeling true to myself then I’m feeling okay”) and non-binary challenges related to passing (e.g., “I don’t think I have anything to pass as except for wanting to not be seen as cisgender” and “it’s not even passing as a guy, but passing as someone that’s not a woman”).
Increased flexibility. Participants, particularly those who self-identified as masculine-of-center, described seeking a middle ground with regard to gender expression and gender performance. For example, when discussing his own process of reaching this balance, one participant stated “I was always into male stuff, but then again I can say you know I was in between balance because I was masculine but I wasn’t macho”. This same participant later stated “I try to explain that to females that yeah I’m male but don’t label me as a typical male of society because I’m not”. Interestingly, another participant described the same process of finding a balance of masculinity: “I feel like there’s this early trans-masculine thing where you’re kind of ‘hyper bro dick-head’. My early transition stuff was very hegemonic masculinity, and I feel like some of that compensatory bro-ness has eased out, my masculinity is taking on a little bit of a gentler approach”.

Transition amnesia. While many participants described transition as a critical process during adulthood, a theme also emerged following this process wherein individuals described a process of distancing oneself from the transition process (social and/or physiological). This distancing was described both in terms of observations made by participants: “I think that binary trans people if/when they get to the point where they are passing well there’s a sort of amnesia that you forget what it’s like for people who are gender non-conforming or transgender and may never experience gender affirmation”, “basically someone may identify as a man of trans experience because they don’t feel like transman is representative of their gender”.

Activism and educating others, or not. Whereas extant literature often highlights the role of activism in the ‘penultimate’ stages of gender identity development, this author hypothesized that participants would describe heterogeneous perspectives and experiences regarding activism. This hypothesis was supported as participants expressed a desire to distance themselves from the
role of educator or activist, and rather to simply live their lives as their experienced gender. For example, one participant stated: “I feel like instead of just sitting there educating the person, also as well what they are interested in and why don’t they go educate themselves on it. You take on the role of educator sometimes sort of trying to teach people hey, there’s a lot more to the world than what you are seeing. Other times you also feel like you need to go and educate yourself as well, like they need to take the initiative”. Other participants briefly described numerous instances wherein they were asked to explain or to be the spokesperson for gender diversity, in which cases many participants reported that they referred the inquirer to the internet and/or to books to answer their question(s) rather than taking on the potentially quite demanding role of educator and/or activist.

**Gender as construct.** Throughout the 15 interviews, participants shared and explored several different perspectives regarding gender as an overall construct, in addition to the discussion of their own experience(s) with gender specifically. As one participant aptly stated: “there is a lot of weight that comes with gender, and sometimes it can be kind of suffocating”. Participant remarks regarding the construct of gender formed three sub-themes: 1) aversion to boxes, 2) “amorphous blob of whateverness”, and 3) zeitgeist intersections. In the first sub-theme, participants described a generalized aversion to the “boxes” which separate gender (e.g., dichotomous male/female “boxes”), stating “it gets in the way of people just relating to each other as one being to another” and “I feel like it makes navigating gender identity that much harder, going from box to box to box.” One participant described their ideal conceptualization of gender: “No boxes. I feel like what’s happening is there is a box, you open that box to find another space, then you find another box, and I just feel like, why can’t it be an open space?” Notably, while this theme of aversion to boxes was pervasive throughout the interviews, equally
prevalent was a caveat regarding emergency medical interventions, wherein several participants highlighted the importance of understanding primary and some secondary sex characteristics to effectively guide medical decision-making.

The second sub-theme was titled “amorphous blob of whateverness”, because the coding team despite their best efforts could not construct any title which better captured this sub-themes sentiments than that participant’s own words: “I don’t know, in some ways I feel like gender identity is an amorphous blob of just, like, whateverness”. Another participant argued for outright elimination of the construct of gender due to its sheer complexity and evasiveness of conclusive definition: “all these different axes and potential analyses, there’s a whole range in there, and everyone’s gonna be in a different place on those things [each axis], and then collectively your gender is somehow like this amalgam of the mean of all these points along all these different axes analyzed by people…we should just let it go because clearly, nobody sits exactly anywhere”, or as another participant more succinctly stated: “whatever you think you captured, it’s not the thing”.

Lastly, participants highlighted the importance of changing times, and changing social norms to the process of conceptualizing gender. Specifically, many participants compared the present to past conceptualizations of gender and gender identity (e.g., “we need to be inclusive because look at the situation nowadays, whereas back then it was much more ‘off the beaten path’”). Other participants highlighted the strengths of the current state of societal conceptualizations of gender while also noting areas for improvement, specifically related to non-binary identities: “while LGB issues have been in this social sphere probably for the past decade, it’s been a little slower to approach just the idea of gender not being binary” and “I think we’re still stuck in the gender binary area so it’s sort of like evolving over time”.

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**Societal messages.** Related to the abovementioned comments regarding gender as a construct, many participants shared their perceptions of societal messages regarding TGNC identities. Five themes of negative messages emerged (outsider, insufficiency, invalidation, identity policing, and implicit binarism) followed by a small number of positive messages.

**Outsider.** When describing this theme of societal messages, participants described feeling like “an outsider”: “if I go in a bathroom or god forbid a shopping mall, or like if I have to go into a dressing room…I just want them to not see me, like I don’t even wanna be part of that”, “I would say that often we [participant’s friends] joke about feeling like aliens…we have this game called ‘transman or alien’ which we use specifically when referring to Prince, it was a fun game we played as gender non-conforming”. While the latter participant described developing a sense of humor in response to societal messages communicating that TGNC individuals and communities are outsiders, other participants struggled with this message: “there’s a taboo associated with transgender identity across the world…people just don’t understand”, “I’ve experienced the sort of like stares and being on the outside”.

**Insufficiency.** Similar to the theme of outsider, participants described a theme of insufficiency wherein they reported experiences in which society communicated to them that they were not “_______” enough, filling in that blank with any number of descriptors. For example, one participant stated “people already view trans people as like fake or phony, not real versions of like man and woman” and some participants demonstrated internalization of insufficiency: “I would feel like less of a man because I’m not born a cisgender male”, “it instills a sense of doubt or I should not be sure of myself”. Participants described these messages as exacerbated for people who identify as non-binary (e.g., “I got the message of no, non-binary people can’t really transition. Like you are not trans, you’re not a real trans person”, “I am like
not trans enough, I don’t suffer enough”) and/or as masculine-of-center (e.g., “the whole thing is that we’re not really men because this phallocentric idea of what a man is, it’s just so reductive”, “and then for trans men it’s because of the absence of this body part they’re not actually men”).

**Invalidation.** Experiences of invalidation pervaded all 15 interviews, across most coding domains. However, this theme was most pervasive in terms of societal messages, where participants described invalidation above and beyond the interpersonal level, rising to the systemic level on a chronic and repetitive basis. For example, one participant described their perception of society’s view on TGNC identities: “from society at large it’s just like, that’s made up, you’re just trying to be special”. Another participant described a particularly invalidating experience with a neighbor that communicated this same message: “when I first came out, before I was on hormones at all, I remember this woman saying ‘oh my goodness, you are such a sissy little gay boy aren’t you?’ and that just like ripped me apart”. Invalidation was described as increasingly poignant and pervasive for non-binary identified participants who face both transgender invalidation and non-binary invalidation combined: “when you are non-binary on top of that, they don’t’ take the need for transition or your realness…basically they don’t take your gender identity seriously”, “people are just like, well now you’re talking crazy like I can’t buy into that. I think that’s a particular non-binary issue”.

**Identity policing.** Similar to the abovementioned interpersonal challenge of other-ascribed identity, wherein others imposed a gender identity upon participants, participants described a related message arising from society: “it’s not okay to be different, it’s not okay to be who you are in your own body”. Specifically, society communicated messages explicitly placing restrictions on how TGNC participants could or should identify and/or express their gender identity. For example, one participant summarized the messages they received: “I have been told
all my life like you can’t show your stomach, you’re fat. You can’t do that or people will stare. If you dress like this you’re butch”.

**Implicit binarism.** Implicit binarism refers to strict binary norms communicated by society including assumptions of masculinity and femininity (and associated norms), or as two participants described it: “boys are one way, girls are another way” and “you’re male or you’re female, there’s nothing else in between”. A third participant elaborated: “society wants people to be binary and society wants people to conform to the sex they are assigned at birth, and society wants masculine-looking people that are interpreted as men to ‘man up’, and they view femininity as putting on an act”. One participant described that even within identity affirming peer groups, implicit binarism became apparent: “even if they accept me being transgender, they have this thing in their head to put me in a box and they are like ‘dude, bro, I accept you bro’ you know”.

**Non-binary invisibility.** Related to implicit binarism, participants described a pervasive sense of non-binary invisibility, wherein society communicated views of non-binary identities as “that it doesn’t exist” or “I feel largely ignored”. Another participant stated “I think because I don’t necessarily feel like I fit into any of the boxes when the larger societal discussions start taking place, everything feels like it doesn’t apply to me”.

**Intersectionality.** Throughout the 15 interviews, participants described their experiences not only related to gender identity, but also in terms of how their gender identity intersected with other social and cultural identities such as sexual orientation, race/ethnicity, health status, and sex assigned at birth. Further, participants described the phenomenon of passing privilege and experiences of multiple intersecting oppressed or marginalized identities.
**Sexual orientation.** Some participants described shifts in their sexual orientation during their gender identity development over time, whereas others denied experiencing any changes in their romantic or sexual attraction. For example, several participants described identifying early in their childhood and adolescence in terms of a sexual orientation identity as lesbian, gay, or bisexual rather than in terms of a TGNC gender identity: “I pretty strongly identified with butch lesbians, tried that on for size for a few years but um, you know I pretty much disposed of that completely once I figured out what a trans guy was”. Other participants described an explicit overlap between their sexual orientation and gender identities: “I still act like what would be sort of like stereotypical lesbian sort of things…but since I don’t identify any longer as a woman, like where does that leave me? One participant described their gender identity as interchangeable with their sexual orientation: “gender fluid is that your gender can change. It’s also sexual fluidity. Sometimes you’re only attracted to very feminine people and sometimes you’re attracted to masculine people”. Another participant described their preferred term for sexual orientation as “queer” due to its ambiguity in terms of gender: “I feel like queer just feels like the better way to describe my sexuality because it doesn’t purport what my gender identity is”. Lastly, one participant described the intersection of sexual orientation and gender identity in terms of safety: “I think there’s a relative safety in people perceiving you to be a harmless gay man around the neighborhood, rather than you being perceived as a transgender male, or a butch female, I feel like there’s less antagonistic behavior”.

**Race/Ethnicity.** Participants described the intersections of race/ethnicity and gender identity largely in terms of two categories: 1) racial/ethnic culture, family, and gender identity development and 2) race/ethnicity, gender, and privilege. With regard to the first category, two participants in particular described challenges associated with growing up as Asian/Pacific
Islander in America, in terms of the unique challenges posed: “starting my transition and coming out as trans was one of the first things that I actually did for myself… in Asian family culture, it’s very much about like, what do your parents want to do?” and “being Filipino, like there are definitely pretty strict gender roles, like in terms of cultural traditions”. A third participant described challenges associated with growing up TGNC in an Asian country: “it was not easy for me because I’m from Asia, and the country where I’m from is a very patriarchal society and these things are not really accepted. There’s a taboo associated with gender change so it was not easy for me to navigate”.

One participant described the intersection of racial/ethnicity and associated stereotypes with gender identity as follows: “there’s a thing in the trans community especially for female assigned at birth people when they are talking about transition, you know where people acknowledge that there’s a difference for people who are perceived white and people who are perceived black. So for people who are perceived white once they start passing as male, they sort of come into privilege in a way that is shocking sometimes for them to experience…that’s not necessarily the case for people who are black or you know, people of color”. Other participants described the role of white privilege in their gender identity development: “I’m white, I’m tall, I’m well-spoken. I’ve got a lot of things going for me in terms of interacting, but still”, “I’m definitely aware that my skin color gets me a pass for other gender non-conforming…like if you are a person of color and gender non-conforming then you are fucked”.

**Health status.** Health status, in terms of both physiological and psychological health, comprised an additional theme of intersection with gender identity. Specifically, three participants described their experiences with polycystic ovary syndrome (PCOS) which significantly impacts the hormones of people who possess ovaries. One participant stated: “I had
been diagnosed with PCOS, so...where does this one start and where does the other one begin? Because in my opinion I am somewhere in like intersex”. Mental health challenges were also described as obstacles to affirming gender identity development, whether in creating a generalized sense of self-doubt (e.g., “I’m diagnosed with depression and anxiety and I think that has just created a lot of doubt in my mind and always makes me second-guess myself”), delaying the opportunity to explore gender (e.g., “whenever I felt a little like, you should explore your sexuality, you should explore your gender…I was like you need to deal with some other stuff first, so I very much compartmentalized that”), or in creating an obstacle to understanding the concept of gender norms overall (e.g., “my boyfriend is autistic [sic], so the way they understand...yeah they just don’t understand. For example, they don’t understand why leggings are gendered female”).

**Sex assigned at birth.** Several participants described differences between the experiences of TGNC individuals assigned female at birth compared to those assigned male at birth. This was described both in terms of privilege for individuals assigned female at birth (e.g., “I think a lot of the leeway I got was being born a female assigned person and having it not be so threatening to shop in the boys section and do masculine things”, “I’ve been very fortunate as a masculine-female-presenting person. People always thought I was a cop, I never had to worry because I was tough looking”) and as a source of compounded challenges (e.g., “I feel like because of the gender I was assigned at birth they were like ‘oh you are a female, so whatever you are saying you are speaking crazy”, “I would say that perhaps the difference between transmasculinities and transfemininities sometimes because you know transfeminine people often have less access to resources”).
**Passing privilege.** “Passing privilege” refers to the often double-edged sword phenomenon wherein some individuals “pass” (or are readily perceived by others as their experienced gender) better than others. Passing privilege was described as varying between binary and non-binary identified participants, and was described as a complex rather than linear phenomenon. That is, higher levels of passing did not necessarily relate to improved experiences among participants. For example, one participant stated “while I often talk about passing privilege because I do think it’s a thing, but people oftentimes don’t take my struggles seriously because they think ‘oh well you pass…”’. Another participant highlighted the critical role passing can play in the experiences of TGNC people: “I’ve been noticing a kind of really sharp divide between passing and non-passing trans people and that sort of rift is really, really a kind of dangerous space”. Non-binary participants also described both challenges and privileges associated with passing: “I think there’s almost a weird fluidity to how I look and how I act that has allowed me to just pass in these really weird ways…I don’t experience a lot of the harassment that people experience” and “people using pronouns doesn’t make me feel like so dysphoric, kind of like I have non-binary privilege that doesn’t make me feel so dysphoric” whereas on the other hand participants reported increased distress regarding passing due to their non-binary identification: “the question is passing as what? I don’t think I ever pass as myself being non-binary, I’m almost never read as a non-binary person”.

**Multiple.** Multiple identities, with mixed varieties of marginalization and privilege, have the potential to profoundly influence experiences with regard to gender and gender identity development in terms of self-concept, safety, and interpersonal interactions. For example, one participant noted how their intersecting identities afforded them a sense of safety: “I feel like my class privilege and my race privilege ha...
kill me”. Similarly, one participant described how they reflect regularly on their privileges: “I have no delusions about how lucky, how incredibly blessed I’ve been in my life. My parents, how I grew up, where I was growing up, etc. Every day I wake up and I’m like ‘I get to choose what I’m having for breakfast. Let me just shut up now because so many people don’t get that’”. Another participant described their experiences with the intersections of race, gender, sexual orientation, and region of the United States: “I’m from the south and I was down in Houston and then I was back up here, and realizing there are things I just know because of the lived experience that we don’t talk about—you just don’t walk around at night…especially if you’re a black gay person”.

**Experiences with mental health systems.** During interviews, participants were asked to describe their experiences with mental health care providers and systems, if any. While participants described both positive and negative experiences, as well as specifying proposed solutions/domains for improvement, one participant centered the following themes effectively: “the bar is set so low that I’m like, I had a neutral experience and it was great! Like this person wasn’t awful and I feel like I can see them for a while. That’s the bar that works, you know like this person didn’t say anything actively offensive and I don’t want to cry, that’s cool!”

**Negative experiences.** Participants described four themes of negative experiences in therapy: 1) un-affirming space, 2) inappropriate gate-keeping, 3) gender spotlight, and 4) egocentrism.

**Un-affirming space.** A theme emerged wherein participants described therapists as creating an un-affirming space through subtle actions or inactions, or through overt actions whether intentional or not. For example, one participant described their experiences with a therapist of 25 years: “this is right after my surgery, before I had gone back to work and
discussing how I was going to dress at work. I felt like she just wasn’t hearing me, like yes I know how to buy men’s clothes. I’ve worn men’s clothes like duh you’ve known me for 25 years, you’ve obviously seen me in men’s clothes…she was just trying to figure out why it was so uncomfortable for me to wear women’s clothes but also not comfortable for me to wear men’s clothes. And I felt like we were just missing each other like this”. With regard to overt actions, one participant described repeated experiences of misgendering from their therapist: “she had misgendered me multiple times and I was like I can’t trust someone to be providing me my mental health when they can’t respect something very basic”. A third participant summarized a series of negative experiences with different therapists: “for some reason the gender stuff confuses people enough so they do not understand the boundary and don’t act in professional ways”.

Inappropriate gate-keeping. Across many jurisdictions, psychologists play a very important gate-keeping role wherein TGNC individuals may require a letter of approval from 1-2 psychologists and/or psychiatrists before they can proceed with gender-affirming surgery. While participants acknowledged the importance of this role when properly utilized (e.g., “I understood where the gatekeepers were coming from, in that they want to make sure that before somebody transitions that they’re in the most stable place they can get them to because it’s going to be a rocky road afterwards”), however several described negative experiences where this gate-keeping power was used in a way that caused the participant more harm than good. For example, one participant stated “my therapist after I came out said ‘what? This is really out of the blue for you, we’re going to have to wait a couple of months for you to start HRT while we figure out where this is coming from’ and I was like have you been paying attention to like anything? Because I’ve told him about it.” Similarly, another participant’s therapist replied to their request
for a letter in support of hormone therapy and potentially later gender-affirming surgery by invalidating the request, and the participant’s identity: “[she] was trying to tell me that I wasn’t actually trans, and that I was just depressed instead. She was trying to tell me that I wasn’t trans because I was able to wash myself in the shower essentially or because I have sex with my genitals, like this is how you get to be trans and otherwise it’s not valid”.

*Gender spotlight.* In contrast to inappropriate gate-keeping, which often involved minimization or avoidance of the participant’s TGNC identity, gender spotlight included participant experiences wherein therapists hyper-focused on their gender identity and/or expression, to the detriment of other more pressing mental health concerns. For example, one participant stated: “I’ve had practitioners who are sometimes distracted by my trans status or my trans history, like even going into an appointment and being very clear about like hey, here’s the deal but that’s not what I’m here for”. Another participant described the extension of the prior experiences of “distraction”: “there’s a shift that happens in the therapy room where I mention I’m trans and then like the whole thing just turns over to that”. Another participant referred to this phenomenon as “sight-seeing”, and described experiencing it as interfering with their receipt of emergency mental health services: “I’ve been in like crisis mental health scenarios where people will start to go into my past a little more and I’m like no no no, that’s not what I want to talk about right now, but [them] not being able to let it go”.

*Egocentrism.* Potentially related to the gender spotlight is the theme of egocentrism, wherein participants described therapists who focused largely on their own education or their own curiosity during sessions rather than emphasizing the care and treatment of the participant. For example, one participant reported that after they obtained a gender-affirming haircut their therapist’s first reaction was “oh, I’m gonna [sic] have to get used to your haircut”. Another
participant reported that their therapist, a graduate student, appeared overwhelmed with the participant’s presentation and thus allowed sessions to sway away from the best interests of the client: “she cried during my therapy sessions and I don’t really think that’s empathy, I don’t know, I felt very uncomfortable. I don’t feel like I really got anything out of it”. Other examples briefly described by participants included therapists utilizing sessions to satisfy their own curiosity regarding gender variance (similar to the gender spotlight), and/or therapists imposing their own beliefs on a TGNC client (e.g., religious or other beliefs regarding the legitimacy of TGNC identities).

**Positive experiences.** Participants who endorsed past experiences with mental health care providers were asked to elaborate on any particularly negative or positive experiences, in order to speak to what was helpful/not helpful for them in therapy. Three positive experience themes emerged: 1) taking the initiative, 2) appropriate therapy foci, and 3) validation.

**Taking the initiative.** In this theme, participants described working with therapists who took it upon themselves to conduct the necessary research in order to ethically work with someone who identifies as TGNC. In some cases, participants reported positive experiences with therapists who specialize in TGNC identities and experiences (e.g., “I have a benefit these days or a privilege of working with a therapist who has built his practice around seeing trans men throughout the course of their transition”). However participants also shared positive experiences with therapists who had a basic understanding of TGNC issues but demonstrated the motivation to learn more (e.g., “I’ve sent her a lot of articles to read and suggested different websites and I think without her explicitly saying she’s done that, I think she probably has, I think that’s very meaningful”), or with therapists who did not initially know much about TGNC experiences, but who were still effective clinicians through self-education: “interestingly I have a therapist I’ve
gone to off and on for 25 plus years, who had no clue even what gender queer meant, but she’s been phenomenal actually in working through this”.

*Appropriate therapy foci.* In addition to taking the initiative, participants described therapists who set and worked toward effective and appropriate therapy goals and foci as particularly helpful. For example one participant highlighted how their therapist asked thought-provoking questions with the purpose of exploration for the client rather than education for the therapist: “she asked me a lot of questions that weren’t for her to gain more knowledge, but she asked me…did you look in the mirror? And I was like of course I did, how did you know to ask that question? So I thought that really showed me she’s sensitive to the process I’m going through and she knows enough about human identity and development and she knows enough about me to know what things would be important or not important to say”. Another participant described a positive experience with appropriate therapy foci at a much more basic level, but one which (as noted above) not all TGNC participants shared: “I’ve made it very clear to any therapist that I’ve started going to that my gender identity and my sexuality aren’t a cause of any distress in my life, and so far that’s totally been respected”.

*Validation.* Lastly, participants described positive experiences when therapists validated their challenges and identities. One quote highlighted the importance of validation overall in therapy: “it’s a huge part of who you are, especially since you are in the midst of this transition process, in terms of labels and deciding where you fit community-wise, that self-exploration is a huge part of every single day of your life so it’s important to have that validated. You can’t go to therapy and have someone not recognizing that.” Elaborating on this point, one participant described an experience with the director of a gender identity clinic in Toronto, ON: “he said, ‘looking back at your childhood, are there events that you would think might have been
influential or a trigger?’ and there were a couple I had and then he said to me ‘okay those had nothing to do with your gender identity formation. The only reason they’re significant is because you don’t identify as male and that you’ve been told you were a boy all the time and you don’t identify that way’. Another participant described their therapist’s affirming response to their challenges of learning how to perform gender as a woman: “I hope you know that you can woman any way you want to, and whether you are wearing a full face of makeup or not, or wearing a dress or not, you can do that in whatever way you want to.”

Need for reform/education. Participants unanimously proposed one solution to the abovementioned limitations in the mental health care experiences of TGNC clients: reform through education. Specifically, participants noted that while trainings and workshops on TGNC experiences may exist, they are often part of a larger “LGBTQ” workshop wherein TGNC-specific experiences may fall through the cracks, and/or the focus is on only one specific aspect of TGNC experiences, thus leaving much information untapped. One participant gave the example “especially nowadays when people go through trainings or whatever the focus is about a trans person in transition and not necessarily how to treat a trans person who doesn’t care about that stuff as much anymore”. Another participant pointed to widespread training limitations with regard to TGNC competencies: “finding trans competent providers has been very difficult and I feel it’s not a part of education or something that’s standard”.

Experiences with criminal justice system. When asked to describe their perceptions of and/or experiences with the criminal justice system, after discussing interactions with mental health systems, one participant stated: “that’s definitely a lot more of a pretty clear cut bad situation. Um, yeah, I don’t know how to put a positive spin on that. Like it’s just not, it’s not good. I mean it’s not even…yeah, it’s so bad”. Other participants echoed this dismal perception
in their reports of two primary themes of negative experiences with criminal justice systems: 1) distrust (a theme of participant perceptions) and 2) profiling “other-ness” (a theme of participant experiences). However, it should be noted that participants did share some positive experiences with the police and other agents of the criminal justice system as well as suggestions for how to improve this system, thus experiences were not unanimously negative.

**Distrust.** One participant described their subjective experience when near a police officer: “so incredibly nervous and uncomfortable, just like passing them and I notice my body tenses up and I walk as quickly as possible”. Similar safety concerns were expressed by other participants and described as exacerbated by their TGNC identity, and further exacerbated for people who identify as TGNC and a person of color: “there is an understanding that some people are safer than others when they get arrested”, “I think that trans people, especially trans women of color face a lot of violence and it doesn’t seem like the police are really interested or invested in protecting our community. I feel that they are very interested in policing our community and controlling the ways in which we present ourselves…I only ever see the message that the police are not there to protect me or my community”. Equally concerning were participant reports that they do not feel safe or comfortable approaching the police for assistance, even if they were the victim of a crime such as a rape or physical assault: “I would be very untrusting and would prefer to go to just about anyone other than the police officer”.

As an antecedent to the distrust described by participants above, many shared personal experiences of discrimination at the hands of police based on their gender identity and/or presentation. For example, one participant described their general perspective on seeking assistance from the police: “what I feel like I pick up on is the more serious the thing gets, the more at risk you are of them misreading the situation and mistaking the seriousness of the
situation and turning it around on you”. Another participant described a personal experience with the police: “I have overheard police officers making really transphobic jokes, and cops have harassed me for looking (before I was on testosterone) for looking really young”.

**Profiling “other-ness”**. Participants described a unique form of profiling related to their gender identity or gender presentation. Participants who identified as non-binary and those who had undergone a lengthy transition process provided experiences for comparison regarding their interactions with police when they were presenting as more masculine, more feminine, passing, etc. For example, one participant observed: “I’ve noticed this thing where if I’m dressed femininely they’re very, very nice to me but when I’m dressed masculine, I get stares”. Another participant described a vague fear that police might profile them, though they stated they had not yet had this experience: “maybe they’re going to single me out…I feel maybe a little more obvious than some other people”, whereas a third participant who identified as a white participant reported: “I have been randomly stopped at the subway, like ‘randomly’ stopped way more than other white people have been”.

**Positive thoughts.** Whereas many participants reported a sense of distrust and hesitance to seek assistance from police, three (of the 15 participants) reported that they would immediately reach out to the police if they felt that they were in danger, or if they had some form of crime to report. This sense of cautious hopefulness is captured in one participant’s quote: “I’m hopeful, which is scary to say because it means things aren’t right, especially in a time when things aren’t so clear, as we kind of know the direction that we’re heading in which is a more accepting overall direction”. As one participant stated: “I would be like, officer, this is your responsibility, you need to come and help”.

Proposed solutions. As with mental health systems, participants largely recommended education and training to reform the criminal justice system to be more TGNC-affirming. However, in addition to education and training, participants noted that systemic reform is also necessary before true progressive change can take place in the criminal justice system: “much like mental health or medical health or other systems, they don’t have adequate training. They don’t really get it or make an effort together to feel that they need to get it”. Participants noted a number of weaknesses in the current training of police: “I think it’s everything, like there’s misinformation, there are misconceptions, there’s lack of information. People are ignorant, people just don’t know, and have their own perceptions…it’s a combination of everything, it’s not one factor”, while also highlighting the wide scope of the necessary changes: “I think just so much reform and education are needed…I feel like it just needs a complete overhaul”, and “I think it goes beyond prisons like American society itself especially schools and the prison pipeline [school-to-prison pipeline] …” One specific recommendation for improvement included “hiring trans people of color and people of color and trans people and non-binary people and actually having the people policing the communities be the same as the people in the communities” (community-based policing).

Chapter 6: Discussion

Summary

The purposes of this study were twofold. First, I (or “the study”) sought to create an improved model of gender identity developmental processes which captures nuances and realities not encompassed within extant models. Second, I sought to utilize this improved understanding paired with the recommendations of TGNC participants to provide recommendations for mental health and criminal justice systems. These recommendations aim to
improve relationships between these systems and the TGNC populations they serve, with collateral reductions in mental health and quality of life disparities faced by TGNC populations. To this end, seven a priori hypotheses were tested, five of which were supported by the data (two of these were partially supported). In addition to these hypotheses, several ancillary analyses were carried out to gain improved depth of understanding of the data and to maximize the scope of the study’s implications.

**Group differences.** Prior to hypothesis-testing, analyses of group differences were conducted to better understand whether participants of different ages, gender identities, and racial/ethnic identities had differential experiences with victimization, gender dysphoria, depression, anxiety, flourishing, GRIT, social support, and/or TGNC community connectedness. Interestingly, none of these identity groups initially significantly differed in terms of victimization experiences or positive mental health (i.e., flourishing and GRIT), however there were some interesting differences across age, wherein older participants tended to report higher levels of depression, anxiety, and gender dysphoria while also reporting higher comfort with all four domains of help-seeking (mental health, medical, criminal justice for minor crimes, and criminal justice for major crimes). These findings are consistent with research indicating that transgender elderly populations face unique challenges particularly regarding healthcare, social support, and legal support (Persson, 2009; Porter et al., 2016; Witten, 2016). Specifically, research seems to indicate that transgender elders face not only the traditional challenges of aging (e.g., isolation, medical challenges, loss and grieving, self-agency challenges) but that these traditional challenges are compounded with the unique stressors associated with having lived their many years as TGNC, encountering chronic minority stress and systemic marginalization (Williams & Freeman, 2008).
Interestingly, when socio-demographic identities of gender identity and race/ethnicity were combined into a smaller number of categories to achieve higher bin frequencies per category, compelling differences did emerge. Within those differences, patterns indicate that binary-identified participants in general fared better than non-binary identified participants (in terms of GRIT, flourishing, help-seeking in terms of criminal justice major and medical, gender dysphoria, and depression). These results are consistent with the over-arching hypothesis echoed throughout this paper—that decreased awareness and acknowledgement of non-binary gender identities may lead to non-binary TGNC individuals facing double marginalization both as a TGNC-identified person (marginalized in comparison to cisgender populations) and as a non-binary-identified person (marginalized in comparison to binary-transgender populations).

In contrast, while findings related to consolidated categories for race/ethnicity (i.e., white, POC, and mixed) were compelling, the emergent pattern was less distinct than in the case of gender identity. For example, while significant differences emerged in terms of mental health help-seeking comfort, gender dysphoria, depression, and anxiety, the nature of these patterns differed based on the construct in question. In terms of mental health help-seeking comfort and anxiety, mixed-race participants scored significantly lower than either POC or white participants. However, in terms of depression and gender dysphoria, mixed-race participants did not significantly differ from either other group, but POC scored significantly lower than white or mixed-race participants. It is possible that these findings may result in part from cross-cultural differences in the expression and/or endorsement of symptoms of distress (i.e., gender dysphoria or depression). Such a conclusion would be consistent with extant literature. For example, Liu, Iwamoto, and Kenji (2006) studied gender role conflicts related to expressing psychological distress among Asian American men. However, common conceptualizations regarding cross-
cultural differences in the expression/endorsement of distress cannot necessarily be assumed to hold in this study. For example, Kirmayer (2001) studied cultural differences in anxiety, specifically the oft-cited example that collectivistic/eastern cultures tend to somatize distress they experience whereas individualistic/western cultures are more prone to share their distress. Contrary to popular belief, the authors found that somatization presented with relative equanimity across cultures, highlighting how crucial it is for researchers and clinicians to avoid jumping to culture-based conclusions. Thus, based on the scope of the present data we cannot reasonably reach any final conclusion regarding these patterns in the data. Rather, we encourage researchers to consider these possible influences and incorporate them into studies of the future, such that a more nuanced understanding may be achieved in the years to come.

**Hypothesis 1.** First, it was hypothesized that participant narratives would indicate greater heterogeneity (particularly during later phases of development) than indicated within previous research. This hypothesis was supported by multiple dimensions of the data. The themes of “transition amnesia” and “increasing flexibility” most directly spoke to this hypothesis, as participants described increasing flexibility in terms of their own gender identities and expressions as well as their conceptualization of gender as a construct toward the later phases of their gender identity development. This flexibility was even described in several cases as culminating in a state of “transition amnesia”, wherein participants no longer endorsed a connection to the process of transition or the identity of transgender, but rather regarded those experiences as a closed chapter in their life which they did not feel compelled to revisit. Lastly, this hypothesis was supported within the developmental theme of adulthood, which comprised a much greater degree of heterogeneity than themes of childhood, adolescence, or early adulthood. For example, while distinct sub-themes emerged for childhood, adolescence was distinctly
influenced by puberty, and early adulthood was distinctly influenced by factors of autonomy and individuation, participants described a variety of different factors which were influential during adulthood (e.g., starting their own families, joining the workforce, traveling, battling breast cancer, joining activist movements, etc.)

**Hypothesis 2.** Second, it was hypothesized that participant narratives would reveal common themes of risk and resiliency within developmental processes. This hypothesis was supported by the data, though it is difficult to accurately assign the terms “risk” and/or “resiliency” to resultant themes as participants described their experiences more in terms of “challenges” compared to “helpful factors”. The most common challenges described included systemic discrimination, lack of media representation (or rather lack of positive, accurate media representation), and bureaucratic hurdles such as name changes and gender markers on legal documents. The most commonly reported helpful factors included being surrounded by affirming people (at work, at home, with friends, with partner/s), as well as having access to information through the internet—described as a crucial tool used by many during their early stages of gender identity exploration. These findings are consistent with prior research which highlights systemic challenges faced by TGNC individuals (Nadal, Skolnik, & Wong, 2012) and the utility of the internet in providing a space for both self-exploration and social support building (Benotsch, Zimmerman, Cathers, McNulty, Pierce, …& Snipes, 2014).

**Hypothesis 3.** Hypothesis three predicted that participants who experienced more frequent victimization would also report higher levels of depression, anxiety, gender dysphoria, and GRIT. This hypothesis was partially supported, in that increased victimization predicted higher levels of depression, anxiety, and gender dysphoria but also lower levels of GRIT. Findings related to depression, anxiety, and gender dysphoria are consistent with both theory
(e.g., minority stress theory; Meyer, 1995; Meyer & Frost, 2012) and extant literature finding that discrimination negatively impacts mental health (for meta-analyses and literature reviews see Mak, Poon, Pun, & Cheung, 2007; Meyer, 2003; Pascoe & Richman, 2009).

The finding that higher levels of victimization predicted lower levels of GRIT, however, stands in contrast to existing literature. Specifically, GRIT refers to perseverance in the face of adversity, and/or as passion and longevity in the pursuit of long-term goals. GRIT has been demonstrated as a protective factor for a number of groups exposed to extensive and unusual amounts of stress including elderly inmates (Harrison, 2006), medical residents (Salles, Cohen, & Mueller, 2014), breast cancer survivors (Vinokur, Threatt, Vinokur-Kaplan, & Satariano, 1990), soldiers (Cornum, Matthews, & Seligman, 2011), and refugees (Grigoleit, 2006). However, the present investigation is the first to directly examine GRIT in relation to victimization (and further, to do so with a sample of TGNC adults). Thus, it is challenging to effectively interpret this result. On the one hand, it may be possible that the measurement of GRIT in this study does not generalize as well to TGNC populations as it was created and validated with cisgender populations (though notably, the GRIT scale demonstrated a Cronbach’s alpha of .85 and indicated convergent validity through positive correlations with flourishing and divergent validity through negative correlations with depression, anxiety, and gender dysphoria). On the other hand, it is possible that GRIT manifests uniquely in relationship to victimization compared to other forms of stress, a possibility supported by the fact that participants who reported higher levels of GRIT also reported higher levels of verbal victimization (lifetime and past-year), higher levels of lifetime physical victimization (but lower past-year levels), and lower levels of sexual victimization (lifetime and past-year). Thus, it seems
that the relationship between victimization and GRIT is much more complicated than previously anticipated, and future research should seek to investigate this complexity.

**Hypothesis 4.** It was predicted that higher levels of victimization would predict lower levels of flourishing, a measure of psychological well-being. This hypothesis was supported with statistical significance; however, the strength of this support is weak. Victimization predicted only 4.7% of variance in flourishing, indicating that over 95% of influences upon flourishing remain undiscovered and unaccounted for within the present investigation. Further, different time periods of victimization (i.e., past-year versus lifetime) and different categories (i.e., verbal, physical, and sexual) inconsistently related to flourishing, thus complicating the understanding of this predictive relationship. For example, victimization in the past-year was most influential in terms of verbal and sexual victimization (theoretically the least and most impactful forms, respectively) whereas only lifetime frequencies of physical victimization predicted flourishing. Thus, much remains to be uncovered regarding the relationships between victimization and positive psychological traits such as flourishing.

These results contrast extant theoretical and empirical literature. For example, in its initial conceptualization by Keyes (2002), flourishing significantly related to psychological well-being, reduced likelihood of psychiatric hospitalization and of depressive symptoms, and related to improved psychosocial functioning. One possible explanation for the disparate results of the present investigation may lie in the conceptualization of flourishing as a continuum of positive mental health. Specifically, researchers have indicated that flourishing may be best conceptualized as a dichotomous construct, wherein individuals could be categorized as either flourishing or languishing, separated by a cut-off score that has yet to be definitively determined (Schotanus-Dijkstra et al., 2015). Research on flourishing remains largely scant, with the
exception of numerous cross-cultural validations of the flourishing scale in cultures around the world. Thus, much remains unknown about the ways in which flourishing may relate (or not relate) to other constructs of psychological distress and/or well-being. Further, this is the first study to specifically assess flourishing with a TGNC sample, thus it is possible that the construct of flourishing may manifest differently within TGNC populations compared to the cisgender populations with which the scale was developed.

**Hypotheses 5 and 6.** Hypotheses 4 and 5 predicted that the relationship between victimization and psychological well-being would be mediated by social support and TGNC community connectedness, respectively. These hypotheses were not supported, as neither social support nor TGNC community connectedness significantly mediated relationships between victimization and any form of well-being (depression, anxiety, gender dysphoria, flourishing, or GRIT). These findings do not align with extant literature, which provides a strong foundation for social support and TGNC community connectedness as mediators (or at the very least, as moderators). For example, Barr, Budge, and Adelson (2016) found that transgender community belongingness was not only strongly related to transgender identity overall, but also that it had a stronger impact on well-being than age, income, or stage of transition, demonstrating the robustness of the positive impacts of TGNC community connectedness. Further, studies have demonstrated relationships between social support and psychological well-being among people who identify as TGNC. For example, Boza and Perry (2014) found that social support was the strongest predictor of (decreased) depressive symptoms in their sample of 243 transgender adults in Australia. Similarly, Pflum, Testa, Balsam, Goldblum, and Bongar (2015) found that social support predicted decreased depression and anxiety in their sample of 865 TGNC adults and
Riggs, Ansara, and Treherne (2015) found that TGNC community connectedness was crucial in mitigating negative mental health experiences among their TGNC sample.

On the other hand, the lack of mediation in the present investigation is not unique among the literature. Davey, Bouman, Arcelus, and Meyer (2014) studied the relationship between social support and psychological well-being among adults with gender dysphoria. The researchers found that while TGNC women reported significantly lower levels of social support compared to matched controls (cisgender women), social support did not significantly impact depression. One possible explanation for the fact that a mediation effect was not found in this study may lie in the role of third variables— influential variables not assessed within the present investigation. For example, Budge, Adelson, and Howard (2013) found that social support impacted depression and anxiety in their sample of transgender adults indirectly, by way of avoidant coping strategies. Thus, it is possible that methods of coping (not assessed within the present investigation) may contribute to mediated moderation (or to moderated mediation) relationships between victimization and well-being. Another possible explanation for the lack of mediation is that the constructs of social support and/or TGNC community connectedness need to be further examined, as they may function in a multi-faceted manner not captured within current measures of either construct. Thus, it is possible that while current measures of these constructs demonstrate statistical reliability and validity, they may lack construct validity in ways which current research has yet to uncover.

**Hypothesis 7.** Hypothesis 7 predicted that victimization would predict decreased help-seeking. This hypothesis was supported, and these results align with existing research indicating that TGNC individuals are often hesitant to seek help from mental health providers (McCann, Sharek, Higgins, Sheerin, & Glacken, 2013; Shipherd, Green, & Abramovitz, 2010). These
results are crucial, as they indicate that TGNC adults are a high risk, high needs population facing increased levels of mental health and quality of life disparities—but with minimal access to affirming resources, and a pervasive discomfort to seek assistance from those resources which do exist.

**Ancillary analyses.** During the consensual qualitative research process of coding the 15 interview transcripts, a number of themes emerged above and beyond the a-priori hypotheses. Among these themes, a series of critical processes were described by participants in much more detail than developmental phases (i.e., childhood, adolescence, early adulthood, and adulthood). This indicates that gender identity development may be best conceptualized as a complex multidimensional ongoing process, rather than as any form of linear process (though chronology certainly has an impact, as the experiences and potential of children versus adults are quite different). Similarly, the present results indicated that while activism was highlighted, or even required by some extant gender identity development models (e.g., Devor, 2004), activism is not a motivation shared by all (or even most) participants. Thus, it is necessary for future researchers as well as clinicians working with TGNC populations to remain cognizant of the heterogeneity of experiences within this unique population, and to remain skeptical of models which may oversimplify TGNC experiences for the sake of brevity, at the expense of realism.

**Implications**

**Implications for Clinical Practice.** The present results indicate that TGNC adults reported not only high rates of experiencing psychological distress such as gender dysphoria, depression, and/or anxiety, but that they also reported profound discomfort regarding seeking mental health services. In many cases, participants described an outright aversion to seeking mental health (or even criminal justice) services regardless of the immense challenges and
disparities they may face, due to concerns regarding poor training among clinicians and possible stigmatization. As a result, people who identify as TGNC must walk through the world bearing the burden of society’s stigma as well as its impact on their own well-being, all with minimal social support and without access to affirming mental health resources that should be guaranteed.

Not only does this circumstance stand in stark opposition to the Declaration of Independence’s promise of “life, liberty, and pursuit of happiness” and with the American Psychological Association’s Ethical Principal A: Beneficence and Non-maleficence (APA, 2010). Psychology, as a discipline concerned with the well-being of all people, has fallen short of its most fundamental principles as it fails to provide services to this underserved and misrepresented population (or worse, provides harmful services which stigmatize TGNC identities and further alienate TGNC communities from the possible benefits of affirming mental health care). Failure to eradicate this circumstance, with due haste, serves at best to prolong the suffering of TGNC populations and at worst to provide (however intentionally) evidence supporting the dehumanization of TGNC individuals.

**Implications for Systems and Institutions.** Participants reported very low levels of comfort seeking assistance from police or mental health care providers, thus it is likely that our already high rates of victimization as we understand them among TGNC communities are likely vast under-representations of actual experiences. As such, the urgency is for improving competency among mental health and criminal justice providers is likely much greater than previously considered. This urgency is compounded by the fact that participants highlighted that one of the largest challenges they faced during their gender identity development lay in a lack of affirming resources for gender identity exploration or support, particularly demonstrated as low competency and high prejudice among mental health care providers.
Further, the present results indicate that societal stigma, and messages communicated regarding TGNC identities and experiences at a systemic level have the opportunity to contribute to either damage or healing. Participants consistently described challenges with poor media representation, including both a lack of seeing relatable images of themselves (i.e., TGNC characters and plot lines) and harmful images when they were projected (e.g., predominant killing off of LGBTQ+ characters, which has been colloquially referred to as the “bury your gays” phenomenon; GLAAD, 2016). Thus, the media holds the powerful potential to begin to revise the systemic narrative regarding TGNC identities and experiences. Specifically, improved media coverage (e.g., both more frequent and more accurate and positive representations of LGBQ and TGNC identities and lives) has the potential to begin to reconstruct the public image and conceptualization of TGNC individuals and experiences. Narrative revisions of this kind have the potential to create collateral positive impacts via at least two avenues: 1) providing education regarding gender diversity and providing relatable images to aid in individual constructions and explorations of their own gender identities and 2) reducing internalized stigma/transphobia/trans-negativity through the provision of positive presentations of TGNC individuals in the media (i.e., portraying TGNC characters in realistic and adaptive plot lines, rather than for sensationalism, comedy, or exotic effect).

**Implications for Education and Training.** Notably, the present results indicate that many of the resources described by participants as particularly helpful (i.e., internet, media, support groups, travel and outreach, activism, creative outlets, college courses, conferences, etc.) may be difficult (or impossible) to access for TGNC people who are homeless (none of our sample were street homeless, though 4 resided in shelters) and/or of low socioeconomic status. Thus, there is a need for expanding the supportive resources available especially for low-income
and multiply marginalized TGNC populations and individuals. The present results suggest that while research regarding TGNC risks, needs, experiences, and identities is experiencing a period of expansion, a portion of TGNC populations (arguably those with the highest needs and fewest resources) may by falling through the cracks of even the most ardent research or social outreach. This dismal reality highlights the imperative for future educators and researchers looking into TGNC experiences and challenges to actively go into TGNC communities, and tailor their research methodologies to capture and provide services to TGNC individuals who are most likely to be struggling and least likely to have access to affirming resources. Unfortunately, if this imperative is not made known to stakeholders of educational organizations training the future generation of mental health service providers, these disparities are only likely to worsen at the immense expense of TGNC lives.

Limitations

The present study, while carefully designed to effectively address the hypotheses and research questions proposed, is not without its limitations. Aside from the traditional limitations of self-report research (i.e., impression management, assumptions regarding introspective and retrospective ability, and response bias), the sample drawn comprised a skewed distribution with regard to the variables included. For example, individuals who experienced severe depression and anxiety may have been unable to participate due to fatigue, anhedonia, amotivation, or decreased ability to concentrate. Severely depressed or anxious individuals may have also been reluctant to participate in a study regarding a topic as personal as their identity. As a result, the sample likely consisted of individuals on the less severe spectrum with regard to anxiety and depression, and on the more secure and self-confident range of gender identity development, thus limiting the generalizability of these results.
Similarly, the sample drawn was likely skewed with regard to identity status and/or process. For example, an individual who experiences a sense of comfort with regard to his/her/their TGNC identity, who lives full time in their preferred role, and who experiences a great deal of satisfaction in life with regard to gender identity may be more likely to participate than an individual who struggles with severe gender dysphoria, identity uncertainty, internalized stigma, and/or unsupportive social environments. Participants may therefore represent only a subset of the TGNC population (those who have achieved a sense of identity stability or achievement and who are open, willing, and ready to share their experiences). Thus, the generalizability of the results are limited to describing and predicting the characteristics only among other samples similarly distributed to the present sample.

Lastly (but not least), the methodology of the present investigation is limited in its ability to obtain a deep understanding of the chronological processes at work in gender identity development. While this cross-sectional and retrospective study will provide valuable insight into the multidimensionality of gender identity, well-being, and experiences of victimization and discrimination, the antecedents and impacts of these variable relationships over time are beyond the scope of this data (and beyond the scope of a reasonable dissertation timeline).

**Future Directions**

This section will include several future directions for research, mental health clinicians, and the criminal justice system, extending from the researcher’s interpretation of the results and their implications. However, the purpose of the present investigation was to center the experiences of TGNC individuals, rather than the perspective of the (cisgender) researcher. Thus, this section will begin with conclusions and recommendations from participants themselves.
Participant concluding thoughts. At the conclusion of each interview, participants were asked if there was anything else they would like to add or elaborate upon. The following themes and quotes emerged from their responses to that final question.

Personal strengths. A handful of participants concluded their interviews by summarizing strengths of their own which they felt were crucial components of their multifaceted identities, in addition to their gender identities. These quotes exemplified the positive skew placed upon many participant responses throughout the 15 interviews, and highlighted participant thought processes as they sought to conclude a discussion of their struggles, their experiences with victimization, and the many challenges they have faced in a cis-normative society, with an emphasis on their own individualized positive traits. For example, one participant emphasized their commitment to diversity and an open mind toward others: “I’m a beautiful person, uh, I’m ambitious, I’m very much goal-oriented…I’m easy going, um, I’m successful. I’m a professional. I take care of people and I do understand that people are from different backgrounds.” A second participant encouraged others to resist the urge of jumping to conclusions based on stereotypes and/or preconceived notions: “I’m a good man. Like take the time like to get to know me, take the time to observe me before you judging knock me before you put you know negativity in the air.”

I exist, and that is valid. Participants also shared statements about themselves that they wished the world could know or understand about them. For instance, one participant simply stated “my experiences are valid”, indicating that simply having their experiences viewed as true, as real, and as valid was of utmost importance to them, thus demonstrating that for many TGNC people this assumption of humanity and respect is not assured. Similarly, another participant drew attention to society’s tendency to hyper-focus on the physical aspects of TGNC individuals, thus detracting attention from who they are as human beings: “I am more than my body”. Lastly,
in many ways summarizing the sentiments of the prior two participants, one stated: “I am also real, and people like me are real, and we should also be included in this conversation”.

**Advice for TGNC people.** In their concluding statements, some participants provided advice to other TGNC individuals struggling with their gender identities and/or with society’s response to those identities. One participant summarized the process of ‘coming out’: “coming out is sort of…you not really being able to escape the truth…like the truth sort of catching up to you and you having to decide like are you going to embrace it or are you going to let it pass?” A second participant provided a reminder to other TGNC people to be gentle with themselves and with others: “sometimes people forget how hard it is to be a person in society, in the world, you really have to like give yourself a break sometimes…especially trans folks who are consistently having to deal with so much just to leave the house. You have to remind yourself that everybody is going through something.”

**Advice for researchers and society.** Similarly, participants also concluded with recommendations for researchers and society to improve the ways in which they relate with TGNC populations. One participant highlighted heterogeneity in the experiences of TGNC people: “there is no real one ‘coming out’ narrative, even like within one person…like one person can experience so many different ways of coming out within their trajectory, within their timeline, and that’s important to acknowledge”. Two participants turned their attention to the “binary narrative”: “people really love that binary narrative. People really love the born this way narrative because I think that makes them feel safe”, and specifically highlighting heterogeneity not only within TGNC narratives but also within non-binary TGNC experiences specifically, “non-binary people and trans people are just as complicated and diverse and multi-dimensional as everyone else and I think it’s very easy to take like one narrative and be like this is what all
trans people look like, and not really humanize the fact that we are all different people with
different experiences who view gender in different ways and fall in different places on the
gender spectrum.”

**Calls to action.** Lastly, but certainly not least, several participants shared calls to action,
urging communities (i.e., queer communities, LGB communities, TGNC communities,
communities of allies) to continue pushing for positive change. While highlighting the enormity
of this task (e.g., “there’s much to do, there are a lot of things to be done yet”), participants
highlighted tools that can facilitate the process (e.g., “there’s this wonderful utility with the
internet”), concluding with a resolute encouragement to “not let our guard down on this, and
fight this any which way we can”.

**Recommendations for future research.** Notably, much this sample (online and
interview) was largely high functioning, from middle class backgrounds and/or with strong
social support and the means to either complete an online survey (i.e., with internet access) or to
travel to midtown Manhattan (i.e., having funds, time, knowledge of the area). Thus, TGNC
individuals without these means are likely being missed not only within this research but in
TGNC research in general. Thus, future research should turn its attention toward finding a way
to safely and effectively access and support the entire TGNC population, to include lower
income, elderly, and/or TGNC individuals struggling with exceptional levels of distress which
may prevent them from seeking assistance above and beyond preventing them from engaging
with research, so these individuals are less likely to fall through the cracks in the future.

It is also crucial as this field of research continues to expand that intersectionality
continue to be explicitly assessed, as participants described many intersectional experiences
(e.g., race/ethnicity, sexual orientation, sex assigned at birth, health status) as well as some that
were not mentioned frequently enough to comprise a theme but which are meaningful nonetheless (e.g., being “fat” and gender non-conforming, being a TGNC cancer survivor, being a TGNC parent, etc.) When addressing intersectionality among TGNC populations, it is particularly important that researchers remain attuned to the potential intersections with age and with better understanding the needs and experiences of TGNC elders who likely have very different experiences than TGNC individuals who grew up within an age of expanded (albeit still quite limited) rights and availability of information. Specifically, researchers may seek to better understand how older TGNC individuals may experience their identities differently, and/or what terms they use to describe their identities. For example, it is possible that older TGNC adults may be more comfortable with terms such as “transsexual” than with terms such as “genderqueer”, based on the relative prevalence of each term throughout their lifetimes.

Future research should also seek to improve our understanding of specific under-studied sub-groups of TGNC individuals, in addition to the elderly. For example, TGNC veterans face multiple marginalization and dual forms of limited resources, which can be further exacerbated among TGNC veterans with multiple marginalized identities. For example, Brown and Jones (2014) found that the compound stigma for Black transgender veterans contributed to increased levels of depression and substance abuse. Similarly, Lindsay et al. (2016) found that transwomen experienced rates of military sexual trauma far above those of any other group of veterans, and that these experiences profoundly negatively impacted their mental health (i.e., post-traumatic stress, depression, anxiety, substance abuse, suicidal ideation). Additionally, it is likely that TGNC individuals who reside in rural rather than urban areas may face a similar degree of increased marginalization compounded with decreased availability of resources as experienced by TGNC veterans. For example, Horvath et al. (2014) found that the exacerbated lack of service
availability in rural areas contributed to increased rates of substance abuse (both alcohol and drugs) and risky sexual behaviors among a sample of rural TGNC adults. Thus, research should seek to better understand the unique experiences of sub-groups of TGNC populations which may face two, three, or multiple layers of marginalization and risk factors above and beyond their identities as TGNC.

Lastly, and in this author’s opinion most importantly, future research should seek to center and uplift the voices of TGNC-identified researchers and authors. The present author collaborated with several TGNC-identified adults utilizing an online platform, and all elements of the study method were examined, discussed, modified, and eventually mutually decided upon by the researcher in collaboration with TGNC individuals in an effort to capture nuances and maximize competency within this research protocol. However, these actions represent only a baby step toward TGNC inclusivity in research and in higher education. Thus far, research regarding TGNC populations has been construed through the eyes of cisgender researchers who, even with the best intentions, cannot truly understand or interpret our data with the same depth that a TGNC researcher could.

**Recommendations for mental health and criminal justice.** Results from the present investigation combined with recently published research call for several concrete recommendations for mental health clinicians, many of which arguably extend to the criminal justice system. First, as previously mentioned in relation to the media, a certain degree of systemic change is necessary to reform mental health and criminal justice systems not only toward non-pathological perspectives of TGNC identities and perspectives, but also toward working with TGNC individuals systemically, rather than acting as though their experiences exist within a vacuum. For example, Porter (2016) highlighted the importance of addressing not
only experiences such as depression, anxiety, or gender dysphoria, but also housing, occupation, education, and social support—all domains in which TGNC populations have been demonstrated to face noteworthy disparities. Above all else, mental health and criminal justice systems should regard each TGNC individual as a human within a context, and provide adequate consideration to the complexities of both the human and of the context.

Second (though under the umbrella of the abovementioned need for systemic change), there is a profound need for improved education and training within both mental health and criminal justice fields. Fortunately, training and education have been demonstrated to reduce prejudices and improve competency to work with TGNC populations (Bidell, 2013). Within this vein, Dickey and Singh (2016) noted that it is the duty of clinicians to remain informed and to monitor their own competencies and to take ownership of their mistakes and/or limitations. Further, the authors provide references to nine publications which clinicians may reference regarding specific TGNC sub-populations (including children and youth, parenting, trans people of color, and TGNC communities in a larger sense). Bidell (2016) echoed Dickey & Singh’s call to action for clinicians, stating that competency requires clinicians to actively maintain awareness of their own limitations, and of the limitations of the field regarding all clients (but especially those who are marginalized).

In addition to these general notes, research has begun to explore some concrete methods for improving education and training of clinicians for TGNC competency. For example, Kalra (2013) found that using film to train clinicians regarding experiences such as coming out, family pressures, discrimination, sexual abuse, and aging can be both cost and time-effective, while also allowing for realism in case examples (with preserved anonymity). Second, Riggs (2016) found that training alone is insufficient to improve clinician competency, but that clinical experiences
with TGNC individuals actively paired with training over time produce ideal circumstances for improved competency. Third, awareness of implicit biases (among both mental health clinicians and agents of the criminal justice system) has been demonstrated as a crucial component of effective training programs. Specifically, training and education should allow learners to explore their implicit biases and/or preconceived notions in relation to other elements of the training, such as epidemiology, prevalence, terminology, assessment, and current standards of care.

While psychotherapy research regarding TGNC populations remains rare, and there are currently no evidence-based treatments for gender dysphoria in the mental health field (APA Presidential Task Force on Evidence-Based Practice, 2006), researchers have begun to broach this topic by empirically assessing modifications to existing psychotherapy protocols as applied to TGNC populations. For example, Austin (2014) described a modified form of CBT which explicitly includes validation and exploration of TGNC identities and experiences in addition to more traditional CBT protocols, with some efficacy (though additional research needs to be conducted). Similarly, Heck (2015) conducted a series of three 12-week psychotherapy groups specifically catered toward TGNC individuals by adapting common process group psychotherapy methods to include explicitly trans-affirming components.

While specific interventions such as those above are slowly emerging and have yet to gain an evidence base, researchers have uncovered some crucial components to psychotherapy with TGNC adults which can be implemented more gradually to improve clinician competency on a smaller scale. Specifically, Benson (2013) found that self-disclosure on the part of clinicians (in terms of their own gender identities, their experiences working with TGNC individuals, their biases regarding TGNC experiences or identities, their own humanity, and/or their own limitations as clinicians) led to TGNC clients reporting that they felt more secure and more safe
within the therapeutic relationship. Additionally, Berke et al. (2016) uncovered six dimensions of psychotherapy which were described as particularly helpful by TGNC adults: authenticity, intersectionality, affirmation, client match, symbolic commitment, and a non-directive therapy approach. Thus, while mental health and criminal justice systems certainly have a long road ahead toward approaching TGNC competency, the groundwork exists such that the steps now need to be taken to begin breaking down systemic marginalization of TGNC identities and creating affirming resources for this marginalized, but tenacious population.
Appendix A: Tables

Table 1. Interview sample characteristics (N = 15)

<table>
<thead>
<tr>
<th>Category</th>
<th>Frequency</th>
<th>Valid Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex Assigned at Birth</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>9</td>
<td>60</td>
</tr>
<tr>
<td>Male</td>
<td>6</td>
<td>40</td>
</tr>
<tr>
<td>Intersex</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Gender Identity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transgender (MtF)</td>
<td>3</td>
<td>20</td>
</tr>
<tr>
<td>Transgender (non-binary)</td>
<td>3</td>
<td>20</td>
</tr>
<tr>
<td>Transgender (FtM)</td>
<td>2</td>
<td>13.3</td>
</tr>
<tr>
<td>Genderqueer</td>
<td>2</td>
<td>13.3</td>
</tr>
<tr>
<td>Female</td>
<td>1</td>
<td>6.7</td>
</tr>
<tr>
<td>Male</td>
<td>1</td>
<td>6.7</td>
</tr>
<tr>
<td>I do not identify with any of these terms. Please specify:</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Gender Identity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I mostly identify with my gender expression, which is generally androgynous. If gender is 0-10 with 0 being 100% masculine and 10 is 100% feminine, I identify as ranging fluidly between 3-6, often slightly masculine. But I count myself as female when asked by government, institutions, etc.</td>
<td>1</td>
<td>6.7</td>
</tr>
<tr>
<td>Prefer NOS or non-binary</td>
<td>1</td>
<td>6.7</td>
</tr>
<tr>
<td><strong>Religion/Spirituality</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Atheist</td>
<td>1</td>
<td>6.7</td>
</tr>
<tr>
<td><strong>Race/Ethnicity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>7</td>
<td>46.7</td>
</tr>
<tr>
<td>Mixed race/ ethnicity</td>
<td>3</td>
<td>20</td>
</tr>
<tr>
<td>Black or African American</td>
<td>2</td>
<td>13.3</td>
</tr>
<tr>
<td>Asian</td>
<td>2</td>
<td>13.3</td>
</tr>
<tr>
<td>Hispanic/Latina/o/x</td>
<td>1</td>
<td>6.7</td>
</tr>
<tr>
<td><strong>Sexual Orientation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Queer</td>
<td>8</td>
<td>53.3</td>
</tr>
<tr>
<td>Pansexual</td>
<td>3</td>
<td>20</td>
</tr>
<tr>
<td>Heterosexual (Straight)</td>
<td>2</td>
<td>13.3</td>
</tr>
<tr>
<td>Homosexual (Gay/ Lesbian)</td>
<td>2</td>
<td>13.3</td>
</tr>
<tr>
<td><strong>Population Density</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Major city</td>
<td>13</td>
<td>86.7</td>
</tr>
<tr>
<td>Medium-sized town or village</td>
<td>2</td>
<td>13.3</td>
</tr>
</tbody>
</table>
### Religion/Spirituality

| Spiritual beliefs do not fit a formal religion | 7   | 46.7 |
| Buddhist                                    | 3   | 20   |
| Catholic                                    | 1   | 6.7  |
| Jewish                                      | 1   | 6.7  |
| Pagan                                       | 1   | 6.7  |
| None                                        | 1   | 6.7  |
| Not Listed, please specify:                 | 1   | 6.7  |

### Housing Status

| Housing Status                  | 10  | 66.7 |
| Renting a home                  | 10  | 66.7 |
| Renting a room                  | 3   | 20   |
| Living with family              | 2   | 13.3 |

### Educational Attainment

| Educational Attainment           |     |    |
| Bachelor’s Degree               | 6   | 40  |
| Advanced Degree (MD, PhD, PsyD, JD, etc) | 4   | 26.7|
| Associate’s Degree              | 2   | 13.3|
| High School Diploma             | 2   | 13.3|
| I did not graduate high school  | 1   | 6.7 |

### Income

| Income                            |     |    |
| Under $20,000                     | 6   | 40  |
| $20,000 - $40,000                 | 5   | 33.3|
| $41,000 - $60,000                 | 3   | 20  |
| Over $100,000                     | 1   | 6.7 |

### Hormone Therapy

| Hormone Therapy                  |     |    |
| HRT                              | 6   | 40  |
| None                             | 5   | 33.3|
| Both                             | 3   | 20  |
| Blockers                         | 1   | 6.7 |
### Table 2. Online survey sample characteristics (N = 342)

<table>
<thead>
<tr>
<th>Category</th>
<th>Frequency</th>
<th>Valid Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex Assigned at Birth</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>229</td>
<td>67</td>
</tr>
<tr>
<td>Male</td>
<td>111</td>
<td>32.5</td>
</tr>
<tr>
<td>Intersex</td>
<td>2</td>
<td>.6</td>
</tr>
<tr>
<td><strong>Gender Identity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genderqueer</td>
<td>71</td>
<td>20.8</td>
</tr>
<tr>
<td>Transgender (non-binary)</td>
<td>71</td>
<td>20.8</td>
</tr>
<tr>
<td>I do not identify with any of these terms. Please specify:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>44</td>
<td>12.9</td>
</tr>
<tr>
<td>Transgender (MtF) Female</td>
<td>38</td>
<td>11.1</td>
</tr>
<tr>
<td>Transgender (FtM) Male</td>
<td>35</td>
<td>10.2</td>
</tr>
<tr>
<td>Female</td>
<td>44</td>
<td>12.9</td>
</tr>
<tr>
<td><strong>Preferred Pronouns</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>They</td>
<td>116</td>
<td>34.2</td>
</tr>
<tr>
<td>She</td>
<td>95</td>
<td>28.0</td>
</tr>
<tr>
<td>He</td>
<td>81</td>
<td>23.9</td>
</tr>
<tr>
<td>One</td>
<td>5</td>
<td>1.5</td>
</tr>
<tr>
<td>Yo</td>
<td>1</td>
<td>.3</td>
</tr>
<tr>
<td><strong>Do you experience your gender identity as fluid?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>190</td>
<td>35.0</td>
</tr>
<tr>
<td>No</td>
<td>119</td>
<td>55.9</td>
</tr>
<tr>
<td>Unsure</td>
<td>31</td>
<td>9.1</td>
</tr>
<tr>
<td>Formerly repressed or confused identity</td>
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<td>28.6</td>
</tr>
<tr>
<td>Identity influenced/changed by different factors at different times (education, present feeling, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-binary</td>
<td>4</td>
<td>14.3</td>
</tr>
<tr>
<td>“I don’t know”</td>
<td>4</td>
<td>14.3</td>
</tr>
<tr>
<td>Exploring different genders</td>
<td>2</td>
<td>7.1</td>
</tr>
<tr>
<td>Gender hasn’t changed but language has</td>
<td>2</td>
<td>7.1</td>
</tr>
<tr>
<td>Unsure if gender identity was the same in childhood</td>
<td>1</td>
<td>3.6</td>
</tr>
<tr>
<td>Agender</td>
<td>1</td>
<td>3.6</td>
</tr>
<tr>
<td><strong>Race/Ethnicity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>269</td>
<td>79.4</td>
</tr>
<tr>
<td>Hispanic or Latina/o/x</td>
<td>27</td>
<td>8</td>
</tr>
<tr>
<td>Mixed race/ ethnicity</td>
<td>21</td>
<td>6.2</td>
</tr>
<tr>
<td>Asian</td>
<td>10</td>
<td>2.9</td>
</tr>
<tr>
<td>American Indian or Alaskan Native</td>
<td>7</td>
<td>2.1</td>
</tr>
<tr>
<td>Black or African American</td>
<td>5</td>
<td>1.5</td>
</tr>
<tr>
<td><strong>Sexual Orientation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Queer</td>
<td>98</td>
<td>28.7</td>
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<tr>
<td>Pansexual</td>
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<td>16.1</td>
</tr>
<tr>
<td>Orientation</td>
<td>Count</td>
<td>Percentage</td>
</tr>
<tr>
<td>----------------------</td>
<td>-------</td>
<td>------------</td>
</tr>
<tr>
<td>Bisexual</td>
<td>44</td>
<td>12.9</td>
</tr>
<tr>
<td>Heterosexual (Straight)</td>
<td>41</td>
<td>12</td>
</tr>
<tr>
<td>Homosexual (Gay/ Lesbian)</td>
<td>36</td>
<td>10.5</td>
</tr>
<tr>
<td>Asexual</td>
<td>32</td>
<td>9.4</td>
</tr>
<tr>
<td>I do not identify with any of these terms. Please specify:</td>
<td>24</td>
<td>7</td>
</tr>
<tr>
<td>Polysexual</td>
<td>12</td>
<td>3.5</td>
</tr>
</tbody>
</table>

**Population Density**

<table>
<thead>
<tr>
<th>Density</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major city</td>
<td>194</td>
<td>56.7</td>
</tr>
<tr>
<td>Medium-sized town or village</td>
<td>101</td>
<td>29.5</td>
</tr>
<tr>
<td>Small town or village</td>
<td>32</td>
<td>9.4</td>
</tr>
<tr>
<td>Very rural area</td>
<td>15</td>
<td>4.4</td>
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</table>

**Religion/Spirituality**

<table>
<thead>
<tr>
<th>Type</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>111</td>
<td>32.5</td>
</tr>
<tr>
<td>Spiritual beliefs do not fit a formal religion</td>
<td>100</td>
<td>29.2</td>
</tr>
<tr>
<td>Not listed please specify:</td>
<td>42</td>
<td>12.3</td>
</tr>
<tr>
<td>Catholic</td>
<td>24</td>
<td>7</td>
</tr>
<tr>
<td>Pagan</td>
<td>24</td>
<td>7</td>
</tr>
<tr>
<td>Protestant</td>
<td>18</td>
<td>5.3</td>
</tr>
<tr>
<td>Jewish</td>
<td>12</td>
<td>3.5</td>
</tr>
<tr>
<td>Buddhist</td>
<td>11</td>
<td>3.2</td>
</tr>
</tbody>
</table>

**Housing Status**

<table>
<thead>
<tr>
<th>Status</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Renting a home</td>
<td>154</td>
<td>45</td>
</tr>
<tr>
<td>Living with family</td>
<td>74</td>
<td>21.6</td>
</tr>
<tr>
<td>Own</td>
<td>58</td>
<td>17</td>
</tr>
<tr>
<td>Renting a room</td>
<td>22</td>
<td>6.4</td>
</tr>
<tr>
<td>Living with friends</td>
<td>15</td>
<td>4.4</td>
</tr>
<tr>
<td>Cooperative community</td>
<td>15</td>
<td>1.2</td>
</tr>
<tr>
<td>Homeless (Shelter)</td>
<td>4</td>
<td>6.4</td>
</tr>
</tbody>
</table>

**Educational Attainment**

<table>
<thead>
<tr>
<th>Attainment</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>High School Diploma</td>
<td>131</td>
<td>38.3</td>
</tr>
<tr>
<td>Bachelor’s Degree</td>
<td>91</td>
<td>26.6</td>
</tr>
<tr>
<td>Advanced Degree (MD, PhD, PsyD, JD, etc)</td>
<td>64</td>
<td>18.7</td>
</tr>
<tr>
<td>Associate’s Degree</td>
<td>32</td>
<td>9.4</td>
</tr>
<tr>
<td>GED</td>
<td>15</td>
<td>4.4</td>
</tr>
<tr>
<td>I did not graduate high school</td>
<td>9</td>
<td>2.6</td>
</tr>
</tbody>
</table>

**Income**

<table>
<thead>
<tr>
<th>Income Range</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under $20,000</td>
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<td>61.8</td>
</tr>
<tr>
<td>$20,000 - $40,000</td>
<td>70</td>
<td>20.6</td>
</tr>
<tr>
<td>$41,000 - $60,000</td>
<td>32</td>
<td>9.4</td>
</tr>
<tr>
<td>$61,000 - $80,000</td>
<td>13</td>
<td>3.8</td>
</tr>
<tr>
<td>$81,000 - $100,000</td>
<td>8</td>
<td>2.4</td>
</tr>
<tr>
<td>Over $100,000</td>
<td>13</td>
<td>3.8</td>
</tr>
</tbody>
</table>

**Hormone Therapy**

<table>
<thead>
<tr>
<th>Therapy</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
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<td>66.5</td>
</tr>
<tr>
<td>HRT</td>
<td>71</td>
<td>20.9</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Both</td>
<td>28</td>
<td>8.2</td>
</tr>
<tr>
<td>Blockers</td>
<td>15</td>
<td>4.4</td>
</tr>
</tbody>
</table>
Table 3. Online survey “not listed” responses

<table>
<thead>
<tr>
<th>Category</th>
<th>Frequency</th>
<th>Valid Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender Identity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genderfluid</td>
<td>12</td>
<td>3.6</td>
</tr>
<tr>
<td>Agender</td>
<td>9</td>
<td>2.6</td>
</tr>
<tr>
<td>Non-Binary</td>
<td>4</td>
<td>1.2</td>
</tr>
<tr>
<td>Bi-Gender</td>
<td>2</td>
<td>.6</td>
</tr>
<tr>
<td>Agender (Transgender NB)</td>
<td>1</td>
<td>.3</td>
</tr>
<tr>
<td>Agender or Genderqueer (Agender is more important)</td>
<td>1</td>
<td>.3</td>
</tr>
<tr>
<td>Agenderflux</td>
<td>1</td>
<td>.3</td>
</tr>
<tr>
<td>Androfemme (Nonbinary/Genderqueer Transfeminine)</td>
<td>1</td>
<td>.3</td>
</tr>
<tr>
<td>Androgyne</td>
<td>1</td>
<td>.3</td>
</tr>
<tr>
<td>Boi, GNC, Genderqueer</td>
<td>1</td>
<td>.3</td>
</tr>
<tr>
<td>Gender = No</td>
<td>1</td>
<td>.3</td>
</tr>
<tr>
<td>Genderfluid Androgyne</td>
<td>1</td>
<td>.3</td>
</tr>
<tr>
<td>Genderfluid, Agender</td>
<td>1</td>
<td>.3</td>
</tr>
<tr>
<td>Genderfluid, Not Identifying at All with Male or Female</td>
<td>1</td>
<td>.3</td>
</tr>
<tr>
<td>Gender Non-Conforming</td>
<td>1</td>
<td>.3</td>
</tr>
<tr>
<td>Non-Binary, Genderqueer, Transboy, Demiboy, FtM, Transgender, Boy, Male, Femme, Masculine, Etc.</td>
<td>1</td>
<td>.3</td>
</tr>
<tr>
<td>I Would Like to Be Able to Live My Life What Would Match How I Believe and Identify (Male), But in a Life Situation Where I Cannot</td>
<td>1</td>
<td>.3</td>
</tr>
<tr>
<td>Queer Non-Binary</td>
<td>1</td>
<td>.3</td>
</tr>
<tr>
<td>Trans Femme</td>
<td>1</td>
<td>.3</td>
</tr>
<tr>
<td>Transgender Non-Binary and Genderqueer</td>
<td>1</td>
<td>.3</td>
</tr>
<tr>
<td>Identity</td>
<td>Count</td>
<td>Percentage</td>
</tr>
<tr>
<td>------------------------------</td>
<td>-------</td>
<td>------------</td>
</tr>
<tr>
<td>Transman, Trans</td>
<td>1</td>
<td>.3</td>
</tr>
<tr>
<td>Two-spirit</td>
<td>1</td>
<td>.3</td>
</tr>
<tr>
<td>Two-spirit or Genderqueer</td>
<td>1</td>
<td>.3</td>
</tr>
<tr>
<td>Very Masculine Heterosexual</td>
<td>1</td>
<td>.3</td>
</tr>
</tbody>
</table>

**Preferred Pronouns**

<table>
<thead>
<tr>
<th>Pronoun</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neutral/unsure/depends</td>
<td>10</td>
<td>30.3</td>
</tr>
<tr>
<td>Ae/aer/aers/elf/ey/em/eirs/</td>
<td>5</td>
<td>15.2</td>
</tr>
<tr>
<td>emself</td>
<td></td>
<td></td>
</tr>
<tr>
<td>It/its</td>
<td>2</td>
<td>6.1</td>
</tr>
<tr>
<td>She/he/they</td>
<td>6</td>
<td>18.2</td>
</tr>
<tr>
<td>Xe/xim/ximself/xem/xyr/xyrs</td>
<td>4</td>
<td>12.1</td>
</tr>
<tr>
<td>Ne/nim/nir/nirs/nemself</td>
<td>1</td>
<td>3.0</td>
</tr>
<tr>
<td>No pronouns</td>
<td>3</td>
<td>9.1</td>
</tr>
<tr>
<td>Us/we</td>
<td>1</td>
<td>3.0</td>
</tr>
<tr>
<td>Miss</td>
<td>1</td>
<td>3.0</td>
</tr>
</tbody>
</table>

**Religion/Spirituality**

<table>
<thead>
<tr>
<th>Religion/Spirituality</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atheist</td>
<td>6</td>
<td>1.8</td>
</tr>
<tr>
<td>Christian</td>
<td>6</td>
<td>1.8</td>
</tr>
<tr>
<td>Agnostic</td>
<td>3</td>
<td>.9</td>
</tr>
<tr>
<td>Unitarian Universalism</td>
<td>3</td>
<td>.9</td>
</tr>
<tr>
<td>Episcopal</td>
<td>2</td>
<td>.6</td>
</tr>
<tr>
<td>Hindu</td>
<td>2</td>
<td>.6</td>
</tr>
<tr>
<td>Religion/Philosophy/Tradition</td>
<td>Count</td>
<td>Reliability Score</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------------------------</td>
<td>-------</td>
<td>-------------------</td>
</tr>
<tr>
<td>Mormon</td>
<td>2</td>
<td>.6</td>
</tr>
<tr>
<td>Satanist</td>
<td>2</td>
<td>.6</td>
</tr>
<tr>
<td>Anti-theistic Atheist</td>
<td>1</td>
<td>.3</td>
</tr>
<tr>
<td>An Amalgam of several traditions and results of one's own transcendental experiences</td>
<td>1</td>
<td>.3</td>
</tr>
<tr>
<td>Catholic; yet no longer connected to anything</td>
<td>1</td>
<td>.3</td>
</tr>
<tr>
<td>Culturally Jewish, spiritually scientific, confused Pagan</td>
<td>1</td>
<td>.3</td>
</tr>
<tr>
<td>Discordian</td>
<td>1</td>
<td>.3</td>
</tr>
</tbody>
</table>

Sexual Orientation

<table>
<thead>
<tr>
<th>Sexual Orientation</th>
<th>Count</th>
<th>Reliability Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘Hard to describe’</td>
<td>319</td>
<td>93.3</td>
</tr>
<tr>
<td>Demi-Pansexual</td>
<td>3</td>
<td>0.9</td>
</tr>
<tr>
<td>Gay but not ‘homosexual’</td>
<td>2</td>
<td>0.6</td>
</tr>
<tr>
<td>Androsexual</td>
<td>1</td>
<td>0.3</td>
</tr>
<tr>
<td>Depressed Sexuality</td>
<td>1</td>
<td>0.3</td>
</tr>
<tr>
<td>I am an agender person who has been in a relationship with a man for 16 years. I don’t have a term for that</td>
<td>1</td>
<td>0.3</td>
</tr>
<tr>
<td>I am attracted to a feminine expression</td>
<td>1</td>
<td>0.3</td>
</tr>
<tr>
<td>I do not know, too soon</td>
<td>1</td>
<td>0.3</td>
</tr>
<tr>
<td>I am attracted to female-presenting folks</td>
<td>1</td>
<td>0.3</td>
</tr>
<tr>
<td>Multisexual</td>
<td>1</td>
<td>0.3</td>
</tr>
<tr>
<td>Non-binary, attracted to cis-girls, FTM, lesbians, non-binary girls</td>
<td>1</td>
<td>0.3</td>
</tr>
<tr>
<td>Omnисexual</td>
<td>1</td>
<td>0.3</td>
</tr>
<tr>
<td>Identity</td>
<td>Score</td>
<td>Confidence</td>
</tr>
<tr>
<td>-----------------------------------------</td>
<td>-------</td>
<td>------------</td>
</tr>
<tr>
<td>Panromantic/asexual (date without sex)</td>
<td>1</td>
<td>0.3</td>
</tr>
<tr>
<td>Prefer not to label</td>
<td>1</td>
<td>0.3</td>
</tr>
<tr>
<td>Queer asexual</td>
<td>1</td>
<td>0.3</td>
</tr>
<tr>
<td>Transvestite</td>
<td>1</td>
<td>0.3</td>
</tr>
</tbody>
</table>

You need to put more thought into this question. Am I gay if I am MTF and like guys or straight. Before transitioning I thought I liked girls, primarily because I never gave males a consideration. Raised that way. Once I accepted and gave it thought, I only like to date males.
Table 4. Construct bivariate correlations

<table>
<thead>
<tr>
<th>Past-Year (v)</th>
<th>MH</th>
<th>Medical</th>
<th>CRJ Minor</th>
<th>CRJ Major</th>
<th>Depression</th>
<th>Anxiety</th>
<th>Gender Dysphoria</th>
</tr>
</thead>
<tbody>
<tr>
<td>.02</td>
<td>-15*</td>
<td>-.20**</td>
<td>-.22**</td>
<td>.01</td>
<td>.19**</td>
<td>.14*</td>
<td></td>
</tr>
<tr>
<td>Lifetime (v)</td>
<td>-.05</td>
<td>-.13</td>
<td>-.24**</td>
<td>-.23**</td>
<td>.06</td>
<td>.13</td>
<td>-.07</td>
</tr>
<tr>
<td>Past-Year (p)</td>
<td>.03</td>
<td>-.03</td>
<td>-.11</td>
<td>-.07</td>
<td>.06</td>
<td>-.00</td>
<td>.07</td>
</tr>
<tr>
<td>Lifetime (p)</td>
<td>-.04</td>
<td>-.21</td>
<td>-.10</td>
<td>-.03</td>
<td>.22</td>
<td>.44**</td>
<td>.45**</td>
</tr>
<tr>
<td>Past-Year (s)</td>
<td>-.13</td>
<td>.03</td>
<td>-.27</td>
<td>-.27</td>
<td>.40**</td>
<td>.24</td>
<td>.01</td>
</tr>
<tr>
<td>Lifetime (s)</td>
<td>-.25</td>
<td>-.21</td>
<td>-.23</td>
<td>-.15</td>
<td>.19</td>
<td>.23</td>
<td>.20</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Social Support</th>
<th>TGNC Connectedness</th>
<th>MH</th>
<th>Medical</th>
<th>CRJ Major</th>
<th>CRJ Minor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>-.27**</td>
<td>-.04</td>
<td>-.10</td>
<td>-.18**</td>
<td>-.22**</td>
</tr>
<tr>
<td>Anxiety</td>
<td>-.21**</td>
<td>-.07</td>
<td>-.04</td>
<td>-.15**</td>
<td>-.21**</td>
</tr>
<tr>
<td>Gender</td>
<td>-.01</td>
<td>.11</td>
<td>-.14*</td>
<td>-.23**</td>
<td>-.19**</td>
</tr>
<tr>
<td>Dysphoria</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flourishing</td>
<td>.41**</td>
<td>.16**</td>
<td>.16**</td>
<td>.23**</td>
<td>.21**</td>
</tr>
<tr>
<td>GRIT</td>
<td>.13*</td>
<td>.01</td>
<td>.10</td>
<td>.16**</td>
<td>.10</td>
</tr>
</tbody>
</table>

Table 5. Victimization descriptives by scale of measurement

<table>
<thead>
<tr>
<th>Victimization</th>
<th>Average Lifetime Frequency</th>
<th>Average Past Year Frequency (SD)</th>
<th>Average Age (SD)</th>
<th>Average Distress (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Continuous</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Verbal</td>
<td>Exponential</td>
<td>12.08 (47.63)</td>
<td>15.30 (10.50)</td>
<td>1.83 (.84)</td>
</tr>
<tr>
<td>Physical</td>
<td>12.4 (43.31)</td>
<td>1.00 (2.89)</td>
<td>16.10 (9.94)</td>
<td>2.42 (.89)</td>
</tr>
<tr>
<td>Sexual</td>
<td>17.11 (53.49)</td>
<td>.51 (1.3)</td>
<td>15.33 (8.04)</td>
<td>2.59 (.64)</td>
</tr>
<tr>
<td></td>
<td><strong>Dichotomous</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Category</td>
<td>Frequency</td>
<td>Valid %</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Verbal</td>
<td>Life Low</td>
<td>103</td>
<td>50.7</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Life High</td>
<td>100</td>
<td>49.3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Past-Year Low</td>
<td>123</td>
<td>56.4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Past-Year High</td>
<td>95</td>
<td>43.6</td>
<td></td>
</tr>
<tr>
<td>Physical</td>
<td>Life Low</td>
<td>25</td>
<td>52.1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Life High</td>
<td>23</td>
<td>47.9</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Past-Year Low</td>
<td>29</td>
<td>61.7</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Past-Year High</td>
<td>18</td>
<td>38.3</td>
<td></td>
</tr>
<tr>
<td>Sexual</td>
<td>Life Low</td>
<td>22</td>
<td>47.8</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Life High</td>
<td>24</td>
<td>52.2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Past-Year Low</td>
<td>36</td>
<td>76.6</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Past-Year High</td>
<td>11</td>
<td>23.4</td>
<td></td>
</tr>
</tbody>
</table>

Notes. “Age” denotes age at first experience. “Distress” ratings reported on a 4-point Likert scale ranging from “Not upset” (0) to “Extremely upset” (3). These levels of victimization are low compared to extant literature, a finding conceptualized herein as resulting from a negatively skewed sample in terms of well-being rather than as a novel finding or watershed shift in experiences of sexual victimization among TGNC communities.
<table>
<thead>
<tr>
<th>Hypothesis #</th>
<th>Prediction</th>
<th>Supported</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Greater degree of narrative heterogeneity in later phases compared to earlier phases.</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Common themes of risk and resiliency in participant narratives.</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Victimization will positively predict depression, anxiety, gender dysphoria, and grit.</td>
<td>Partial (+) for depression, anxiety, and gender dysphoria</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Victimization will negatively predict flourishing.</td>
<td>Partial (-) for GRIT</td>
<td>Victimization is a predictor, but weakly (4.7%) and critical time-period of victimization (e.g., past-year versus lifetime) varied across predictors).</td>
</tr>
<tr>
<td>5</td>
<td>Social support will mediate the relationship between victimization and psychological well-being.</td>
<td>No</td>
<td>Social support neither mediated nor moderated significantly.</td>
</tr>
<tr>
<td>6</td>
<td>TGNC community connectedness will mediate the relationship between victimization and psychological well-being.</td>
<td>No</td>
<td>TGNC community connectedness neither mediated nor moderated significantly.</td>
</tr>
<tr>
<td>7</td>
<td>Victimization will relate to decreased help-seeking.</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>
### Table 7. CQR themes and sub-themes

<table>
<thead>
<tr>
<th>Developmental Phases</th>
<th>Themes and Sub-Themes</th>
<th>Summary/Quote</th>
<th>Frequency Category</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Childhood</strong></td>
<td>Early discomfort</td>
<td>“feeling really uncomfortable inside gender identity of male and like the societal expectations”</td>
<td>General</td>
</tr>
<tr>
<td></td>
<td>Instinctive identity expression</td>
<td>“[I] did not understand certain differences, like why I had to wear a shirt you know, when it was really hot”</td>
<td>Typical</td>
</tr>
<tr>
<td><strong>Adolescence</strong></td>
<td></td>
<td>“When I had puberty, stuff was happening and I was having like panic attacks and freaking out”</td>
<td>General</td>
</tr>
<tr>
<td><strong>Early Adulthood</strong></td>
<td>Autonomy, Individuation</td>
<td></td>
<td>General</td>
</tr>
<tr>
<td><strong>Adulthood</strong></td>
<td>Transition, Post-Transition, Activism (or not)</td>
<td></td>
<td>Variant</td>
</tr>
<tr>
<td><strong>Challenges/Risk Factors</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Personal</strong></td>
<td>Lack of information/resources</td>
<td>“no frame of reference for what I’m going through” “I didn’t really know that there were other options”</td>
<td>General</td>
</tr>
<tr>
<td></td>
<td>Internalized transphobia/transnegativity</td>
<td>“I actually got like really depressed because of internalized transphobia and all that nonsense of like…I’m this, but this is a terrible thing to be”</td>
<td>Typical</td>
</tr>
<tr>
<td></td>
<td>Learning how to perform gender</td>
<td>“I’m always trying to figure out how to woman, like how to do that” “that sort of like male posturing, I feel like maybe one of the biggest challenges is that I don’t recognize that are socialized male, I don’t understand them”</td>
<td>Typical</td>
</tr>
<tr>
<td><strong>Interpersonal</strong></td>
<td>Other-imposed identity</td>
<td>“my ex-partner had this whatever that I’m attracted to women or I’m attracted to you so you must be a woman”</td>
<td>Typical</td>
</tr>
<tr>
<td></td>
<td>Exclusion from binary trans* spaces</td>
<td>“I just feel like we stopped when it comes to the ‘T’…we have the ‘T’, but like our ‘T’ is still”</td>
<td>Variant</td>
</tr>
<tr>
<td>Family tolerating but not accepting</td>
<td>“you can dress however you want but don’t be one of those people who like has surgery and takes hormones” Typical</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Romantic relationships</td>
<td>“[my partner], she would you know knock and bash me for who I was” Typical</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Systemic</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Systemic bias</td>
<td>“trying to deal with a cis-normative society for sure” General</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of media representation</td>
<td>“It’s hard to constantly see images of myself like being punished [on television]” Typical</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public spaces</td>
<td>Beaches, bathrooms—self-presentation and safety Typical</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overt discrimination</td>
<td>“call me like a tranny, a dyke, a faggot” Variant</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>“[assumptions that TGNC people] are going to try to kill you, rape you, test you and all this stuff”</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Helpful/Protective Factors**

**Social Support**

| Peers | “just having a network of friends who identify as queer” General |
| | “talking with friends who’ve had previous experience with thinking about and talking about gender” |
| Family | Supportive, social-justice oriented parents Typical |
| Larger communities | “having access to those communities [transmasculine and gender non-conforming communities] has been really huge” Typical |
| Partner(s) | “[my partner] she’s been amazing and is like ‘wherever you land is fine with me, it’s your life, your body, your gender, go for it’” Typical |

**Resources**

| Media and technology | “I typed into Google ‘I think I might be a girl’ and thank goodness the search results came General |
up with just all these wonderful transgender stories”

Educational resources
Judith Butler books, Philadelphia Transgender Health Conference, Gender Odyssey Conference

Support groups
“I think it gives a unique, a lot of opportunities for sort of like niche audiences…I’m in a bottom surgery support group for trans masculine people right now”

Exposure through travel/outreach/etc.
“I have been traveling the world because of my professional work so I have a good understanding of how transgender people are in the rest of countries”

Creative outlets
“feeling good about my body through dancing…when I’m using my body creatively it’s almost like…I’m not gendered in my body anymore, I’m sort of free and powerful”

Validating Experiences
Being read consistent with gender identity
“I knew I was passing because white women were uncomfortable around me”
[Black trans man]

Identity Development
Critical Processes

Identity Selection
“I don’t think that I’m trans so I’m just trying to figure out something in between”

Spectrum preferences
“Masculinity is something that I’ve been less comfortable with than femininity”

Navigating Names
Pros and cons of name changes

Reclaiming Self/Body
“it was the process of like internet culture and sort of reclaiming myself, my identity away from society”

Navigating Disclosure
Comfort in relationships “socially it’s always sort of genderqueer trans-masculine, or the thing that I like to really use

Typical
Variant
Typical
Variant
Typical
Variant
Typical
General
<table>
<thead>
<tr>
<th>Category</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inconsequential contacts</td>
<td>“to the people in the grocery store I identify as male but if I’m like on a panel, I identify as trans-masculine”</td>
</tr>
<tr>
<td>Interview/occupational</td>
<td>“When I go to a job interview I kind of take it out as an act…[once] I didn’t do very well just because the whole time I was in a dress and I wanted to cry”</td>
</tr>
<tr>
<td>Age</td>
<td>“it depends on the audience. With younger people it’s much easier”</td>
</tr>
<tr>
<td>Path of least resistance</td>
<td>“I’d just choose the one that I know they want me to say”</td>
</tr>
<tr>
<td>Navigating Self-Presentation</td>
<td>“When I’m on the bus going through Newark, if I wear eye makeup I wear shades so I don’t get called out on the bus”</td>
</tr>
<tr>
<td>Safety concerns</td>
<td>“as long as I’m passing within myself, as myself, and feeling true to myself then I’m feeling okay”</td>
</tr>
<tr>
<td>Passing concerns</td>
<td>“It’s important, it’s not even passing as a guy but passing as someone that’s not a woman is what’s really important to me”</td>
</tr>
<tr>
<td>Increased Flexibility</td>
<td>“I feel like some of that compensatory bro-ness has eased out, my masculinity is taking on a little bit of a gentler approach”</td>
</tr>
<tr>
<td>Transition Amnesia</td>
<td>“I think that binary trans people if/when they get to the point where they are passing well, there’s a kind of amnesia that you forget what it’s like”</td>
</tr>
<tr>
<td>Activism (or not)</td>
<td>“when it comes down then we just have to educate people with it”</td>
</tr>
<tr>
<td></td>
<td>“my friends and I have a phrase: ‘I don’t’ have time to teach old white men this stuff, you have the internet’”</td>
</tr>
<tr>
<td>Aversion to Boxes</td>
<td>“It makes navigating gender identity that much harder, going from box to box to box”</td>
</tr>
<tr>
<td>---------------------------</td>
<td>---------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>“Amorphous Blob of Whateverness”</td>
<td>“Whatever you think you captured, it’s not the thing”</td>
</tr>
<tr>
<td>Zeitgeist Intersections</td>
<td>“We’re still stuck in the gender binary so it’s sort of like evolving over time”</td>
</tr>
</tbody>
</table>

### Societal Messages

<table>
<thead>
<tr>
<th>Outsider</th>
<th>“it just makes me feel like a bit of an outsider”</th>
<th>General</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insufficiency</td>
<td>“People already view trans people as like fake or phony, not real versions of like man and woman”</td>
<td>Typical</td>
</tr>
<tr>
<td>Invalidation</td>
<td>“from society at large it’s just like ‘that’s made up, you’re just trying to be special”</td>
<td>Typical</td>
</tr>
<tr>
<td>Identity Policing</td>
<td>“it’s not okay to be different, it’s not okay to be who you are in your own body”</td>
<td>Typical</td>
</tr>
<tr>
<td>Implicit Binarism</td>
<td>“boys are one way, girls are another way”</td>
<td>General</td>
</tr>
<tr>
<td>Non-Binary Invisibility</td>
<td>“being non-binary, I feel like, basically at least for me, I feel like largely ignored”</td>
<td>Variant</td>
</tr>
</tbody>
</table>

### Intersectionality

<table>
<thead>
<tr>
<th>Sexual Orientation</th>
<th>“I still act like what would be stereotypical lesbian sort of things…I don’t identify any longer as a woman so where does that leave me?”</th>
<th>Variant</th>
</tr>
</thead>
</table>
| Race/Ethnicity            | “being Filipino there are definitely like pretty strict gender roles”
   “I’m definitely aware that my skin color gets me like a pass for gender-nonconformity” | Typical |
| Health Status             | “I had been diagnosed with PCOS…where does this one start and the other one begins?” | Variant |
| Sex Assigned at Birth     | “transfeminine people often have less access to resources”
   “a lot of the leeway I got is [from] being born a female assigned person” | Typical |
<table>
<thead>
<tr>
<th>Passing Privilege</th>
<th>“I’ve been noticing…a really sharp divide between passing and non-passing trans people and that rift is really a dangerous space”</th>
<th>Variant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multiple</td>
<td>“my class privilege and my race privilege have made it so like, I don’t generally feel like the police might kill me”</td>
<td>Variant</td>
</tr>
</tbody>
</table>

### Mental Health System

#### Negative Experiences

<table>
<thead>
<tr>
<th>Un-affirming space</th>
<th>“I tried to come out to her, and the space wasn’t really there for that” “she had like misgendered me multiple times”</th>
<th>Typical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inappropriate gate-keeping</td>
<td>“my first therapist was trying to tell me that I wasn’t actually trans, that I was depressed instead…because I was able to wash myself in the shower…because I have sex with my genitals”</td>
<td>General</td>
</tr>
<tr>
<td>Gender spotlight</td>
<td>“there’s a shift that happens sometimes in the therapy room where I mention that I’m trans and then like the whole thing just turns over to that”</td>
<td>Typical</td>
</tr>
</tbody>
</table>

#### Positive Experiences

<table>
<thead>
<tr>
<th>Taking the initiative</th>
<th>Researching on their own time to better understand and relate, rather than expecting client/participant to explain everything and educate the clinician.</th>
<th>Variant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appropriate therapy foci</td>
<td>“I’ve always made it very clear to any therapist that my gender identity and my sexuality aren’t a cause of any distress in my life, and so far that’s totally been respected”</td>
<td>Variant</td>
</tr>
<tr>
<td>Validation</td>
<td>“it’s a huge part of who you are, especially since you are sort of in the midst of this transition process…it’s a huge part of”</td>
<td>Typical</td>
</tr>
</tbody>
</table>
every single day of your life so it’s important to have that validated, you can’t go to therapy and have someone not recognizing that”

### Need for Reform

“I think that a lot of times when people go through trainings, a lot of the focus is about a trans person in transition and not necessarily how to treat a trans person who like, doesn’t care about that stuff as much anymore”

### Criminal Justice System

#### Distrust

“I definitely only ever see the message that the police are not there to protect me or my community…they are very interested in policing our community and controlling the ways in which we present ourselves”

#### Profiling “Other-ness”

“I feel maybe a little more obvious than some other people”

“if I’m dressed femininely they’re very, very nice to me, but if I’m dressed masculine they’re like, I get stares”

#### Positive Thoughts

“I’m hopeful…especially in this time where things aren’t so clear as we kind of know the direction that we’re heading in is a more accepting overall direction”

#### Proposed Solutions

“Much like mental health or medical health or other systems, they don’t have adequate training”

“I feel like it just needs a complete overhaul”

“they need to start hiring like trans people of color, like people of color and trans people and non-binary people”

### Last Thoughts

“I am a beautiful person”

“I do the best that I can in
<table>
<thead>
<tr>
<th>I Exist, and that is Valid</th>
<th>“I’m also real, and people like me are real, and we should also be included in the conversation”</th>
<th>Typical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advice for TGNC People</td>
<td>“I feel like sometimes people forget how hard it is to be a person…give yourself a break sometimes”</td>
<td>Variant</td>
</tr>
<tr>
<td>Advice for Researchers/Society</td>
<td>“There is no real one ‘coming out’ narrative, even like within one person”</td>
<td>Typical</td>
</tr>
<tr>
<td></td>
<td>“non-binary people and trans people are just as complicated and diverse and like multi-dimensional as everyone else…it’s very easy to take one narrative and…not really humanize the fact that we are like all different people with different experiences”</td>
<td></td>
</tr>
<tr>
<td>Calls to Action</td>
<td>“You have the time and you have the utility to find things, I feel like it’s your duty to go out and find out about other people instead of exploiting them”</td>
<td>Typical</td>
</tr>
<tr>
<td></td>
<td>“not let our guard down on this and fight this any which way we can”</td>
<td></td>
</tr>
</tbody>
</table>

**Notes.** Participant quotes used when feasible in terms of space, summaries provided otherwise. Frequency categories rather than quantitative frequencies provided per Hill et al. (2005), “General” indicates presence in at least 14 cases, “Typical” indicates 8-13 cases, “Variant” indicates 2-7 cases, no themes derived from single cases.
### Table 8. Construct scale descriptives

<table>
<thead>
<tr>
<th>Scale</th>
<th>Mean (SD)</th>
<th>Cronbach’s Alpha</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender Dysphoria</td>
<td>12.00 (3.25)</td>
<td>.72</td>
</tr>
<tr>
<td>Depression (PHQ-9)</td>
<td>11.32 (6.97)</td>
<td>.90</td>
</tr>
<tr>
<td>Anxiety (GAD-7)</td>
<td>9.59 (5.97)</td>
<td>.91</td>
</tr>
<tr>
<td>Social Support</td>
<td>4.86 (1.92)</td>
<td>.90</td>
</tr>
<tr>
<td>Community Connectedness</td>
<td>6.98 (4.23)</td>
<td>.74</td>
</tr>
<tr>
<td>Flourishing</td>
<td>39.63 (9.71)</td>
<td>.89</td>
</tr>
<tr>
<td>GRIT</td>
<td>2.21 (.61)</td>
<td>.85</td>
</tr>
<tr>
<td>Consistency of Interest</td>
<td>1.79 (.87)</td>
<td>.84</td>
</tr>
<tr>
<td>Perseverance of Effort</td>
<td>2.45 (.78)</td>
<td>.81</td>
</tr>
<tr>
<td>Ambition</td>
<td>2.45 (.86)</td>
<td>.78</td>
</tr>
<tr>
<td>Help-Seeking</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td>63.46 (29.48)</td>
<td></td>
</tr>
<tr>
<td>Medical</td>
<td>58.36 (28.80)</td>
<td></td>
</tr>
<tr>
<td>Criminal Justice (minor)</td>
<td>58.69 (28.91)</td>
<td></td>
</tr>
<tr>
<td>Criminal Justice (major)</td>
<td>57.72 (32.12)</td>
<td></td>
</tr>
</tbody>
</table>

*Notes.* Help-Seeking measured on a scale from 0-100, thus each value denotes the extent to which participants, on average, feel comfortable seeking assistance in percentage form. Alphas not reported for help-seeking as each measured by one item.
<table>
<thead>
<tr>
<th>Variable</th>
<th>“Low”</th>
<th>“High”</th>
<th>Median</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verbal Lifetime</td>
<td>0-12</td>
<td>&gt;12</td>
<td>12</td>
<td>5-1000</td>
</tr>
<tr>
<td>Verbal Past-Year</td>
<td>0-2</td>
<td>&gt;2</td>
<td>2</td>
<td>0-200</td>
</tr>
<tr>
<td>Physical Lifetime</td>
<td>0-3</td>
<td>&gt;3</td>
<td>3</td>
<td>1-300</td>
</tr>
<tr>
<td>Physical Past-year</td>
<td>0</td>
<td>&gt;0</td>
<td>0</td>
<td>0-2</td>
</tr>
<tr>
<td>Sexual Lifetime</td>
<td>0-2</td>
<td>&gt;2</td>
<td>2</td>
<td>1-300</td>
</tr>
<tr>
<td>Sexual Past-Year</td>
<td>0</td>
<td>&gt;0</td>
<td>0</td>
<td>0-6</td>
</tr>
</tbody>
</table>
Table 10. Relationships between victimization and well-being

<table>
<thead>
<tr>
<th>Observed Victimization (Set 1)</th>
<th>Latent Victimization (Variate 1)</th>
<th>Observed Well-Being (Set 2)</th>
<th>Latent Well-Being (Variate 2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verbal Lifetime</td>
<td>-.14*</td>
<td>Depression</td>
<td>.61*</td>
</tr>
<tr>
<td>Verbal Past-Year</td>
<td>.35</td>
<td>Anxiety</td>
<td>-.78*</td>
</tr>
<tr>
<td>Physical Lifetime</td>
<td>-1.29*</td>
<td>Gender Dysphoria</td>
<td>-.81*</td>
</tr>
<tr>
<td>Physical Past-Year</td>
<td>-.19</td>
<td>GRIT</td>
<td>.37*</td>
</tr>
<tr>
<td>Sexual Lifetime</td>
<td>.48*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual Past-Year</td>
<td>-.24*</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Unique Proportion of Variance Explained

|                                       | 32.8%                          | 27.6%                         |

Notes. Values listed are standardized canonical correlation coefficients or $r_s$. *Canonical loading > .3.
Table 11. Predicting flourishing from victimization

<table>
<thead>
<tr>
<th>Variable</th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
<td>SEB</td>
<td>β</td>
</tr>
<tr>
<td>Past-Year Verbal</td>
<td>-.00</td>
<td>.00</td>
<td>-.15</td>
</tr>
<tr>
<td>Lifetime Physical</td>
<td>-</td>
<td>.00</td>
<td>-.09</td>
</tr>
<tr>
<td>Past-Year Sexual</td>
<td>-</td>
<td>.05</td>
<td>.02</td>
</tr>
<tr>
<td>$R^2$</td>
<td>.02</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$F$ for change in $R^2$</td>
<td>7.18**</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Notes. *p < .05. **p < .01.*
<table>
<thead>
<tr>
<th>Observed Victimization (Set 1)</th>
<th>Latent Victimization (Variate 1)</th>
<th>Observed Help-Seeking (Set 2)</th>
<th>Latent Help-Seeking (Variate 2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verbal Lifetime</td>
<td>.24*</td>
<td>Mental Health</td>
<td>-.25*</td>
</tr>
<tr>
<td>Verbal Past-Year</td>
<td>.87*</td>
<td>Medical Health</td>
<td>-.17*</td>
</tr>
<tr>
<td>Physical Lifetime</td>
<td>.03*</td>
<td>CRJ Minor</td>
<td>-1.17*</td>
</tr>
<tr>
<td>Physical Past-Year</td>
<td>.09</td>
<td>CRJ Major</td>
<td>.67*</td>
</tr>
<tr>
<td>Sexual Lifetime</td>
<td>-.13*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual Past-Year</td>
<td>-.07</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Unique Proportion of Variance Explained</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>32.8%</strong></td>
<td></td>
<td><strong>21.2%</strong></td>
</tr>
</tbody>
</table>

*Notes. Values listed are standardized canonical correlation coefficients or \( r_s \). *Canonical loading > .3.*
<table>
<thead>
<tr>
<th>Transcript</th>
<th>Gender Identity</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>&quot;gender queer&quot;</td>
<td>&quot;it means a little bit of fuck you I don't have to choose&quot; or alternative quote, &quot;I don't think that I'm trans so I'm just trying to figure something out in-between.&quot;</td>
</tr>
<tr>
<td>2</td>
<td>&quot;I'm a heterosexual male&quot;</td>
<td>&quot;Me being with women&quot;</td>
</tr>
<tr>
<td>3</td>
<td>&quot;gender fluid&quot;</td>
<td>&quot;I go between she, her, hers, to they, them, theirs.&quot;</td>
</tr>
<tr>
<td>4</td>
<td>&quot;slightly confused and gender queer&quot;</td>
<td>&quot;I don't really identify with any binary.&quot;</td>
</tr>
<tr>
<td>5</td>
<td>&quot;gender non-conforming identity&quot;</td>
<td>&quot;kind of like non-binary but also just kind of like, like I don't mind using trans as an umbrella term&quot;</td>
</tr>
<tr>
<td>6</td>
<td>&quot;trans-masculine or FTM&quot;</td>
<td>&quot;generally male, pretty binary&quot;</td>
</tr>
<tr>
<td>8</td>
<td>&quot;a being&quot;</td>
<td>&quot;I was born and I'm in this, in whatever body I ended up being inhabiting in the location that I was and all the social stuff that I was already in&quot;</td>
</tr>
<tr>
<td>9</td>
<td>&quot;I mostly like don't really identify with anything&quot;</td>
<td>&quot;More androgynous than a specific noun&quot;</td>
</tr>
<tr>
<td>10</td>
<td>&quot;female MTF&quot;</td>
<td>&quot;male to female&quot;</td>
</tr>
<tr>
<td>11</td>
<td>&quot;transsexual woman&quot;</td>
<td>&quot;somebody who has changed their gender and their sex&quot;</td>
</tr>
<tr>
<td>12</td>
<td>&quot;non-binary&quot;</td>
<td>&quot;my internal sense of self and what makes me feel I don't know comfortable... I you know choose things from-from anything that I like appearance wise&quot;</td>
</tr>
<tr>
<td>13</td>
<td>&quot;non-binary... if it is left blank, I like to enter NOS&quot;</td>
<td>&quot;people are people, and not parts&quot;</td>
</tr>
<tr>
<td>14</td>
<td>&quot;I'm not entirely sure&quot;</td>
<td>&quot;I've stopped caring about labels&quot;</td>
</tr>
<tr>
<td>15</td>
<td>&quot;non-binary&quot;</td>
<td>&quot;I experience my gender as both male, female, and other&quot;</td>
</tr>
<tr>
<td>Page</td>
<td>Term</td>
<td>Description</td>
</tr>
<tr>
<td>------</td>
<td>------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>16</td>
<td>&quot;non-binary demi-boy&quot;</td>
<td>&quot;middle of like a male female spectrum, but more like oriented towards masculinity... I think the idea of like, being a boy sometimes, it like, feels right.&quot;</td>
</tr>
<tr>
<td>17</td>
<td>&quot;bi-gender&quot;</td>
<td>&quot;shifting between male and uh neutral gender&quot;</td>
</tr>
</tbody>
</table>
Appendix B: Terms and Definitions

**Sex:** Assigned at birth based on physical characteristics including: chromosomes, hormones, internal reproductive organs, and genitals.

**Gender Identity:** One's internal, personal sense of gender. For transgender people, their birth-assigned sex and their own internal sense of gender identity do not match.

**Cisgender:** Describes a gender identity which matches one’s sex assigned at birth.

**Non-binary:** Gender identities that are non-binary do not fall into the distinct categories of “male” or “female”. These individuals may feel in between the two genders, may identify as being “neither male nor female” or may identify their gender in a way that has nothing to do with masculinity or femininity. Non-binary gender identifications can take on many names including but not limited to: bi-gender, pangender, agender, gender variant, genderqueer, and genderfluid.

**Bigender:** A term describing individuals who sometimes experience their gender as female, and other times experience their gender as male. The term *genderfluid* has a similar meaning.

**Gender Expression:** How individuals externally present their gender identity to the world, usually expressed through "masculine," "feminine" or gender-variant behavior, clothing, haircut, voice or body characteristics.

**Sexual Orientation:** Describes an individual’s enduring physical, romantic and/or emotional attraction to another person. Gender identity and sexual orientation are not the same and you cannot discern an individual’s sexual orientation from their gender identity, nor vice versa.

**Transgender:** An umbrella term (adj.) for people whose gender identity and/or gender expression differs from the sex they were assigned at birth. The term may include but is not limited to: transsexuals, cross-dressers and other gender-variant people. Transgender people may identify as female-to-male (FTM) or male-to-female (MTF). Use the descriptive term (*transgender, transsexual, cross-dresser, FTM or MTF*) preferred by the individual.

**Transsexual:** An older term which originated in the medical and psychological communities. While some transgender people still prefer to use the term to describe themselves, many transgender people prefer the term *transgender* to *transsexual*. Unlike *transgender, transsexual* is not an umbrella term, as many transgender people do not identify as transsexual. It is best to ask which term an individual prefers.

**Transvestite**: Derogatory see *Cross-Dressing*

**Transition:** A complex process of altering one’s physical and/or hormonal characteristics to match their gender identity instead of their sex assigned at birth. Transition can involve: telling one's family, friends and/or co-workers; changing one's name and/or sex on legal documents; hormone therapy; and possibly (though not always) one or more forms of surgery.
Gender Confirmation Surgery (GCS): Refers to surgical alteration, and is only one small part of transition (see Transition above). Preferred term to "sex change operation." Not all transgender people choose to or can afford to have GCS. Researchers and clinicians should avoid overemphasizing the role of GCS in the transition process. Also known by more stigmatized term “sex reassignment surgery” or “SRS”.

Cross-Dressing: To occasionally wear clothes traditionally associated with people of the other sex. Cross-dressers are usually comfortable with the sex they were assigned at birth and do not wish to change it. "Cross-dresser" should NOT be used to describe someone who has transitioned to live full-time as the other sex or who intends to do so in the future. Cross-dressing is a form of gender expression and is not necessarily tied to erotic activity. Cross-dressing is not indicative of sexual orientation.

Gender Identity Disorder (GID): A DSM-IV diagnosis given to transgender and other gender-variant people. This diagnosis pathologized gender variance and is thus no longer in effect as of 2013. See gender dysphoria for the current most similar diagnostic category.

Gender Dysphoria: A DSM-V diagnosis given to individuals whose gender identity does not match the sex they were assigned at birth, and for whom this conflict causes significant impairment and distress in daily life.

Intersex: Describing a person whose primary and/or secondary sex characteristics are viewed as ambiguous within the binary, dichotomous gender system. There are many genetic, hormonal or anatomical variations that make a person's sex ambiguous (e.g., Klinefelter Syndrome). Parents and medical professionals usually assign intersex infants a sex and perform surgical operations to conform the infant's body to that assignment. This practice has become increasingly controversial as intersex adults speak out against the practice. The term intersex is not a synonym for transgender.

Hermaphrodite*: is an outdated and offensive term which has been replaced by intersex.

Androgyne: a person who live without appearing or behaving particularly male or female.

Agender: Literally “without gender”. This term describes a person who may identify more with terms such as human or person rather than with a specific gender identity. These individuals may prefer gender-neutral pronouns such as “they” (singular) or invented gender-neutral pronouns such as “zi/sie/mir/hir”.

Androgynous: having the characteristics of both male and female.

Drag: a type of expression involving exaggerated performance of stereotypical gender characteristics. A performer is called a drag queen if they perform as a woman or a drag king if they perform as a man. One does not have to identify as transgender to perform drag.
Two-Spirit: A term for both same gender loving and transgender individuals that emerged from various Native American traditions. In many traditions, this term has a meaning similar to “one who has transformed”.

Asexual: lack of sexual attraction toward others, or lack of sexual desire (sometimes referred to as a lack of sexual orientation, though not all asexual-identified individuals relate to the latter interpretation)

Bisexual: attraction toward two genders (also sometimes used as an umbrella term for anyone attracted to more than one gender)

Heterosexual (Straight): attracted to the “opposite” gender from how one identifies (typically interpreted via a binary system of male/female)

Homosexual (Gay/Lesbian): attracted to the same gender as one identifies

Pansexual: attracted to all genders/gender identities

Polysexual: attracted to multiple genders/gender identities, but not all

Queer: sometimes an umbrella term for all individuals who are not heterosexual or a term for individuals who does not fit any specific sexuality

Note. * Indicates terms generally understood as pathological/inappropriate.
Appendix C: Demographic Questionnaire

1. What is your age? _________
2. What sex were you assigned at birth?
   a. Male
   b. Female
   c. Intersex
3. What is your gender identity?
   a. Male
   b. Female
   c. Transgender (MtF)
   d. Transgender (FtM)
   e. Transgender (non-binary)
   f. Genderqueer
   g. I do not identify with any of these terms (please specify: _________)
4. What best describes your race/ethnicity?
   a. Hispanic or Latina/o/x
   b. White
   c. Black or African American
   d. Native Hawaiian or other Pacific Islander
   e. American Indian or Alaskan Native
   f. Asian
   g. Mixed race/ethnicity
5. Which best describes your sexual orientation?
   a. Asexual
   b. Bisexual
   c. Heterosexual (Straight)
   d. Homosexual (Gay/Lesbian)
   e. Pansexual
   f. Polysexual
   g. Queer
   h. I do not identify with any of these terms (please specify: _________)
6. What best describes the area where you live?
   a. Small town or village
   b. Very rural area
   c. Medium-sized town or village
   d. Major city
7. How would you describe your religion/spirituality?
   a. Catholic
   b. Islamic
   c. Jewish
   d. Protestant
   e. Buddhist
   f. Pagan
   g. Spiritual beliefs do not fit a formal religion
   h. None
i. Not listed (specify): _____________________

8. What best describes your housing status?
   a. Owning a home/apartment
   b. Renting a home/apartment
   c. Renting a room in someone else’s home/apartment
   d. Street homeless
   e. Homeless (living in a shelter)
   f. Living with friends
   g. Living with family
   h. Cooperative/communal living arrangement
   i. Residential treatment program

9. What is the highest degree you have completed?
   a. I did not graduate high school
   b. GED
   c. High School Diploma
   d. Associate’s Degree
   e. Bachelor’s Degree
   f. Advanced Degree (M.D., Ph. D., Psy. D., J. D., etc.)

10. What is your annual (individual) income?
    a. under $20,000
    b. $20,000 – $40,000
    c. $41,000-$60,000
    d. $61,000-$80,000
    e. $81,000-$100,000
    f. Over $100,000

11. Which best describes your current status with regard to hormone therapy?
    a. I am currently taking hormone blockers (estrogen or testosterone)
    b. I am currently taking cross-sex hormones (hormone replacement therapy or HRT)
    c. I currently take both hormone blockers and cross-sex hormones
    d. I do not take hormones

12. To what extent would you feel comfortable seeking mental health services (e.g., therapist, psychologist, psychiatrist)?
13. To what extent would you feel comfortable seeking medical services (e.g., medical doctor, nurse)?
14. How likely would you be to seek help from the criminal justice system (e.g., police, courts, jails, prisons) if someone committed a minor crime against you (e.g., stole your phone, whispered a derogatory message, etc.)?
15. How likely would you be to seek help from the criminal justice system if someone committed a major crime against you (e.g., rape, assault, etc.)?
Appendix D: Gender Identity Interview

1. How do you experience your gender identity?
   a. [all interview items are free response]
2. What does that gender identity mean to you?
3. Describe the time when you first began to identify in this way?
   a. How old were you when you first identified in this way?
4. Do you identify in this way at all times, in all settings, with all people? Why or why not?
5. What has helped you develop and come to terms with your gender identity? (e.g., specific people, institutions, experiences, ideas, etc.).
6. What factors have made it difficult for you to develop and come to terms with your gender identity? (e.g., specific people, institutions, experiences, ideas, etc.).
7. Describe your experiences with other individuals in your life who identify similarly to you (e.g., who identify as transgender, TGNC, genderqueer, etc.)
8. Describe your experiences with other individuals in your life who identify as cisgender.
9. What messages have you received from society regarding your gender identity?
10. What positive messages have you received from society regarding your gender identity?
11. What negative messages have you received from society regarding your gender identity?
12. What is it like for you to identify with your gender identity given these societal messages?
13. Do you feel like there is a community for your identity? Why or why not?
14. Have you ever considered or participated in medical interventions (e.g., hormones, surgery) to align your body and gender presentation with your experienced gender identity? Why or why not?
15. Have you legally changed your name, or asked others to refer to you by a name other than what you were assigned at birth? Why or why not?
16. How important is “passing” to you? Please explain.
17. As you developed your gender identity, what experiences were particularly helpful/validating for you?
18. What experiences were particularly harmful/invalidating for you?
19. Do you currently have a sexual or romantic partner or partners?
   a. How does your partner experience you/your sexuality/your gender?
   b. Has your sexual orientation or sexuality changed as your identity as your TGNC identity developed?
   c. What one way your romantic/sexual partner(s) have positively influenced your gender identity development?
   d. What one way your romantic/sexual partner(s) have negatively influenced your gender identity development?
20. Have you ever sought mental health services (e.g., individual or group therapy, peer counseling)?
   a. What was one particularly positive experience you had in therapy?
   b. What was one particularly negative experience you had in therapy?
21. What is one thing you wish the world knew about you as a person?
Appendix E: Victimization Survey

1. Have you ever been called names, teased, or threatened because of your actual or perceived gender identity/presentation?
   a. In your lifetime, approximately how many times has this occurred? [numerical free response]
   b. In the past year, approximately how many times has this occurred?
   c. How old were you first experienced this?
   d. Think of one event which was most memorable for you. What was the perpetrator’s gender?
      i. Male
      ii. Female
      iii. Transgender
      iv. Genderqueer
      v. Gender not listed (please specify)
   e. Who was the perpetrator in this most memorable event?
      i. Co-worker
      ii. Work supervisor
      iii. Fellow student/peer
      iv. Teacher
      v. Stranger
      vi. Member of your religious community
      vii. Member of your racial/ethnic community
      viii. Police officer or other public safety personnel
      ix. Military personnel
      x. Healthcare provider
      xi. Casual friend/acquaintance
   f. How upset are you when you experience these events?
      i. 4-point Likert scale from “not upset” to “extremely upset”

2. Have you ever been punched, kicked, beaten, or hurt with a knife, gun, or other weapon because of your actual or perceived gender identity/presentation?
   a. [Same questions as #1]

3. Has anyone ever sexually abused or raped you as a result of your actual or perceived gender identity/presentation?
   a. [Same questions as #1]
Appendix F: Gender Expression/Experiences/Identity Questionnaire

1. Do you experience your gender identity as fluid or changing over time?
   a. Yes
   b. No

2. What pronoun(s) do you feel most comfortable with?
   a. She
   b. He
   c. They
   d. One
   e. Yo
   f. Ze/Zie/Sie/Zir/Hir/Mir
   a. Pronoun(s) not listed
      i. [please specify]

3. Which public restroom do you use?
   a. Men’s/Women’s/Varies
   b. I do not use public restrooms
   c. Please explain (optional): [free response]

4. To what extent does having to choose one feel uncomfortable to you?
   a. Not at all/A little bit/Moderately/Very/Extremely/Varies

5. At what age did you first experience yourself as a gender other than your birth sex?
   a. [numerical free response]

6. At what age did you begin to present yourself as your experienced gender identity?
   a. [numerical free response]
   b. I do not yet present myself as my experienced gender identity

7. At what age did you first identify as TGNC?
   a. [numerical free response]

8. At what age did you first tell someone you identified as TGNC?
   a. [numerical free response]
   b. I have not told anyone

9. Who was the first person you told that you identify as TGNC?
   a. I have not told anyone
   b. Trans friend
   c. Cisgender/conventionally gendered friend
   d. Sibling
   e. Parent
   f. Other close relative
   g. Other distant relative
   h. Stranger
   i. Therapist/counselor
   j. Teacher
   k. Coworker
   l. Lover/Partner/Spouse
   m. Other: __________

TGNC Community Connection
10. How connected do you feel to the TGNC community?
   a. Not at all/A little bit/Moderately/Very much/Extremely

11. How often do you go to TGNC bars, clubs, or parties?
   a. Never/Rarely/Sometimes/Often/Very often

12. How often do you attend other events that are specifically TGNC (e.g., political rallies, parades, discussion groups, professional meetings, etc.)?
   a. Never/Rarely/Sometimes/Often/Very often

13. How often do you participate in or visit online TGNC chat rooms, discussion boards, support forums, etc?
   a. Never/Rarely/Sometimes/Often/Very often

14. Think of the 5 people in your life that you are closest to. How many of them are TGNC?
   a. 0-5
Appendix G: Gender Dysphoria Questionnaire

In the past 12 months…
1. Have you felt satisfied with the gender you were assigned at birth (your birth sex)?
2. Have you felt uncertain about your gender?
3. Have you felt pressured by others to conform with social expectations for your birth sex, although you don’t really want to?
4. Have you felt “different” from most individuals of your birth sex? (e.g., if you were assigned male at birth, do you feel unlike other males?)
5. Have you felt like it might be better for you to live in the role of your birth sex?
6. Have you been distressed by others perceiving you as a gender other than the gender you identify with?
7. Have you felt like you don’t have anything in common with either men or women?
8. Have you felt like you are different from most people who identify as transgender?
9. Have you been bothered by having to check the box of “male” or “female” on official forms (e.g., employment applications, driver’s license, passport)?
10. Have you felt uncomfortable using public restrooms?
11. Have strangers treated you as a gender other than your gender identity (e.g., using incorrect pronouns)?
12. Have people you are close to (e.g., friends, family) treated you as a gender other than your gender identity?
13. Have you dressed in a way that aligned with your experienced gender identity?
14. Have you disliked typically gendered parts of your body (e.g., penis, vagina, breasts, Adam’s apple)?
15. Have you wished for or planned to have an operation or undergo hormone treatment in order to change a gendered portion of your body?
16. Have you thought of yourself as a cisgender male or female?
17. Have you thought of yourself as a transgender woman or man?
18. Have you thought of yourself as a non-binary gender identity (e.g., genderqueer, bigender, agender)?
Appendix H: Patient Health Questionnaire (PHQ-9)

Over the past 2 weeks, how often have you been bothered by any of the following problems?

Scale:
0 - Not at all
1 - Several days
2 - More than half the days
3 - Nearly every day

1. Little interest or pleasure in doing things
2. Feeling down, depressed, or hopeless
3. Trouble falling or staying asleep, or sleeping too much
4. Feeling tired or having little energy
5. Poor appetite or overeating
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down
7. Trouble concentrating on things, such as reading the newspaper or watching television
8. Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual
9. Thoughts that you would be better off dead or of hurting yourself in some way
10. If you have experienced any of these things, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?
   a. Not difficult at all/Somewhat difficult/Very difficult/Extremely difficult
Appendix I: Generalized Anxiety Scale (GAD-7)

Over the past 2 weeks, how often have you been bothered by the following problems?

Scale: [same as for PHQ-9]

1. Feeling nervous, anxious, or on edge
2. Not being able to stop or control worrying
3. Worrying too much about different things
4. Trouble relaxing
5. Being so restless that it’s hard to sit still
6. Becoming easily annoyed or irritable
7. Feeling afraid, as if something awful might happen
8. If you have experienced any of these things, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?
   a. Not difficult at all/Somewhat difficult/Very difficult/Extremely difficult
Appendix J: Social Support Questionnaire

Do you feel there is someone in your life who you can count on to...

1. …distract you from your worries when you feel under stress?
   a. [All 6-point Likert]
2. …help you feel more relaxed when you are under pressure or tense?
3. …accept you fully, including both your best and your worst points?
4. …care about you, regardless of what is happening to you?
5. …help you feel better when you are feeling generally down-in-the-dumps?
6. …console you when you are very upset?
Appendix K: Flourishing Scale

Below are eight statements with which you may agree or disagree. Using the scale provided, indicate your agreement with each statement by choosing the appropriate score.

7 = Strongly agree
6 = Agree
5 = Slightly agree
4 = Neither agree nor disagree
3 = Slightly disagree
2 = Disagree
1 = Strongly disagree

1. I lead a purposeful and meaningful life.
2. My social relationships are supportive and rewarding.
3. I am engaged and interested in my daily activities.
4. I actively contribute to the happiness and well-being of others.
5. I am competent and capable in the activities that are important to me.
6. I am a good person and live a good life.
7. I am optimistic about my future.
8. People respect me.
Appendix L: Grit Scale

Please respond to the following 17 items. Be honest – there are no right or wrong answers!

5 = Very much like me
4 = Mostly like me
3 = Somewhat like me
2 = Not much like me
1 = Not like me at all

1. I aim to be the best in the world at what I do. _______
2. I have overcome setbacks to conquer an important challenge. _______
3. New ideas and projects sometimes distract me from previous ones. _______
4. I am ambitious. _______
5. My interests change from year to year. _______
6. Setbacks don’t discourage me. _______
7. I have been obsessed with a certain idea or project for a short time but later lost interest. _______
8. I am a hard worker. _______
9. I often set a goal but later choose to pursue a different one. _______
10. I have difficulty maintaining my focus on projects that take more than a few months to complete. _______
11. I finish whatever I begin. _______
12. Achieving something of lasting importance is the highest goal in life. _______
13. I think achievement is overrated. _______
14. I have achieved a goal that took years of work. _______
15. I am driven to succeed. _______
16. I become interested in new pursuits every few months. _______
17. I am diligent.
Appendix M: Figures

Figure 1. Gender Identity Dimensions. This figure illustrates the multi-dimensional components of gender identity.
<table>
<thead>
<tr>
<th>Stage</th>
<th>Characteristics</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normative Identification</td>
<td>Self-identification with binary sex assigned at birth (male/female)</td>
<td>Conformity to societal expectations for birth sex</td>
</tr>
<tr>
<td>Experience of Discontinuity or Conflict</td>
<td>Experience self as “different” from others of the same assigned sex</td>
<td>Anxiety, self-doubts, potential reactive conformity to societal norms</td>
</tr>
<tr>
<td>Identity Comparisons</td>
<td>Awareness of alternative gender identities (e.g., transgender or genderqueer)</td>
<td>Self-education regarding alternative identifications, comparisons of experienced gender identity with alternative identifications</td>
</tr>
<tr>
<td>Identity Confusion</td>
<td>Doubts about one’s authenticity and/or belongingness in alternative identity category</td>
<td>Anxiety, additional self-education and identity comparisons</td>
</tr>
<tr>
<td>Self-identification as TGNC¹</td>
<td>Selection of a gender identity which differs from birth sex</td>
<td>Self-exploration, rigidity of TGNC identity self-conceptualization</td>
</tr>
<tr>
<td>Interpersonal Disclosure</td>
<td>Negotiation of who/what/when/where/why of identity disclosure</td>
<td>Disclosure of TGNC identity to others</td>
</tr>
<tr>
<td>Identity Exploration</td>
<td>Decreasing rigidity of TGNC identity self-conceptualization</td>
<td>Participation in TGNC community events, incorporation of TGNC-identified peers in friend group</td>
</tr>
<tr>
<td>Identity Negotiation</td>
<td>Increased flexibility of gender identity and gender presentation</td>
<td>Information gathering, potential exploration of alternative identifications</td>
</tr>
<tr>
<td>Acceptance</td>
<td>Lasting commitment to (a)-gender identification</td>
<td>Stability in self-identification and disclosure</td>
</tr>
<tr>
<td>Consideration of Transition</td>
<td>Consideration of social and physical transitions aligning with experienced gender identity</td>
<td>Seeking social support, research on transition options</td>
</tr>
<tr>
<td>Social Transition</td>
<td>Engaging in lived roles consistent with experienced gender identity</td>
<td>Changes in self-presentation, peer group, and activities</td>
</tr>
<tr>
<td>Physical Transition²</td>
<td>Modifying physiological characteristics to align with experienced gender identity</td>
<td>Hormone blocking, cross-hormone treatment, sex-reassignment surgery, and/or</td>
</tr>
<tr>
<td>Post-Transition Acceptance</td>
<td>Exploration and increasing comfort with modified physiological characteristics</td>
<td>Exploration and variable levels of conformity with societal expectations for gender identity</td>
</tr>
<tr>
<td>---------------------------</td>
<td>---------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Integration</td>
<td>Changes in salience and centrality of gender and gender identity in daily life</td>
<td>Increased focus on global self, integration of additional identities (e.g., student, sibling, profession, race/ethnicity, etc.)</td>
</tr>
<tr>
<td>Pride^2</td>
<td>Stability in sense of self (including integrated gender identity)</td>
<td>Engagement in advocacy related to gender identity</td>
</tr>
<tr>
<td>Continued Re-Evaluation</td>
<td>Individuals may pass through these stages again, in variable order, based upon life experiences</td>
<td>Actions vary based upon individual differences</td>
</tr>
</tbody>
</table>

Notes. Red font indicates stages proposed in extant research which the present investigations seeks to critically evaluate.

^1TGNC herein used as umbrella term encompassing gender identities which differ from sex assigned at birth

^2The present investigation posits greater heterogeneity in these phases than noted within extant research

^3The present investigation proposes this “final” phase as differentially manifesting across individuals, contrary to extant research proposing a ubiquitous culminating identity state
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