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Posttraumatic Stress in the Trans Community: The Roles of Anti-Transgender Bias, Non-Affirmation, and Internalized Transphobia

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Transgender people have higher rates of posttraumatic stress disorder (PTSD) than the general population. This risk can be partially understood by conceptualizing day-to-day bias-related stressors and non-affirmation as potentially traumatic, but there is currently limited empirical evidence to support such a framework. This study aimed to explore this framework by testing the hypothesis that exposure to anti-transgender bias and non-affirmation are related to PTSD symptom severity, even after controlling for exposure to traditionally defined potentially traumatic events. Drawing upon shame-based models of PTSD, this study also tested the hypothesis that internalized transphobia partially mediates the relationships between both bias and non-affirmation and PTSD symptom severity. Cross-sectional data were collected online from 575 individuals who identified as having a gender different from their sex assigned at birth. Data were analyzed utilizing structural equation modeling. As hypothesized, participants with greater exposure to anti-transgender bias and higher levels of non-affirmation experiences had increased PTSD symptom severity, even after controlling for exposure to other trauma. These relationships were partially explained by internalized transphobia. These findings document meaningful relationships between anti-transgender bias, non-affirmation, internalized transphobia, and posttraumatic stress. They provide initial support for conceptualizing anti-transgender bias and non-affirmation experiences as potentially traumatic themselves and/or as trauma response triggers and highlight a potential role of internalized transphobia in PTSD symptoms. Clinical implications for working with trans populations are discussed.

Public Significance Statement
This study found that anti-transgender bias, non-affirmation of gender, and internalized transphobia were related to PTSD symptom severity. When psychologists or the general public make efforts to understand trans people's increased rates of PTSD symptoms and diagnoses—or participate in efforts to improve mental health in the trans community—they should attend to anti-transgender bias, non-affirmation, and internalized transphobia.

Keywords: bias, internalized transphobia, non-affirmation, PTSD, transgender

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The literature on transgender mental health indicates that trans people are at greater risk for mental health difficulties, including depression, anxiety, self-harm, suicidality, and psychiatric diagnoses, when compared with the cisgender population (e.g., Hanna et al., 2019). With regard to posttraumatic stress disorder (PTSD) specifically, studies of transgender adults have found that between 17.5% and 45% of participants met criteria for PTSD (Reisner et al., 2016; Shipherd et al., 2011). These proportions are markedly higher than the prevalence rates of PTSD in the general population (5% to 10%; Kessler et al., 1995). The increased risk for

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posttraumatic stress is likely related to transgender people's increased risk of victimization and trauma (Nuttbrock et al., 2010; Shipherd et al., 2011). Additionally, studies have repeatedly documented that many mental health risks in the trans community are at least partially explained by living in a "hostile and stressful social environment" (Meyer, 2003, p. 674; Testa et al., 2012) - specifically, exposure to the gender minority stressors of anti-transgender bias and non-affirmation (e.g., dickey et al., 2015; Shipherd et al., 2011; Testa et al., 2012).

According to the gender minority stress model (Hendricks & Testa, 2012; Testa et al., 2015), the experience of gender- or trans-related marginalization predicts negative mental health experiences. The model describes distal stressors (discrimination, rejection, harassment, and non-affirmation) and proximal stressors (internalized transphobia/transnegativity, expected rejection, and concealment) and has been validated in multiple cross-sectional studies (e.g., McQuillan et al., 2020; Tebbe & Moradi, 2016), demonstrating that these stressors predict psychological distress and a range of negative outcomes. Richmond and colleagues (2012, 2017) proposed conceptualizing anti-transgender bias and non-affirmation as traumatizing. This framework provides both a potential mechanism for the impact of these experiences and emphasizes their severity. Defining bias experiences and non-affirmation as trauma requires an expansion of mainstream definitions of posttraumatic stress that are contingent upon exposure to an objectively defined extreme event. For decades, trauma psychologists have been calling for an expansion to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) Criterion A for PTSD, which requires that a person's PTSD symptoms are linked to a stressor of threatened death, actual or threatened serious injury, or actual or threatened sexual violence to receive a PTSD diagnosis. A robust body of research has demonstrated that stressors which fail to meet Criterion A are still uniquely associated with clinically significant elevations in PTSD symptoms (e.g., Long et al., 2008; Mol et al., 2005; Van Hooff et al., 2009).

This tension is part of a long history of medical, scientific, and psychological debate over determining the validity of trauma sequelae and their sources (Herman, 2015; Weisaeth, 2014). For example, only in the late 1970s after intense advocacy efforts from veterans and women were the relationships between the symptoms of posttraumatic stress and combat and rape accepted by mainstream psychologists (Herman, 2015; van der Kolk, 2007). That shift in the defining and understanding of trauma was critical in veterans and sexual assault survivors gaining access to effective treatment and relief. Similarly, understanding anti-transgender bias and non-affirmation events as potentially traumatic would depathologize and destigmatize transgender and nonbinary individuals who struggle with mental health and allow for the development of more effective mental healthcare that better targets the sources of people's distress (Richmond et al., 2012).

There is support in existing literature for conceptualizing anti-transgender bias and non-affirmation as potentially traumatic for transgender people. For example, psychologists have established trauma frameworks for understanding racism and ethnoviolence (e.g., Helms et al., 2012). Whereas mainstream fear- and anxiety-based models of trauma and PTSD propose that posttraumatic stress develops as a result of fear associated with threats to one's physical self (e.g., Foa & Cahill, 2001; Foa & Kozak, 1985; Kilpatrick et al., 1985), racism-based trauma frameworks

Richmond and colleagues' (2012, 2017) trauma framework for transgender mental health are built upon feminist trauma theory positing that perceived threats to one's social and psychological self can elicit similar symptoms. Namely, Root's (1992) construct of insidious trauma—the accumulative traumatic effect of regular bias events—and her feminist reconstruction of posttraumatic stress development offer a model of understanding trauma as the destruction or incomplete development of security dimensions, which can be physical, psychological, or interpersonal. Without a stable sense of physical, psychological, and interpersonal security, individuals may engage in maladaptive behaviors forged out of self-preservation/survival mode and efforts to build some sense of safety. For example, in this approach, hypervigilance and social withdrawal would be discussed as efforts (conscious or unconscious) to feel or be safe in the face of perceived ongoing threat to various dimensions of security.

Research establishing relationships between anti-LGBTQ (lesbian, gay, bisexual, transgender, and queer) and racist discrimination and PTSD symptoms has provided empirical support for the construct of insidious trauma (e.g., Liu et al., 2014; Szymanski & Balsam, 2011). With regard to transgender populations, only one known study has examined the relationship between discrimination and PTSD in a discretely transgender sample. In this study, exposure to discrimination was significantly associated with an increase in PTSD symptom severity, even after controlling for Criterion A trauma exposure (Reisner et al., 2016); this is transgender-specific evidence for the designation of bias as potentially traumatic.

Non-affirmation occurs when a transgender or nonbinary person's gender and internal sense of self is not respected or reflected in their interactions with others or systems. Non-affirmation experiences, such as misgendering, are disruptive to the psychological needs of coherence and belonging (McLemore, 2015); under Root's (1992) model of insidious trauma they have the potential to accumulate into destabilizing experiences. The construct of non-affirmation has received markedly less attention in quantitative research than anti-transgender bias (Tan et al., 2020; Valentine & Shipherd, 2018), despite non-affirmation events like misgendering being frequently cited as painful and damaging in qualitative studies of transgender and nonbinary individuals' experiences, especially when seeking mental and medical health care (e.g., James et al., 2016; Morris et al., 2020). Although a small number of studies have demonstrated that non-affirmation is associated with increased depressive symptoms, anxiety symptoms, suicidality, and high-risk behavior (e.g., McLemore, 2018; Scheim et al., 2020), all of which can be manifestations of traumatic stress, no known studies have explicitly examined the relationship between non-affirmation and symptoms of PTSD.

Both mainstream and feminist/racism-based models of PTSD development recognize that posttraumatic stress develops in part owing to (a) unnecessarily extreme efforts to retain a sense of security following a trauma and (b) avoidance, both conscious and not, that prevents adequate processing of the trauma memories, responses, and/or security behaviors (Foa & Cahill, 2001; Herman, 1992; Root, 1992). Shame may be a key piece in understanding why some trauma survivors engage in avoidant-based coping (Budden, 2009; Lee et al., 2001). Many trauma survivors report peritraumatic and posttraumatic shame experiences, and shame is associated with increased PTSD symptom severity, as well as

increased avoidance (e.g., Andrews et al., 2000; Leskela et al., 2002). Internalized stigma, a construct involving shame experiences that result from the internalization of negative stereotypes about a held identity, has been found to mediate the relationship between bias event exposure and PTSD in lesbian and gay samples (Gold et al., 2009, 2011). Theory thus suggests that internalized transphobia, the internalized stigma specific to transgender identity, would similarly mediate the relationship between anti-transgender bias event exposure and PTSD symptoms in a discretely transgender sample. Although internalized transphobia is acknowledged by clinicians as a highly common and difficult struggle for transgender people and is associated with negative mental health outcomes (Austin & Craig, 2015; Lev, 2004; Testa et al., 2015), the relationship between internalized transphobia and PTSD symptoms has not been explicitly examined.

Understanding how anti-transgender bias events and non-affirmation, and particularly their chronicity and accumulation, are related to posttraumatic stress appropriately destigmatizes and depathologizes transgender people with poor mental health and facilitates better treatment for these individuals (Richmond et al., 2012, 2017). This understanding, however, is hindered by the dearth of research examining these variables and possible mechanisms of posttraumatic stress development. In the current study, we tested two hypotheses. First, we hypothesized that anti-transgender bias exposure and experiences of non-affirmation would be associated with PTSD symptom severity, such that participants with higher levels of exposure to anti-transgender bias and non-affirmation would display more severe symptoms. Our second hypothesis was that this relationship would be partially mediated by internalized transphobia, such that increased levels of internalized transphobia will explain some, but not all, of the association between anti-transgender bias exposure and non-affirmation and PTSD symptoms. These hypothesized relationships extended from the theoretical framework of the potentially traumatic impacts of anti-transgender bias and non-affirmation on transgender people and the role that shame (specifically, internalized transphobia) may play as a mechanism in the development and maintenance of trauma sequelae related to these experiences.

Method

Data Collection and Sample Demographics

Participants were recruited via social networking platforms, LGBTQ and transgender-specific listservs, and emails to LGBTQ community and university centers, transgender support and social groups, therapists working with transgender clients, and contacts within the transgender community. Participants were asked to complete a one-time online questionnaire, including a demographic questionnaire and questions about gender-related discrimination, gender-related rejection, gender-related victimization, non-affirmation of gender, exposure to potentially traumatic events, internalized transphobia, and PTSD symptoms. An initial pool of 729 individuals consented to participate. However, 111 of those did not complete any survey items, and an additional 27 completed only the demographics questions; these cases were removed. Additionally, we removed data for 16 participants who indicated that their age was under 18 or who did not disclose their age.

The final sample included 575 participants. Participants were asked to indicate whether "man," "woman," or "nonbinary" best described their gender identity; 42% (n = 243) selected nonbinary, 36% (n = 206) selected man, and 22% (n = 126) selected woman. All participants were also given the option to report the gender identity labels they used for themselves. Participants reported a wide array of gender identities, including agender, bigender, boi, enby, femme, FTM, genderqueer, gender fluid, gender neutrois, MTF, nonbinary, man, trans feminine, trans man, trans masculine, trans woman, two-spirit, and woman. The majority of the sample reported that they were female assigned at birth (72%; 27% reported being male assigned at birth; 1% reported being assigned intersex at birth). The mean age of participants was 31.51 (SD = 11.84; range = 18–73). With regard to race and ethnicity, 81% (n = 467) of the sample were White, Non-Hispanic; 11% of the sample endorsed multiple racial and ethnic categories; 6% identified as Latinx/Hispanic; 5% identified as Native American or First Nations; 4% identified as having Asian or Pacific Islander heritage; 3% identified as Black or of African heritage; 1% identified as Middle Eastern. See Supplemental Table 1 for full demographic information. The authors expand upon limitations related to the underrepresentation of BIPOC participants and trans people who were assigned male at birth in the Discussion section.

Measures

Bias-Related Discrimination, Rejection, and Victimization

Participants' exposure to experiences of anti-transgender bias was measured by three subscales of the Gender Minority Stress and Resilience measure (GMSR) developed by Testa and colleagues (2015): *gender-related discrimination* (five items; sample item: "Because of my gender identity or expression, I have had difficulty finding a bathroom to use when I am out in public"); *gender-related rejection* (six items; sample item: "I have been rejected or distanced from family because of my gender identity or expression"); and *gender-related victimization* (five final items; sample item: "I have been threatened with physical harm because of my gender identity or expression"). For each of the subscales, participants responded to items by checking all that apply of the following: *Never*; *Yes, before age 18*; *Yes, after age 18*; *Yes, in the past year*. Thus, for each item, participants received a score between 0 and 3, which represented the total number of "yes" responses they selected or 0 if they selected "never." In Testa and colleagues' (2015) validation study internal consistency reliability of the three subscales in question ranged from .61 to .77 (Testa et al., 2015). Testa and colleagues' (2015) study also demonstrated adequate criterion-related validity for each subscale. In the current study, reliability of scores for these subscales was higher than in prior research: gender-related discrimination: α = .70 (95% CI [.66, .74]); gender-related rejection: α = .77 (95% CI [.74, .80]); gender-related victimization: α = .81 (95% CI [.78, .83]).

Non-affirmation of Gender Identity

We measured the extent to which participants experienced non-affirmation of their gender identity with the six-item non-affirmation of gender identity subscale from the Gender Minority Stress and Resilience scale (GMSR; Testa et al., 2015; sample items: "People do not respect my gender identity because of my

appearance or body," "I have difficulty being perceived as my gen-der accurately"). Participants responded to each item using a 5-point Likert-type scale (0 = *strongly disagree*, 4 = *strongly agree*). Items on this subscale demonstrated high internal consistency within Testa and colleagues' (2015) transgender sample: α = .93, and the scale demonstrated good criterion-related validity. In the current study, items demonstrated similarly high internal consis-tency (α = .92; 95% CI [.91, .93]).

Potentially Traumatic Event Exposure

We used the Traumatic Life Events Questionnaire (TLEQ; Kubany et al., 2000) to measure exposure to potentially traumatic events (PTEs). This 22-item scale is used to assess the frequency of exposure to a wide range of potentially traumatic events, from natural disasters to intimate partner violence victimization. Partici-pants report the frequency of exposure to each event on a 7-point Likert-type scale (0 = *never*; 6 = *more than five times*). This scale is widely used and is consistently found to be predictive of PTSD symptoms and diagnoses (Kubany et al., 2000). In the current study, this measure was used to control for exposure to traumas that are perceived to be unrelated to anti-transgender bias. Thus, for each trauma item, we asked that participants use the 7-point Likert scale separately for frequency of events due to transgender status and frequency of events unrelated to transgender status. In the current study, items from this adapted bias-unrelated TLEQ demonstrated sufficient internal consistency: α = .78 (95% CI [.76, .81]).

Internalized Transphobia

We used the eight-item Internalized Transphobia subscale of the GMSR (Testa et al., 2015) to measure the internalized stigma or shame that participants feel due to being transgender. When appro-priate, we adapted scale items to include transition history as a source of shame (sample items: "I often ask myself: Why can't my gender identity, expression, or history just be normal?"; "I envy people who don't have a transition history or a gender identity/expression like mine"). Participants responded to each statement using a 5-point Likert-type scale to indicate their degree of agree-ment (0 = *strongly disagree*; 4 = *strongly agree*). Original scale items have demonstrated high internal consistency in transgender populations: α = .91, and good criterion-related validity (Testa et al., 2015). In the current study, items (including those adapted to include history) yielded a satisfactory internal consistency: α = .89 (95% CI [.87, .90]).

PTSD Symptoms

Symptoms of posttraumatic stress were measured with the PTSD Checklist for *DSM–5* (PCL-5; Weathers et al., 2013), a 20-item scale assessing symptoms that correspond with *DSM–5* diagnostic criteria for PTSD. Participants rate how much they were bothered by each symptom within the past month using a 5-point Likert-type scale (0 = *Not at all;* 4 = *Extremely*). The PCL-5 has demonstrated strong convergent and divergent validity and been found to have a seven-factor structure: reexperiencing, avoidance, negative affect, anhedonia, externalizing behaviors, anxious arousal, and dysphoric arousal (Armour et al., 2015; Blevins et al., 2015; Liu et al., 2014). PCL-5 items demonstrated very high full-scale inter-nal consistency in the current study (α = .96; 95% CI [.95, .97]).

Analytic Strategy

We conducted structural equation modeling (SEM) analyses using Mplus v7.4 (Muthén & Muthén, 2015). Demographic, data cleaning, and assumption-checking analyses were conducted in SPSS v25.0. Prior to conducting analyses, 14 extreme cases (z score > 3.0) were identified. Each case was determined to be valid and, therefore, necessary to retain. To reduce likelihood of undue influence, however, we did a logarithmic transformation to the three variables with extreme cases (Discrimination, Victimization, and Bias-Unrelated PTEs). All other assumptions, such as multi-variate normality, were met.

Missing Data

Missingness was assessed for every observed variable using the Missing Value Analysis module in SPSS (Version 25.0). Percent missing ranged from .7% to 10.3%. Little's test was statistically significant, c^2 (1084) = 1248.06, $p < .001$, meaning that data can-not be assumed to be missing completely at random (MCAR). The final scale of the questionnaire, the PCL-5, demonstrated the great-est proportion of missing values (9.7% to 10.3%). Data were deter-mined to be missing at random (MAR) after mean scores between participants who had completed the PCL-5 and participants who had not were compared and yielded no statistical differences. Because data met the assumption of MAR, missing data during SEM analyses were handled using Full Information Maximum Likelihood estimation.

Model Specification

The structural equation model was tested via the two-step proce-dure recommended by Anderson and Gerbing (1988), first estab-lishing a measurement model that demonstrated adequate fit, before incorporating path analysis techniques to build and estimate structural paths. To determine adequacy of model fit, we reviewed the Tucker-Lewis index (TLI), the comparative fit index (CFI), the root mean square error of approximation (RMSEA), and χ^2 fit index values, as is recommended for SEM (Adelson, 2012; Kline, 2015). To compare the fit of non-nested models, we also reviewed the Akaike information criterion (AIC) and the Bayesian informa-tion criterion (BIC), and used a cut-off of 10 to determine whether AIC and BIC differences were meaningful (Burham & Anderson, 2002; Raftery, 1995).

After respecifying the measurement model and determining it had adequate fit, we incorporated structural paths using Bollen's (1989) method of first testing a saturated model with all possible structural paths to ensure that significant paths were not excluded from estimation. We removed any nonsignificant paths that were not parameters of interest. The final hybrid model was then eval-uated for fit. Finally, we estimated the size and significance of all parameters of the final model using Maximum Likelihood.

Evaluating Indirect Relationships

In addition to the direct paths estimated, our model included two indirect relationships: between Non-affirmation and PTSD Symptom Severity and between Bias Experiences and PTSD Symptom Severity, both of which were hypothesized to be par-tially mediated by Internalized Transphobia. Following the recom-mendation of Preacher and Hayes (2008), we used the MODEL

INDIRECT and BOOTSTRAP functions in Mplus and were able to evaluate the size and significance of both the indirect relationships (via bootstrapping) and the total relationships (via normal-theory methods).

Results

Descriptive Statistics and Frequencies

It is worth highlighting some of the descriptive and frequency statistics in participants' scores on the measures used in this study. The rates of exposure to anti-transgender bias were extremely high, with 92.6% reporting at least one experience of transgender-related discrimination, 94.2% reporting at least one experience of anti-transgender rejection, and 78.9% reporting at least one experience of anti-transgender victimization.

Participants' total scores on the PCL-5 indicated that a large portion of the sample experienced PTSD symptoms (Median = 27.00; M = 29.99, SD = 20.77). The National Center for PTSD (2021) recommends a preliminary cutoff of 33 for the overall PCL-5 score, with scores of 33 or greater representing clinically significant overall PTSD symptom severity (possible range is 0 to 80). Nearly half (46%) of participants in this study had scores of 33 or greater. Because the PCL-5 was designed to evaluate the symptoms listed as diagnostic criteria for PTSD in the DSM–5, participant responses also can be used to make provisional diagnoses (National Center for PTSD, 2021). Per the recommended guidelines, we treated each item with a symptom severity rating of "Moderately" or higher as an endorsed symptom and identified participants who endorsed symptoms across DSM–5 criterion clusters (at least one each in criteria B and C, and at least two each in criteria D and E). By this approach, 44.2% of participants met criteria for a provisional diagnosis of PTSD, with 62.8% endorsing at least one symptom of Criterion B, 59.9% endorsing at least one in Criterion C, 66.1% endorsing at least two in Criterion D, and 60.6% endorsing at least two in Criterion E.

Rates of exposure to PTEs were also high, with the vast majority of participants (93.1%) reporting exposure to a PTE related to being transgender and 93% reporting exposure to a PTE unrelated to being transgender. See Supplemental Table 2 for frequencies for each assessed PTE.

Building the Measurement Model

We then tested the a priori measurement model (Measurement Model 1), which was based on the scales' validated factor structures. This initial measurement model did not demonstrate adequate fit; fit indices fell just outside cutoffs for good fit (see Table 1). The poor fit appeared to be primarily due to anti-transgender bias factors not operating as expected. Discrimination,

Rejection, and Victimization all loaded onto the latent variable of Bias Experiences (β = .69, β = .83, and β = .74, respectively), but Non-affirmation failed to adequately load (β = .19). To address this, we respecified Measurement Model 2 to include Non-affirmation as a distinct observed exogenous variable and removed the parameter that had made it an indicator of Bias Experiences in Measurement Model 1. Implications of this are reviewed in the Discussion section.

We next reviewed the modification indices. Before evaluating any models, the lead author had proposed a number of correlated errors that were theoretically justified. We examined the output to determine which of the a priori correlated errors exceeded 10.0. We incorporated eight correlated errors into the model, adding correlations stepwise (prioritizing by size of modification index) until no a priori modification index was greater than 10.0. Measurement Model 2 includes those additional correlated errors. Fit indices suggested this model had good fit, and review of the changes to AIC and BIC suggested that the improved fit was worth the increased number of evaluated parameters (see Table 1).

Building the Hybrid Model

As the second step in Anderson and Gerbing's (1988) methodology, we incorporated structural parameters into the final measurement model. Per Bollen's (1989) method for specifying structural parameters, we first tested a saturated model to ensure that significant paths were not excluded from estimation. The only non-hypothesized path was from Bias-Unrelated PTEs to Internalized Transphobia. As expected, this path was not statistically significant (p = .79) and was removed from subsequent analyses.

We next determined the fit of the overall model and tested hypothesized structural parameters for significance. Each of the proposed pathways was statistically significant (p < .05), and the fit indices indicated adequate to good overall model fit, $\chi^2(155)$ = 439.65, p < .001; CFI = .95; TLI = .93; RMSEA = .06, 90% CI [.050, .063]. Therefore, this was our final model (see Figure 1) used to estimate direct and indirect parameters.

Model Estimation

The final model was run with a bootstrap sample draw of 1000. All hypothesized relationships were statistically significant. See Table 2 for a summary of parameter estimates. Both Bias Experiences and Non-affirmation had statistically significant direct relationships with Internalized Transphobia (β = .18, p < .01, and β = .22, p < .001, respectively) and PTSD Symptoms (β = .17, p < .001 and β = .26, p < .001, respectively). Internalized Transphobia also predicted PTSD Symptoms to a statistically significant degree (β = .21, p < .001).

Table 1
Model Fit Indices for Measurement Models

Model	χ^2	df	CFI	TLI	RMSEA	AIC	BIC
Model 1	736.39***	165	.89	.88	.08 (.072, .084)	38,227.73	38,510.42
Model 2	439.43***	154	.95	.93	.06 (.051, .063)	37,921.01	38,251.54

Note. AIC = Akaike information criterion; BIC = Bayesian information criterion; CFI = comparative fit index; RMSEA = root mean square error of approximation; TLI = Tucker-Lewis index.
***p < .001.

Figure 1
Final Hybrid Model With Standardized Path Estimates
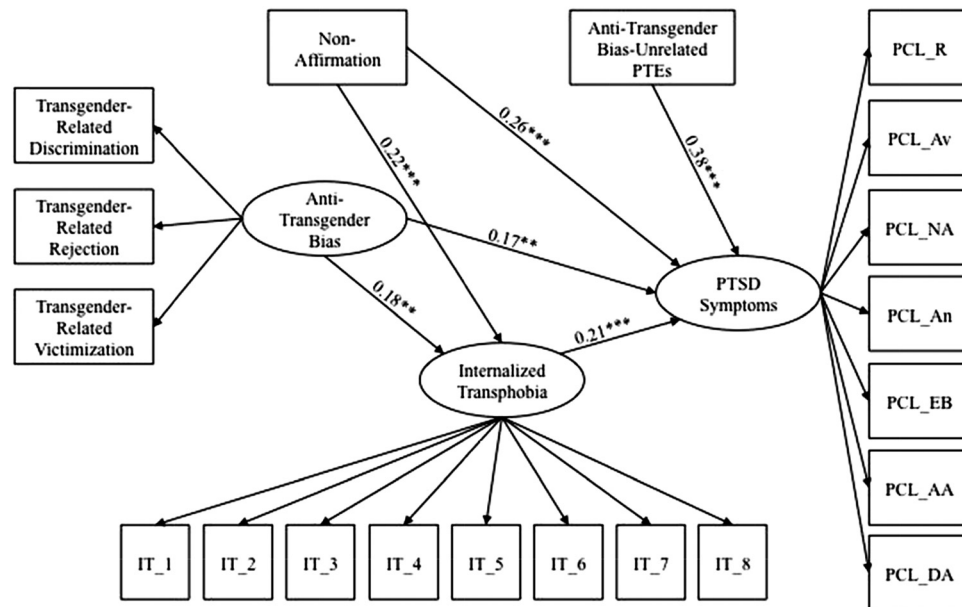
Note.   ** $p < .01$, *** $p < .001$.

The indirect relationship between Bias Experiences and PTSD Symptoms was statistically significant ($\beta = .04$, $p < .01$). Similarly, there was a statistically significant indirect relationship between Non-Affirmation and PTSD Symptoms ($\beta = .05$, $p < .01$). Thus, the total relationship between Bias Experiences and PTSD Symptoms was small, statistically significant ($\beta = .21$, $p < .001$), and partially mediated by Internalized Transphobia (proportion of total effect mediated = 15.24%). The total relationship between Non-Affirmation Experiences and PTSD Symptoms was also statistically significant but moderate in size ($\beta = .30$, $p < .001$) and also partially mediated by Internalized Transphobia (proportion of total effect mediated = 15.13%).

As hypothesized, the control variable of potentially traumatic events unrelated to transgender bias (Bias-Unrelated PTEs) had a moderate relationship with PTSD Symptoms ($\beta = .38$, $p < .001$). The correlation between Bias-Unrelated PTEs scores and Bias Experiences was statistically significant and moderate in size ($\beta = .37$, $p < .001$). The correlation between Bias-Unrelated PTEs and Non-affirmation was not significant ($\beta = .06$, $p = .11$). There was a small but statistically significant correlation between Bias Experiences and Non-Affirmation experiences ($\beta = .17$, $p < .001$).

Discussion

Difference Between Anti-transgender Bias and Non-affirmation

In the current study, the constructs of non-affirmation and anti-transgender bias performed differently than was proposed in the original measurement development and validation study (Testa et al., 2015). Ultimately, it is conceptually beneficial to consider non-affirmation as distinct from bias experiences and not

altogether surprising that analyses differentiated between these measures. Non-affirmation measures the extent to which people experience not being validated in their gender, not being seen for who they are. Anti-transgender bias factors of discrimination, rejection, and violence measure the extent to which people are mistreated for who they are (Hendricks & Testa, 2012; Sevelius, 2013). These are experientially different (Johnson et al., 2020). Other researchers have begun to study non-affirmation or invalidation of trans identity as a unique construct and risk factor for poor mental health outcomes (e.g., Parr & Howe, 2019; Reisner et al., 2020). In our study, there is clear benefit to examining non-affirmation as a standalone predictor, because trans individuals report non-affirmation experiences in clinical/psychotherapy spaces, romantic relationships, and friendships, even when there is an absence of anti-transgender discrimination, rejection, or violence (e.g., Galupo et al., 2014; Morris et al., 2020; Pulice-Farrow et al., 2017).

High Rates of PTSD Symptoms and Trauma Exposure

Using the recommended cutpoint for the overall measure, 46% of this sample reported clinically significant posttraumatic stress, and 44% of participants met criteria for a provisional diagnosis of PTSD based on *DSM–5* symptom endorsement. The common endorsement of clinically significant PTSD symptoms in our sample is concerning. For comparison, a 2013 study of general population adults in the United States ($N = 2,953$) estimated that 3.8% met *DSM–5* criteria for PTSD within the six months prior to participation (Kilpatrick et al., 2013). Additionally of note are the high rates of exposure to bias and potentially traumatic events. This is consistent with prior research (e. g., James et al., 2016; Reisner et al., 2016) and suggests that rejection, discrimination, victimization, and other traumas

Table 2
Model Results

DV	IV	β	SE
Direct path coefficients			
Internalized transphobia	Nonaffirmation***	0.22	0.04
	Bias experience**	0.18	0.05
PTSD symptoms	Nonaffirmation***	0.26	0.04
	Bias experience**	0.17	0.05
	Internalized transphobia***	0.21	0.04
	Bias-unrelated PTEs***	0.38	0.04
Indirect path coefficients			
PTSD symptoms	Nonaffirmation***	0.05	0.01
	Bias experience**	0.04	0.02

Latent Variable	Observed Variable	β	SE
Factor loadings			
Bias experience	Discrimination***	0.69	0.03
	Rejection***	0.83	0.03
	Victimization***	0.75	0.03
Internalized transphobia	IT_1***	0.69	0.03
	IT_2***	0.79	0.02
	IT_3***	0.81	0.02
	IT_4***	0.75	0.02
	IT_5***	0.65	0.03
	IT_6***	0.63	0.03
	IT_7***	0.61	0.03
	IT_8***	0.61	0.03
PTSD symptoms	PCL-5: Re-experiencing***	0.88	0.01
	PCL-5: Avoidance***	0.81	0.02
	PCL-5: Negative Affect***	0.90	0.01
	PCL-5: Anehedonia***	0.76	0.02
	PCL-5: Externalizing Behaviors***	0.69	0.03
	PCL-5: Anxious Arousal***	0.78	0.02
	PCL-5: Dysphoric Arousal***	0.77	0.02

Note. DV = dependent variable; IV = independent variable; IT = Internalized Transphobia; PCL-5 = PTSD Checklist for *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition; PTE = potentially traumatic event; PTSD = posttraumatic stress disorder.
**p < .01, ***p < .001.

attributable to one's gender identity, expression, or history are endemic in transgender populations. A very small minority of participants in this study denied having experienced any bias or other traumatic event owing to their trans identity or history. Note that our sample was overrepresented by white trans people who are female assigned at birth. White transmasculine people are less likely than BIPOC trans people and transfeminine individuals to face bias and other sources of trauma (e.g., James et al., 2016), so it is probable that prevalence rates of exposure are actually lower in our sample than in the community at large. The prevalence of PTSD in our study, however, is consistent with previous research with more racially and gender diverse samples of transgender people (Reisner et al., 2016). This may indicate that the relationships between bias and non-affirmation and PTSD symptoms are different for trans women of color. It may be that trans women of color employ more helpful coping, seek or have access to resilience resources, or are more likely to express a different manifestation of the traumatic impact (outside of *DSM–5* PTSD symptoms), but further research is needed to establish whether there are indeed group differences and what the potential mechanisms of such differences are.

Potential Roles of Anti-transgender Bias Experiences and Non-affirmation in Posttraumatic Stress

As hypothesized, we observed small to moderate relationships between both anti-transgender bias experiences and non-affirmation and PTSD symptoms. Although this was partially mediated by internalized transphobia, 85% of each of the relationships was direct, indicating that although internalized transphobia is an important part of understanding how these factors relate to posttraumatic stress, other mechanisms must be at play. These findings lend support to the conceptualization of anti-transgender bias experiences and non-affirmation as potentially traumatic events themselves that can directly contribute to the development of posttraumatic stress symptoms. This interpretation is consistent with feminist and multicultural models of trauma and posttraumatic stress (Helms et al., 2010; Herman, 1992), in which bias experiences and non-affirmation are conceptualized as insidious trauma and violations of various psychological and interpersonal security dimensions (Root, 1992). Similar to the ways in which racist experiences "violate one's existing way of making sense of self and the world, [creating] intense fear and destabilization" (Bryant-Davis & Ocampo, 2005; McFarlane & de Girolamo, 1996, p. 485), anti-transgender bias experiences and *particularly* non-affirmation experiences could have similar impacts on transgender people. Additionally, it cannot be ignored that although not always threats of direct physical violence, experiences of bias can threaten livelihoods/income, shelter, medical care, et cetera, and thus can be experienced as violations of even physical dimensions of security. These threats to security, sense of safety, and stability could explain increased risk of posttraumatic stress symptoms, which are typically considered to be maladaptive efforts at rebuilding safety in the aftermath of trauma (Briere & Scott, 2014).

Another way of interpreting these findings is to conceptualize anti-transgender bias experiences and non-affirmation as trauma response triggers. Triggers are internal or external stimuli associated with an individual's trauma memory that when experienced signal threat to the individual or cue re-experiencing symptoms (Foa & Cahill, 2001). Brown (2008) described oppression-based experiences as triggers that remind a person "that someone somewhere is trying to make you and people like you less welcome on the planet" (p.103). As an example, a transgender person might have been traumatically assaulted because of their gender identity or expression, or they may have borne witness to this happening to someone in their community (e.g., vicarious traumatization via social media); some time later, a person mistreating them because of their gender identity or expression (e.g., staring at them, using invalidating pronouns or a slur) may trigger memories or responses related to the traumatic assault, resulting in the persistence of PTSD symptoms.

The Mediating Role of Internalized Transphobia

Our findings also demonstrate that internalized transphobia is a relevant construct when discussing posttraumatic stress in transgender populations. Consistent with our hypotheses and models of shame-based PTSD (Budden, 2009), in which attacks on the social self activate and/or contribute to shame-based understandings of traumatic events, internalized transphobia explained approximately 15% of the relationships between anti-transgender bias and

non-affirmation and posttraumatic stress. Research on shame and trauma implicates internalized stigma in the avoidance of adaptive processing of traumatic experiences (Gold et al., 2009, 2011). We propose that avoidance could be a major mechanism in the relationship found between internalized transphobia and PTSD symptom severity and is worthy of further inquiry. It may also be that transgender people with higher levels of internalized transphobia are less likely to use coping strategies that rely on connection to the transgender community as a method of avoiding triggering a sense of shame (Budge et al., 2013; Lee et al., 2001). This could be impactful, as an emerging body of literature proposes that connection to, support from, and belonging within the transgender community are key factors in trans people's positive mental health outcomes (e.g., Austin & Goodman, 2017; Barr et al., 2016; Bowling et al., 2020).

The statistically significant and meaningful relationships between internalized transphobia and both anti-transgender bias experiences and non-affirmation can be understood through the process of internalizing external stigma (Herek et al., 1999). Transgender people who experience higher levels of anti-transgender bias and non-affirmation are experiencing increased levels of negative messages about being transgender. This is indeed a risk factor for integrating these messages into one's own worldview and view of oneself (Feinstein et al., 2012).

Study Limitations and Future Research Directions

An important limitation to the current study is the restriction of outcome variables to *DSM–5* PTSD symptoms. Many psychologists who study the role of oppression in posttraumatic stress propose a framework of Complex PTSD (e.g., Helms et al., 2010; Richmond et al., 2012, 2017), which includes symptoms and sequelae that expand beyond those contained within the *DSM–5* PTSD diagnostic criteria. By zeroing in on discrete *DSM–5* PTSD symptoms rather than broader Complex PTSD symptoms, we believe we offered particularly strong support to trauma-based frameworks for understanding trans people's experiences. This decision, however, means that our study likely only partially captured the relationships among bias, non-affirmation, internalized transphobia, and mental health. With the current study's findings as foundation, we encourage future studies to examine these relationships with Complex PTSD symptom measures as outcome variables. Future studies could also offer important expansions to our work by modeling protective factors and sources of resilience or other potential moderators. These relationships may be helpful in understanding the experiences of trans individuals who experience bias and/or non-affirmation and other potentially traumatic events but do not report clinically significant trauma sequelae.

Additionally, our study lacked the ability to model and measure participants' multiple and intersecting forms of marginalization (Moradi & Grzanka, 2017). Because we evaluated bias exclusively related to being transgender, we cannot use these data to evaluate the interplay of transgender identity and other sources of oppression. Although this study offers important contributions to the understanding of transgender mental health, future research will be more valuable if it can incorporate analysis of intersecting oppressions and/or disparities. Related, this study's sample was overrepresented by participants who identified as White and non-Hispanic (81%), as well as individuals who were female-assigned

at birth (72%). Trans women of color are more likely to experience bias and trauma than white or transmasculine members of the trans community and may employ resilience strategies unique to experiencing multiple forms of oppression (Singh & McKleroy, 2011). More research is needed to understand whether the relationships we've documented are true across different racial and gender groups. The overrepresentation in our study may in part be attributable to the first author's identity as a white trans man and the limitations of having a research team without BIPOC trans people or trans women and transfeminine people, in terms of earning community trust and interest in participation. More effective representation might be gained by utilizing community-based participatory action research models and/or ensuring that research teams are more representative of the broader community they are working with (Adams et al., 2017).

Finally, there were some limitations related to the Gender Minority Stress and Resilience Measure (GMSR; Testa et al., 2015) and its constructs. Although ultimately it was conceptually beneficial to model Non-Affirmation as a distinct construct, our a priori model (on which we based power analyses) used the original factor-structure of the GMSR; thus, we did not have enough power to enter Non-affirmation as a latent variable and instead treated it as an observed variable. This means that relationships with Non-affirmation could have been attenuated by measurement error in ways that parameters with Anti-Transgender Bias were not. Additionally, scoring protocol for the Victimization, Rejection, and Discrimination subscales of the GMSR are not ideal for research questions like ours. Rather than asking participants to endorse frequency of bias events, scale instructions had participants provide ratings based on whether they had experienced the event at all in certain periods of their lives. To illustrate, in the current study a participant who experienced bias every day could report the same score as a person who experienced a bias event once in the past year. Given that the frequency of the experiences measured is likely relevant to internalized transphobia and PTSD symptom severity, this way of scoring the measures may have weakened the relationships we modeled. For both these reasons, direct comparison of Non-affirmation and Anti-Transgender Bias is inappropriate. We recommend that future studies consider alternative scoring instructions and alternative factor structures for the GMSR.

Clinical Implications

This study's finding that both non-affirmation and experiences of anti-transgender bias are directly and indirectly related to the severity of posttraumatic stress suggests multiple opportunities for interventions that would improve transgender people's mental health. The first is to reduce transgender people's experiences of non-affirmation and bias, which can begin with ourselves as psychologists and mental health providers (Puckett et al., 2018). Unfortunately, many transgender people report experiences of bias and non-affirmation when receiving mental health care (Mizock & Lundquist, 2016; Morris et al., 2020). Clinicians must be diligent in efforts to avoid being perpetrators of bias or non-affirmation against the trans community, particularly those under our care. Such diligence is required of all clinicians, whether they are trans or cisgender, as we all likely have internalized cisgenderism that can lead to perpetration of interpersonal bias and non-affirmation (Ansara & Hegarty, 2012). We recommend that clinicians seek

opportunities to improve their ability to provide affirming services via ongoing training, supervision, and consultation. Clinicians can also play an important role advocating against bias and non-affirmation in the institutions in which they exist (e.g., ensuring access to safe and affirming bathrooms, preventing misgendering in medical records and case discussions, etc.), in clients' larger systems (e.g., families, schools), and at the governmental level (e.g., advocacy related to potential laws).

In addition to working to reduce acts of bias or non-affirmation, our findings suggest that those tasked with supporting transgender people's mental health should facilitate recovery and healing from the impacts of anti-transgender bias and non-affirmation. Our findings support Richmond and colleagues' (2012, 2017) call for thorough assessment of transgender clients' trauma histories and sequelae, including evaluation of the person's experience with bias and non-affirmation. This is consistent with a solidifying standard of best practice. The American Psychological Association's (2015) guidelines for working with transgender populations calls for specific attention to the impact of bias and stigma. Conceptualizing these experiences and the less often discussed experiences of non-affirmation as sources of trauma responses provides a helpful starting point in considering how to approach treatment that adequately addresses their impact. We support Richmond and colleagues' (2012) recommendation to adapt models of trauma recovery for this work. Specifically, clinicians should consider adapting Herman's (1992, 2015) three-stage model of recovery from complex posttraumatic stress. In the first stage of therapy, *safety and stability* are established, first through an affirmative stance and therapeutic bond. This stage might also include facilitating desired steps in gender transitions to alleviate gender dysphoria, building helpful coping and self-care strategies (Richmond et al., 2012), psychoeducation about trauma and/or the impact of bias and non-affirmation, and a strengthening of factors known to increase trans people's resilience capacity (Matsuno & Israel, 2018). In the second stage, interventions focus on *remembrance and mourning*—this could also be considered the processing phase from Foa and Cahill's (2001) Prolonged Exposure treatment model. This stage involves the client naming the traumas they've faced and experiencing and expressing related emotions and thoughts within a relationally warm and supportive therapeutic space (Skinta, 2021). The focus of the third stage is *reconnection*, in which a person works toward greater integration within society or community; this could involve work focused on self-actualization and posttraumatic growth, as well as relationships with others, both within and outside of the trans community.

An area of literature that is particularly relevant to the question of how to clinically address the impacts of ongoing anti-transgender bias and non-affirmation is that of treatment for racism-based posttraumatic stress. A growing number of psychologists have proposed models that range from broad approaches (Bryant-Davis & Ocampo, 2006) highlighting various treatment focuses (e.g., acknowledgment, sharing, mourning, anger, self-care, coping, and resistance) to more specific strategies and protocols (e.g., Williams et al., 2014, 2017). Although review of this literature is beyond the scope of the current study, future work adapting these models to be inclusive of anti-transgender bias and non-affirmation experiences would be of great benefit to the transgender community.

Finally, the mediating role of internalized transphobia indicates that attention to this construct and related distress in psychotherapy

could be of benefit to clients experiencing bias- or non-affirmation-related posttraumatic stress. Strategies for supporting the reduction of internalized transphobia and its impact on mental health include cognitive–behavioral models that emphasize psychoeducation about internalized transphobia, externalizing of stigma, and challenging of negative thoughts about one's transgender identity and history and/or the transgender community (Austin & Craig, 2015; Austin et al., 2017; Israel et al., 2020). A reduction in internalized transphobia can also be achieved through exploration of fragmented and disavowed pieces of the client's ego and/or history (McBee, 2013) which, when done in an empathic and holding relational environment, allows a reconstruction of a cohesive narrative and unified sense of self (Borden, 2009; Fraser, 2009). Finally, group psychotherapy allows for psychoeducation, self-exploration, and naming and challenging of internalized stigma in a context that inherently provides normalization (dickey & Loewy, 2010); it also facilitates connection to the transgender community, which has consistently been found to relate to better mental health in general and decreased internalized transphobia specifically (e.g., Barr et al., 2016; Singh et al., 2011).

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