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Abstract

The present work is aimed at understanding how social environment and interpersonal interactions influence the mental health and well-being of gender-diverse individuals, approaching some of the relevant issues in the field from the perspective of both social and clinical psychology. The first three studies presented in the thesis adopt the perspective of social psychology to investigate the experiences of discrimination faced by transgender individuals in mental health contexts. We will look at the problem from two different viewpoint: the one of psychotherapists and the one of transgender clients that approached mental health services. The first study aims at investigating the role of anti-transgender bias in the psychological assessment of transgender (vs. cisgender) patients in a sample of female sample of licensed psychotherapists. The second study aims at investigating whether microaggressions are perpetrated by psychotherapists when confronted to lesbian or transgender fictitious clients (vs. cisgender heterosexual). The third study assumes the perspective of transgender people accessing mental health contexts. In order to provide an understanding of transgender peoples' help-seeking experiences, the study aimed to investigate their positive experiences of identity microaffirmations within a therapeutic relationship.

The last two studies will be focused on the consequences of minority stress for the mental health and well-being of transgender individuals. The fourth study is inherently clinical and will be focused on the investigation of

personality patterns of medicalized transgender men and women, by evaluating both the dimensional personality domains proposed by the Alternative Model of Personality Disorders and the categorical DSM-IV personality disorder (PD) diagnoses. The fifth study will look at the effects of societal gender norms in a different psychological domain, that is sexuality. In particular, the study will focus on sexual imagery and fantasy, that are key aspects of human sexuality as they are associated with sexual arousal and sexual response.

Introduction

The present work is a collection of the research studies I conducted during the doctoral program in Psychology, Linguistics and Neuroscience at the University of Milano – Bicocca. The main objective underlying all of the studies concerns the understanding of how social environment and interpersonal interactions influence the mental health and well-being of gender-diverse individuals. Throughout the work, I will approach some of the relevant issues in the field from the perspective of both social and clinical psychology. This dual perspective enables to capture the complexity of transgender issues, bearing in mind the different variables intervening in affecting health outcomes.

The importance of social relations for psychological well-being is well documented in literature, dating back to Durkheim (1951), who recognized a link between social isolation and a decreased well-being (Kawachi & Berkman, 2001). Later on, two models were proposed to explain social influences on psychological outcomes (Cohen, Wills, 1985; Kawachi & Berkman, 2001). The first model recognized social support as a stress-buffer. Thus, only individuals exposed to stressors can benefit from social ties. The second model acknowledged the role of social relationships in promoting well-being and mental health, regardless of exposure to stress (Cohen, Wills, 1985). Different aspects of social relations contribute to explain the outcomes of the two models. In particular, social structure would support psychological well-being

independently from stress. Hence, being part of an extended social network or being well-integrated would have a main effect in increasing health. Functional aspects of sociality, such as the perceived support, would be a protective factor when individuals are exposed to stress (Kawachi & Berkman, 2001).

If, on the one hand, sociability is associated with positive outcomes, on the other hand there are many other aspects of social interactions that are considered risk factors for well-being. Social ostracism, social isolation and the effects of prejudice and discriminations could affect mental health negatively. Without getting into the nature vs. nurture debate, it has now become clear that the social environment has a crucial role in shaping opinions and behaviors. Individuals are subjected to social influences for a number of reasons. One reason is that people often conform to social norms to fulfill their need for acceptance and to avoid the negative consequences of social ostracism (Ash, 1955; Baumerister & Leary, 1995; Eisenberg, Lieberman & Williams, 2003). The threat of being ostracized puts enormous pressure on individuals to conform, to be liked and respected by other members of their social group.

Gender is one of the aspects of our identity that is dramatically constrained by society (Butler, 2004). The norm forces to think about gender as binary: women or men, female or male, femininity or masculinity, are presented as juxtaposed constructs. In-between or beyond these two opposite boxes there is no space left for any other gender identity. Every culture and society define what genders should look like prescribing gender roles. Contemporary critical

psychology increasingly adopts an intersectional and interdisciplinary approach to gender, examining how gender intersects with other aspects of identity. Research suggests that there are multiple ways of being cisgender (Richards & Barker, 2014). Although people have choices about how to live and perform their cisgender identities, many people experience pressure to conform to dominant cisgender and (hetero)sexual norms (Richards & Barker, 2014). What happens when you cannot conform to gender norms and societal expectations? Are there consequences for people that break the rules about gender and sexuality? In the present work, I will try to answer these questions from the different perspectives of social and clinical psychology.

The first chapter presents a brief clarification of the terms I will use throughout the thesis. The second and the third chapter introduce the theoretical framework that constituted the basis of the research work. The second chapter focuses on the minority stress model and the third illustrate the recent strand of research about microaggressions. The fourth chapter presents studies focused on discrimination and biases in mental health professionals, with a predominantly social perspective. The fifth chapter has a more clinical focus, exploring how societal norms and believes have influenced some aspects of gender minorities subjectivity. The last chapter of the thesis is intended to draw the conclusions and some final reflections when thinking about all the studies taken together.

1.1 Language use

Language in Gender Studies is particularly important for at least two reasons. Firstly, because researchers in the field have used the same words with different meanings, often conflating the concepts of sex, gender and sexual orientation or mistaken them for each other. Secondly, the common use of many words is often different from the use of the very same words in the field (i.e., sexual identity is commonly used to refer to one's identity as gay, straight, bisexual, etc. that instead is defined as sexual orientation or preference) (Diamond, 2002). For the sake of clarity, I will provide a brief definition of the terms I will use throughout the dissertation.

Sexual Identity

Sexual identity is a complex construct that reflects how an individual perceives themselves on four dimensions: sex assigned at birth, gender identity, sexual orientation and gender role (Shively & De Cecco, 1977).

Sex

We currently refer to sex assigned at birth to what was formerly called "biological sex". Sex is determined by chromosomal asset, gonads, hormones and genitalia of an individual.

1.2 Gender Identity

We refer to gender identity as one's sense of self as belonging to a gender. In many cases, people identify with their gender assigned at birth, in other cases they may feel they belong to the opposite gender or to an alternative gender.

Gender Role

Gender roles and expressions are strictly dependent on the socio-cultural environment individuals belong to. Gender roles refer to all the behavioral norms and societal expectations around gender. For example how men and women are expected to appear, speak, dress, behave, etc. are normed by gender roles.

Transgender

The term "transgender" as an umbrella term to refer to people who do not identify with the gender they were assigned at birth; being transgender is no synonym to suffering from gender dysphoria (APA, 2015; Coleman et al., 2012). "Cisgender" refers, on the contrary, to people who identify with their assigned gender at birth.

Non-binary

Non-binary represents "an umbrella term for any gender (or lack of gender) that would not be adequately represented by an either/or choice between 'man' or 'woman'" (Titman, 2014). Generally, individuals that are represented within this category may identify on a fixed position along a gender spectrum, or they

may move fluidly on the spectrum. Others have no gender or question the very existence of gender (Richards, 2017).

Minority Stress Model

1.3 Health disparities: a brief overview

When comparing sexual and gender minorities to the cisgender heterosexual population, it is possible to observe a recurrent pattern of health disparities. With regard to mental health, gender minorities experience a significant lower state of health when compared to cisgender individuals (Cohn, Casazza & Cottrell, 2018). Psychiatric disorders, such as anxiety and depression, are generally reported to be higher in transgender individuals. Whereas severe psychiatric conditions, like schizophrenia or bipolar disorder, show the same prevalence rates of the cisgender population (Dhejne, Van Vlerken, Heylens & Arcelus, 2016).

Starting from depression, transgender and gender non-conforming individuals report a higher level of depressive symptoms and are more likely to meet the criteria for a clinical significant distress, almost doubling the likelihood of being clinically depressed than cisgender people (Reisner, Katz-Wise, Gordon, Corliss & Austin, 2016), with an incidence of 52% of individuals meeting the criteria for clinical depression counter to 27 % of cisgender population (Reisner et al., 2016). The same pattern could be described for anxiety disorders, with gender minority individuals reporting higher level of anxiety symptoms and being more vulnerable to developing anxiety disorders (Reisner et al., 2016). Gender minority individuals not only

are more exposed to traumatic events throughout their lives but are also more likely to develop a post-traumatic stress disorder (PTSD), with a prevalence rate of 18% of transgender people reporting a PTSD compared to 5 - 10% of general population (Cohn, Casazza & Cottrell, 2018; Shipherd, Maguen, Skidmore & Abramovitz, 2011). Suicide attempts rates are also dramatically high in the transgender population, ranging from 18% to 45% compared to 2.7% of the general population (Haas, Rodgers, & Herman, 2014 ; Marshall, Claes, Bouman, Witcomb, & Arcelus, 2016; Nock et al., 2008; McManama O'Brien, Liu, Putney, Burke & Aguinaldo, 2018). Furthermore, the risk for committing suicide increases of 20% when individuals lack a supportive environment (Hatzenbuehler, 2011). Transgender people are also at higher risk for nonsuicidal self-injury in both youth and adults with rates ranging from 19% to 41.9% (Claes et al., 2015; Davey, Arcelus, Meyer, & Bouman, 2015; dickey, Reisner, & Juntunen, 2015; Marshall et al., 2016). Transgender individuals are also more vulnerable to substance use, with more elevated prevalence of alcohol and drug use compared to cis people (Keuroghlian, Reisner, White, Weiss, 2015; Cabaj, 2014). When exposed to high level of discrimination and violence, transgender women were three to four eight times more likely to be alcohol or drug users (Nuttbrock et al., 2014). Gender minority individuals have also been found to report higher rates of eating disorders and obesity compared to their cisgender counterparts (Diemer, Grant, Munn- Chernoff, Patterson, Duncan, 2015, Van Kim, 2014, Friedriksen-Goldsen et al., 2014).

1.4 Minority Stress as a causal factor

The Minority Stress Model offers a conceptual framework to explain health disparities in transgender individuals (or other marginalized identities) when compared to the cisgender general population (Herek, Chopp & Strohl, 2007). The theory posits that being part of a marginalized group exposes individuals to prejudice and discrimination which are conceptualized as unique kind of stressors. These stressors constitute the minority stress (Meyer, 2003). I do prefer to use the word marginalized instead of minority intentionally as groups or identities that are marginalized and exposed to discrimination do not necessarily represent a minority, for example women.

Marginalized identities, namely LGBT individuals, are exposed to minority stress in addition to the general stressors that are correlated to life events that everybody experiences, which make this stress unique. Moreover, minority stress is defined as chronic, for its relatively stable nature, and socially-based, as it stems from social structures and norms (Meyer, 2003, 2007). Minority stress affects mental health and general well-being throughout two types of processes that can be described as opposite poles on a continuum that goes from distal stressors to proximal stressors. Meyer (2003; 2007) describes the process of minority stress on different levels from distal to proximal: (1) external objective stressful events (chronic and/or acute), (2) expectations of negative experiences, (3) concealment of sexual identity, and (4) internalized transphobia (or homophobia). It is important to remind that

individuals may belong to different marginalized groups at a time (i.e. transwomen of color). Thus, for some LGBT individuals, additional stressors unique to some groups may be added together (i.e. a transgender woman can identify as intersex and lesbian). Objective conditions and events, such as violence and overt discrimination due to the individual's marginalized status, are defined as distal stressor. Discriminatory events undergo a subjective cognitive appraisal and emotional evaluation, which establish the psychological relevance of others' negative attitudes. Proximal stressors stem from these subjective perceptions and appraisals, and are therefore strictly connected to one's self-identity as a minority. For example, a woman may have a transgender history without necessarily identifying as transgender. Nonetheless, she may be perceived by others as trans and being discriminated against for being trans (distal stressor). On the other hand, a transwoman who strongly identifies as trans may be extremely affected by internalized negative societal attitudes (proximal stressor). To summarize, being part of a gender (or sexual, ethnic, etc.) minority exposes people belonging to that marginalized group to an additional amount of stress that impacts their well-being (see Figure 1). Minority stressors may be correlated to external events (distal stressors) or may occur as a consequence of self-identification as a minority member. It is important to acknowledge that a minority identity does not yield just negative consequences. Resilience, coping strategies and other individual characteristics may also impact mental health positively (Meyer, 2003; 2007).

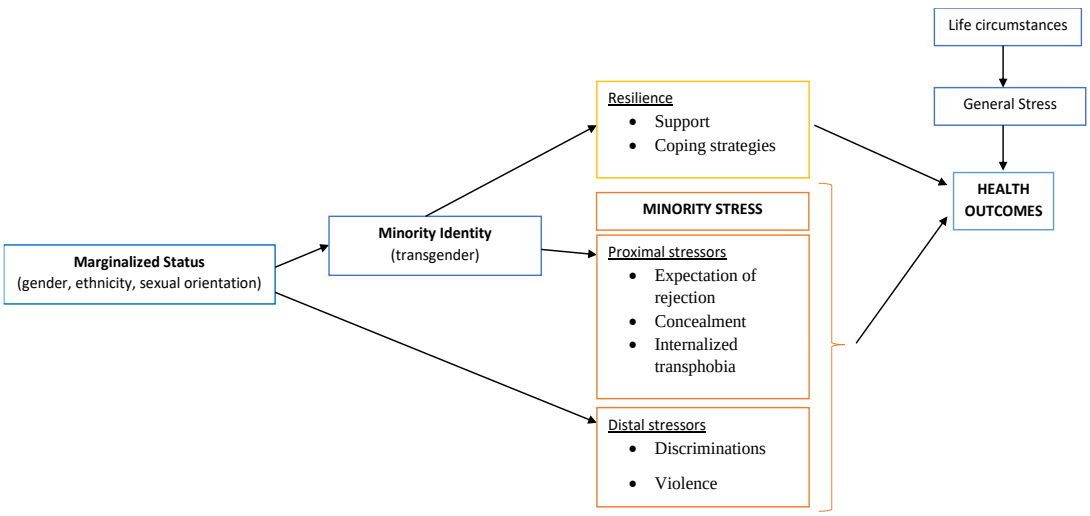


Figure 1. Minority Stress Model. Adapted from: Meyer (2007) *Prejudice and Discrimination as Social Stressors.*

1.5 Gender Identity as a facet of Social Identity

As mentioned above, some of the processes explained in the minority stress model are mediated by the person's marginalized identity. Gender identity can be perceived as one of the facets of individuals' social identity, that is being a member of the group of cisgender women, cisgender men, or transgender identities. Group identities are a relevant part of the people's emotional functioning as they respond to basic needs for affiliation.

Certain characteristics of a marginalized identity may affect mental health. The mere group membership, for example as a transgender person, may have a direct effect in causing distress. Thus, every negative response from others towards one's self-identity impacts well-being. Differently, a minority identity might also have an indirect effect altering the outcomes in terms of mental health. In this case, for example, the more the minority identity is salient

for a person, the more negative the impact of minority stressors can be. On the contrary, it may also occur that a strong minority identity can strengthen the sense of community support for some individuals and then buffer the effects of stressors. In particular, there are three dimensions of group identity, in this case gender identity, that moderate the effect of stress on mental health outcomes.

Firstly, the prominence (or salience) of the gender identity may have a role in moderating stress. A simplistic way to observe the problem is that the more an individual has a strong trans identity the more they might be impacted by a discriminatory event (Thoits, 1999; Meyer, 2007). However, the salience of identity is not stable and fixed, but it may vary depending on the social context (Brewer, 1991). Not only the salience of identity varies based on the social environment the individual is situated (i.e., being in a gay bar vs. being at work) but also it may vary based on the life-cycle phase the individual is navigating (Nealy, 2017). For example, for a transgender youth who is facing a coming out process with their family and peers, gender identity might be a very salient part of their identity, compared to an adult who already navigated through this phase.

Secondly, the valence of the identity refers to the evaluating component of one's marginalized identity. Negative valence, closely linked with internalized transphobia, has been correlated with mental health issues.

Finally, the last dimension is the integration of the identity under consideration with other identities of the individual (Meyer, 2007). A

transgender identity poorly integrated with the general identity of the individual results to be negatively correlated with well-being.

1.6 Minority stress: distal factors

Several studies, carried out both in the United States and in Europe, have shown that transgender people — more so than any other sexual minority group (Browne & Lim, 2008) — are often victims of discrimination, harassment, or violence as a result of social stigma (Bockting et al., 2013). This can take the form of overt physical violence and even lead to murders (Harper & Schneider, 2003; Prunas et al., 2015). Transphobic violence has indeed reached alarming proportions in Italy, which is the second European country in the number of homicides of transgender people, according to a recent report from Transgender Europe (2016).

A National US survey on violence against transgender people revealed that 48% of respondents had been victims of assaults, and 78% had experienced verbal harassment (Wilchins, Lombardi, Priesing & Malouf, 1997). Other studies conducted in the US found that 43% of participants had been victims of violence or crime, with 75% attributing the motive to either transphobia or homophobia (Xavier, 2000). Similar results were also found in a large survey carried out across several European countries (Turner, Whittle & Combs, 2009).

The most recent study carried out by the European Union Agency for Fundamental Rights (2014), involving over 6.000 self-identified trans participants from 28 countries showed that more than half of the whole sample

of respondents (54%) felt discriminated against or harassed in the year preceding the survey because they were perceived as trans. At the present time, the EU Agency launched a second investigation on the experiences of lesbian, gay, bisexual, trans and - for the first time - intersex people across Europe (FRA, 2019). Results will be published in 2020.

For people belonging to sexual minorities, stigmatization, discrimination and harassment invade all arenas in life, including where people usually spend most of their time: at work (Pichler & Ruggs, 2015). In the European Union Agency for Fundamental Rights report (2014), work was found to be the area of social life in which the likelihood of being discriminated against was higher, with 37% of trans respondents reporting discrimination when looking for a job, and 27% discrimination at work. Breaking down the whole sample in subgroups, transwomen and people who self-identified as transgender were found to be particularly at risk for discrimination when looking for a job and at work. Looking at respondents' nationalities, the Italian respondents reported a prevalence of discrimination in the workplace of 22%, while 43% of them felt discriminated against while looking for a job. Other areas of social life that are particularly at risk for discrimination are education and healthcare. Twenty-nine percent of students reported having been harassed by school personnel. One in five respondents (22%) who accessed healthcare services in the previous year reported being harassed by medical personnel. Often the openness about being trans is correlated with a higher chance of being victim of discrimination and

harassment (FRA, 2014). These episodes are not just inherently negative, but they have significant consequences. Mistrust and discouragement in authorities lead trans people not to report episodes of discrimination because they think that nothing would change anyway (62%), because they are used to be victims of harassment (47%) and because they fear they won't be taken seriously (40%) (FRA, 2014). Additionally, the situation concerning health is even more alarming. Previous negative experiences lead to avoid seeking psychological or medical help for being trans. Participants declared not to dare to consult a professional (30%), and to be afraid of prejudice from the healthcare providers (23%) (FRA, 2014).

Among the reasons why transgender people are exposed to more stigma and discrimination than the LGB group is the fact that, while it is possible to hide one's own sexual orientation, gender expression is much more difficult to conceal.

1.7 Minority stress: proximal factors

As mentioned above, discrimination and victimization represent external processes and experiences faced by transgender individuals. It is likely that transgender individuals also experience internal stressors: 1) expectations of rejection, 2) concealment, and 3) internalized transphobia. Proximal stress processes are subjective and therefore more affected by one's identity as transgender (Meyer, 2007). These three proximal stressors can be defined along a continuum that progressively describe internal processes closer to the self.

Expectations of rejection

Expecting rejection is described in literature as a form of perceived stigma that entails the anticipation of being stereotyped or discriminated against in a given situation as a result of on one's marginalized status (Rood et al., 2016). Expectation of rejection is associated with higher levels of psychological distress and investment in passing (Bockting et al., 2013). "Passing" is a term that has been used to describe transgender people that live as member of the opposite gender trying to "pass" for cisgender people, living highly closeted. It has been hypothesized that high investment in passing could represent a limit in identity affirmation and positive self-evaluation (Bockting et al., 2013). Expectation of rejection is reported to be pervasive and often triggered by situations that include gender markers and the binary system (public restrooms, request of identification), public spaces, employment and work settings, and with people that knew the individual pre-transition (Rood et al., 2016).

Transgender individuals describe going through the expectation of rejection as an anxious and stressing experience that elicit fear, worry about their safety or violence and feeling of alert (Rood et al., 2016). As mentioned in the previous paragraph, these experiences are not just distressing but they may bring negative consequences, such as avoidance or safety behaviors or the adoption of maladaptive coping strategies (i.e. alcohol or substance use) (Rood et al., 2016).

Concealment

As expectation of rejection, identity concealment represents a proximal stressor in Meyer's (2003) minority stress model. Identity concealment is a psychological construct that has been introduced to distinguish between the experiences of those who possess a stigmatized trait that is obvious to others, namely being a member of a racially stigmatized group, and those individuals that possess a concealable stigma (i.e., being gay or transgender) (Pachankis, 2007). Even though it might seem easier for individuals with a concealable identity to navigate through life avoiding prejudice and discrimination, they may also face significant stressors (Pachankis, 2007). One of the challenges faced by individuals with a concealable stigma is choosing whether, when, and how to disclose their identity in every new situation they might encounter (Pachankis, 2007). For transgender individuals, concealment of identity has specific implications when compared to cisgender individuals. Some transgender people may decide to actively "pass" (see § Expectations of rejection) by trying to modify or conceal some aspects of their appearance or behaviors. Instead, other individuals may consider more important to express their true gender, although not conforming to social norms may expose them to negative reactions (Rood et al., 2017).

Passing and concealment are strictly related constructs but they do not overlap completely as individuals might try to conceal their trans identity without passing, or on the contrary, not trying to conceal their identity but pass

instead (Rood et al., 2017). The term passing has recently been replaced by "recognition" or "blending", considered to be more affirming terms. Passing/blending might be an important safety resource to avoid distal stressor in certain environments. However, the importance of passing/blending might vary over time and across different contexts (Rood et al., 2017).

Internalized transphobia

The most proximal position along the continuum is represented by internalized transphobia. Experiencing distal stressor may have an impact on trans individuals' acceptance of their gender identity and their well-being. In particular, internalized transphobia is described as the personal acceptance of the stigmatized identity in one's value system (Herek, Gillis & Cogan, 2015; Austin & Goodman, 2017). In other words, the internalization of societal negative attitudes towards transgender individuals leads to self-devaluation, internal conflicts and low self-esteem (Bockting et al., 2013; Meyer, 2007). Rood and coll. (2017) reviewed the recent literature that investigated internalized transphobia with quantitative methodology. Quantitative research mainly investigated the association between self-stigmatization and psychosocial health indicators, highlighting a correlation between internalized transphobia and psychological distress (Breslow et al., 2015), ineffective coping strategies (Mizock & Mueser, 2014), uncertainty and inconsistency of one's self concept (Reyes et al., 2016), higher rates of suicide attempts, depression and

anxiety (Perez-Brumer, Hatzenbuehler, Oldenburg & Bockting, 2015; Testa, Habart, Peta, Balsam & Bockting, 2015).

As for qualitative research, internalized transphobia has been investigated mainly in studies that primarily focused on other constructs, but that highlighted important aspects of the problem. Literature shows how resilience may intervene in buffering the effects of societal negative messages on one's self (Singh, Hays & Watson, 2011). Experience of negative social messages have a distressful emotional impact on transgender people, as in-depth analysis of trans individuals' experience revealed that internalizing negative messages could also be linked to risky behaviors, such as substance use or sexual risk behaviors (Nemoto, Operario, Keatley & Villegas, 2004; Reisner, Perkovich & Mimiaga, 2010; Rood et al., 2017).

1.8 Resilience

Resiliency pertains to the resources and the learned behaviors that an individual could deploy to navigate a stressful situation (Harvey, 2007; Singh, Hays & Watson, 2011). Meyer's minority stress model includes both individual and group-level resilience that would intervene in buffering the detrimental effects of stigma LGBT people are exposed to. Thus, a marginalized status is associated not only with stress but also with positive resources that protect the individual from the adverse effects of minority stress on mental health (Meyer, 2007). Social and community support appear to be a particularly relevant protective factor for transgender individuals. In particular, social support

resulted to be associated with the use of positive coping strategies (i.e., humor, gender affirming psychotherapy, hobbies, etc.), a decrease in psychological distress related to minority stress and positive health outcomes (Budge et al., 2013; Sanchez & Vilain, 2009; Grant et al., 2011). For example, a good support network has been shown to be important to learn about medical resources and to have a discussion about political concerns (Pinto, Melendez & Spector, 2008). On the contrary a lack of social support has been correlated to risky sexual behaviors in transwomen (Golub, Walker, Longmire-Avital, Bimbi, & Parsons, 2010), and depressive symptoms and anxiety (Nemoto Bödeker & Iwamoto, 2011; Pflum, Testa, Balsam, Goldblum & Bongar, 2015). Social support is generally intended as the individual's network of friends, family and romantic relationships, but another relevant resource for transgender individuals is represented by trans communities. Transgender individuals look for support from their peers to validate their emotions and experiences related to discrimination (Pflum et al., 2015). Trans-peer support resulted to buffer the associations between stigma and depression and anxiety symptoms (Pflum et al., 2015). The relationship between different resources of social support (i.e., family, peers) and positive health outcomes may vary among cultures. Family support contribute to explain positive mental health outcomes relevantly for Italian transgender people (Scandurra et al., 2017); differently, American transgender communities rely more on peer than family support (Bockting et al., 2013; Scandurra et al., 2017).

As for individual factors that foster resilience in transgender adults, literature has identified the definition of one's gender identity, and embracing the fluidity and evolving nature of self-definition (Sigh et al., 2011; Singh, Meng & Hansen, 2014). "Trans adults indicated that intentionally attending to issues of self-worth, while also maintaining an awareness of transphobia and trans prejudice in the world, was the basis for their resilience" (Singh et al., 2014).

Microaggression Theory[1]

1.9 Microaggression Theory: key concepts

The overt forms of distal stressors described in the minority stress model, such as violence and explicit negative attitudes towards marginalized groups, have become less socially acceptable. Prejudice and discriminations have transformed into more subtle and implicit forms. “Microaggressions are the brief and commonplace daily verbal, behavioral, and environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial, gender, sexual-orientation, and religious slights and insults to the target person or group” (Torino, Rivera, Capodilupo, Nadal and Sue, 2019, p. 5). This definition comprises all of the key concepts developed within the microaggression theorizing. Firstly, microaggressions communicate prejudice and biases that can be delivered implicitly or explicitly through various communication channels (Sue, 2010). Secondly, these aggressions are delivered just because of the marginalized status of the targeted individual or group. And thirdly, this kind of assaults differ from overt forms of discrimination and violence that occur more sporadically, because of their everyday nature.

[1] This section consists of the partial authorized reproduction of: Anzani A. (2019). “You look good, I would never tell you are trans!”. A Literature Review on Microaggressions against Transgender People. *PuntO.org International Journal.*

Microaggressions have been categorized on the basis of their manifestations in three subtypes: microassault, microinsult, and microinvalidation (Sue, 2010). Microassaults are conveyed in most cases consciously and deliberately to attack and explicitly hurt the individual or the group identity. The ultimate goal of these messages is to threaten the target individual or group or to demean them (Sue, 2010). Microassaults are quite similar to heterosexist and transphobic forms of discrimination with an essential distinction. Whereas both microassaults and discriminative behaviors consist in overt and deliberate acts, microassaults are more likely to be expressed under conditions that offer some sort of safeguard to the perpetrator (Sue, 2010). When some degree of anonymity is present, or when perpetrators are in the presence of people that share their same believes and values, some kind of protection is ensured. Another situation in which people engage in microassaults and publicly display a biased attitude is when they lose control of their feelings (i.e. anger outbursts).

Microinsults are behaviors or messages that most of the time are outside the perpetrator's awareness (Sue, 2010; Torino, Rivera, Capodilupo, Nadal and Sue, 2019). The underlying sense of these communications is insulting, rude or insensitive of the person's identity. Microinsults often refer to stereotypes. For example, a person that comments on a good-looking transwoman something like "You must have dated a lot of guys". This message layers two meanings: probably, the intention of the person was to make a compliment on their

appearance, but the second meaning relies on the stereotype that transwomen are hypersexual and have a promiscuous sexual life.

Microinvalidations are messages that exclude or deny the personal experience, emotions or thoughts of an individual (Sue, 2010; Torino, Rivera, Capodilupo, Nadal and Sue, 2019). These comments could be intentional or unintentional and are directed to undermine the other person's experience. Comments like "You're just too sensitive! I'm not being transphobic" or "You talk about discrimination all the time" are examples of microinvalidations.

1.10 Literature on microaggression toward TGNC people

The last few years have been characterized by a flourishing body of literature on transgender microaggressions that empirically supported the theoretical work carried out at the beginning of the last decade on transgender experiences of microaggressions (Sue, 2010; Nadal, Rivera, Corpus, 2010).

The credit for having clearly defined a taxonomy of microaggressions towards TNGC people goes to Nadal and colleagues (2012). Using a qualitative approach, Nadal and coll. (2012) identified specific themes in TGNC individuals' experiences of microaggressions. The direct content analysis they carried out revealed 12 themes: using transphobic or incorrectly gendered terminology (1); the assumption of a universal transgender experience (2); exoticization (3); discomfort/disapproval for transgender experience (4); endorsement of gender normative and binary culture or behavior (5); denial the

existence of transphobia (6); assumption of pathology or abnormality (7); physical threat (8); denial of individual transphobia (9); denial of bodily privacy (10); familiar microaggressions (11); systemic microaggressions regarding the use of public restrooms, the criminal justice system, health care and identification documents (12) (Nadal, Skolnik and Wong, 2012; Nadal, Whitman, Davis, Erazo, Davidoff, 2016).

Another line of research has explored the experiences of microaggressions of TGNC people in different relationship contexts. With regard to friendships, Galupo, Henise, and Davis (2014), using a mixed-method study, highlighted that there is a different propensity in perpetrating microaggressions across the sexual orientation and gender identity of a friend. Cisgender heterosexual friends are most frequently behaving micro-aggressively, but participants reported the most hurtful experience was when the microaggression came from a friend with a similar identity (Galupo, Henise, Davis, 2014). Microaggressions that come from a friend are especially detrimental since they are experienced as particularly upsetting (Galupo et al., 2014), and interpersonally aggressive (Chang, Chung, 2015).

Pulice-Farrow, Clements and Galupo (2017) described and compared the experiences of transfeminine, transmasculine, gender nonconforming and agender individuals with microaggressions that occurred from a close friend. Across all four gender identities, three main themes emerged with different connotations. The first theme enclosed all the situations in which the “realness”

or the authenticity of an individuals' identity was questioned or challenged (Pulice-Farrow, Clemens and Galupo, 2017). The patterns of microaggressions challenging authenticity differ between binary and non-binary identities: while binary identities are questioned about not being "real women" or "real men", non-binary identities are doubted about being "real trans" (Pulice-Farrow, Clemens and Galupo, 2017). The second theme identified in friendship relationships refers to visibility and included passing (being seen as a cisgender person), or the use of incorrect pronouns. This theme emerged as transition-dependent, namely people report a change in experiencing microaggressions depending on the stage of transition they were navigating. Again, differences emerged between binary identities who were misgendered by being referred to with their gender assigned at birth, and non-binaries who were misgendered using a binary language (Pulice-Farrow, Clemens and Galupo, 2017). Also, transfeminine people reported discrimination in spaces designated for women only, while transmasculine people reported an increased social power and privilege, and non-binary identities reported being passively rejected and a push-back experienced especially in feminist contexts (Pulice-Farrow, Clemens and Galupo, 2017). Transgender microaggressions within friend relationships impact the closeness and trust toward the friend, leading to disruption of social support (Galupo, Henise, and Davis, 2014).

Another acknowledged resource for transgender mental health and well-being is romantic relationships (Meier, Sharp, Michonski, Babcock and

Fitzgerald, 2013). Thus, experiencing microaggressions within a romantic relationship might have a very negative impact, given the importance and the closeness of the relationship (Pulice-Farrow, Brown and Galupo, 2017). A qualitative study by Pulice-Farrow, Brown and Galupo (2017) showed interesting findings: although microaggressions are defined as especially detrimental for their day-to-day nature, the authors found that, in romantic relationships, even single, isolated events could have a tremendous impact. The study highlights how the pervasiveness of gender binary assumptions of the partner affected all aspects of the relationships, from expectations during sexual intimacy to the experience of gender role behavior within the relationship (Pulice-Farrow, Brown and Galupo, 2017). The consequences were not limited to the individuals involved, but affected how they negotiated the relationship when interacting with the outside world (Pulice-Farrow, Brown and Galupo, 2017).

1.11 Emotional, cognitive and behavioral reactions to microaggressions

As microaggression theorists proposed, reacting and responding to microaggressions implies several cognitive and emotional processes (Sue et al., 2007; Nadal, Davidoff, Davis and Wong, 2014). The double-messages underlying a microaggression might complicate the process. In fact, experiencing an unpleasant situation or event triggers targeted people to try to understand if the “incident” was motivated by their gender (or sexual, ethnic,

etc.) identity or not, eventually deciding how to respond (Sue, 2010; Nadal et al., 2014). A qualitative study conducted by Nadal et al. (2014) investigated the process that TGNC people undergo when they experience microaggressions, focusing on their emotional, cognitive and behavioral responses. As regard to emotions, a microaggression triggers feelings of anger, betrayal, distress, hopelessness and not being understood (Nadal et al., 2014). Cognitively, participants reported to deal with the struggle of these ambiguous situations with rationalizations, vigilance and self-preservations (Nadal et al., 2014). On the one hand, these cognitive strategies could assure safety and be very adaptive in some contexts to navigate a hostile social environment; on the other hand, repeated episodes of microaggressions could elicit an expected response of discrimination. The result of this process is a hypervigilant attitude that leads the trans person to search for hostility (vs. safety) clues in every context (Sue, 2010). Behaviorally, trans people adopt three main strategies to cope with microaggressions: direct confrontation, indirect confrontation and passive coping. A direct confrontation consists in reacting to a microaggression with some sort of verbal assertion: from providing education, correcting the use of improper language or pronouns to stronger reactions in replying to more explicit transphobic comments (Nadal et al., 2014). Indirect confrontations consist in establishing clear boundaries, clarifying that any inappropriate trespass will not be tolerated. A more passive coping strategy consists in

avoiding situations in which there could be a direct or indirect confrontation (Nadal., 2014).

1.12 Impact of microaggression on health and implications for clinical practice

Microaggression theory and research yield several implications for clinical practice. The continuous experience of microaggressions and overt discrimination in several contexts of their lives may have a detrimental impact on trans people physical and mental health. Unfortunately, literature that specifically focus on the impact of microaggressions in the transgender population is lacking, but it would be fair to hypothesize such negative consequences according to two scientifically-based arguments. Firstly, the negative impact of microaggressions has been reported for other marginalized groups (i.e., sexual minorities and racial-ethnic minorities) (Owen, Tao and Drinane 2019, pp 69-70). A review conducted by Owen, Tao and Drinane (2019), that included 21 studies investigating the consequences of microaggressions on mental health of diverse minorities, reveals that microaggressions are associated with several aspects of psychological functioning: depressive traits, self-esteem, anger, substance use, psychological distress and well-being, rumination and stress (Owen, Tao and Drinane 2019).

Secondly, although the consequences of microaggressions have not been studied in isolation for the trans population, there is compelling evidence of the impact of overall discrimination on mental health and well-being (Anzani,

Prunas, Sacchi, 2019). The higher risk for mental disorders, such as depression, anxiety, suicide risk in transgender people have been widely demonstrated in studies based on the minority stress model (Bockting, Miner, Swinburne Romine, Hamilton and Coleman, 2013; Budge, Adelson and Howard, 2013; Tebbe and Morandi, 2016). However, these studies did not separate the effects of overt forms of biases from more subtle and indirect microaggressions. Further investigations are necessary to study the different impact of these forms of discriminations in transgender population.

Thus, understanding how minority stress (including microaggressions) impacts trans peoples' lives becomes essential in clinical practice (Nadal, Skolnik and Wong, 2012). Psychologists should offer a non-judgmental environment and must be careful to not replicate in the clinical setting microaggressions trans people are already exposed to. Making a step further, mental health professionals could also provide coping strategies and support in dealing with and overcoming such discrimination (Nadal, Skolnik and Wong, 2012). The acknowledgment of hetero-cis-normativity (Worthen, 2016), as the backdrop of the social world we live in, could represent a first step in this direction (Anzani, Morris and, Galupo, in press).

Another important aspect to keep in mind both in research and in clinical practice concerns intersectionality. Social identity is a multifaceted construct that reflects a person's sense of who they are based on their group

membership (Tajfel, 1978). Of course, gender identity is one of the salient variables that constitute an individual's social identity, but it is not the only relevant one. Ethnicity, race, sexual orientation, social class and religiosity are some of the other facets of social identity. An intersectional approach in psychological research tries to consider this complexity (Cole, 2009). The intersection between different facets of social identity might results in a conflict, i.e. being trans and have a strong catholic faith (Nealy, 2017). It could also be that an individual is part of different marginalized groups (i.e., an African American transgender woman). In this sense, intersectionality has particularly relevant implications. In clinical practice, it is important not to focus on one single element of social identity but consider the individual as a whole. A person with multiple characteristics, that might be in conflict among each other or that make the client more vulnerable to develop health disparities (Sue, 2010).

Anti-transgender discrimination and biases in mental health professionals

The studies presented in this chapter adopt the perspective of social psychology to investigate the experiences of discrimination faced by transgender individuals in mental health contexts. We will look at the problem from two different viewpoint: the one of psychotherapists and the one of transgender clients that approached mental health services.

The first study aims at investigating the role of anti-transgender bias in the psychological assessment of transgender (vs. cisgender) patients. To this purpose, a female sample of licensed psychotherapists (N = 218) was presented with clinical vignettes that described a transgender (vs. cisgender) man (vs. woman) reporting depressive symptoms or anger outbursts. Participants were asked to evaluate the fictitious patient answering questions on their diagnostic impressions (e.g., psychopathological severity). Moreover, the respondents' individual variables (i.e., right-wing authoritarianism) were also assessed.

The second study aims at investigating whether microaggressions are perpetrated by psychotherapists when confronted to lesbian or transgender fictitious clients (vs. cisgender heterosexual). A sample of 135 licensed psychotherapists (110 women, 25 men) agreed to participate in the study. Participants were presented with an audio file of a woman (trans vs. lesbian vs. heterosexual) introducing herself during the first session with a therapist. They

were asked to listen carefully to the audio in order to complete a questionnaire. Participants were asked to assess the relevance (from 1 “not relevant at all” to 7 “extremely relevant”) of 10 questions (5 neutral and 5 microaggressive), that once asked the client would allow them to have a better understanding of the case in order to form a clinical impression. Participants were more prone to consider as relevant microaggressive questions if the sexual identity of the client was of a lesbian or a trans woman. In particular, microaggressions were perpetrated significantly more towards the lesbian and the transgender client compared to the heterosexual one. Not only the microaggressions were perpetrated more, but also the neutral questions were considered less relevant for the trans client than for the heterosexual client.

The third study assumes the perspective of transgender people accessing mental health contexts. In order to provide an understanding of transgender peoples’ help-seeking experiences, the study aimed to investigate their positive experiences of identity microaffirmations within a therapeutic relationship. Sixty-four transgender participants answered an open-ended question online regarding their experience of gender identity-based affirmations in therapy. Using thematic analysis, responses were evaluated and four main themes were identified: 1) absence of microaggressions, 2) acknowledging cisnormativity, 3) disrupting cisnormativity, and 4) seeing authentic gender.

1.13 Study 1 – Facing Transgender and Cisgender Patients: The Influence of The Client's Experienced Gender and Gender Identity on Clinical Evaluation[2]

Introduction

Transgender and gender nonconforming (TGNC) people are frequently exposed to the effects of anti-transgender prejudice (Pflum, Testa, Balsam, Goldblum & Bongar, 2015). Prejudice towards TGNC individuals may take the form of gender discrimination, harassment or violence, and transgender people are exposed to this kind of experiences more often than any other sexual minority group (Browne & Lim, 2008). Scientific studies have consistently been reporting that violence and overt forms of discrimination against transgender people are a public health concern worldwide, in particular against transwomen (Bockting, Miner, Swinburne Romine, Hamilton & Coleman, 2013; Fernández-Rouco, Fernández-Fuertes, Carcedo, Lázaro-Visa & Gómez-Pérez, 2017; Grant, et al., 2011; Kosciw, Greytak, Bartkiewicz, Boesen & Palmer, 2011; Langenderfer-Magruder et al., 2016; Rodríguez-Madera et al., 2017). A recent report from Transgender Europe (TGEU, 2016) has shown that, among European countries, Italy holds the second highest rate of murders of trans people after Turkey. It has also been shown that Italian trans people face

[2] This section consists of the authorized reproduction of: Anzani, A., Prunas, A., & Sacchi, S. (2019). Facing Transgender and Cisgender Patients: the Influence of the Client's Experienced Gender and Gender Identity on Clinical Evaluation. *Sexuality Research and Social Policy*, 1-9.

discrimination in the workplace or accessing the healthcare system, and that 36% of them claim to be victims of violence (Prunas et al., 2016).

The Minority Stress Model (Meyer, 2003) provides a conceptual framework to explain the negative outcomes of discrimination on physical and mental health in the TGNC population (see Chapter 2).

It must be pointed out that, although a non-heterosexual sexual orientation can be kept undisclosed, transgender identity is often clearly visible, which makes transgender people more easily targeted. Dichotomic norms pertaining to gender and sex are highly internalized in Western societies (Tauches, 2006). Sometimes these beliefs are so ingrained that they activate the perception of threat once they are challenged. Transgender people are particularly vulnerable to discrimination and harassment because transgender experience not only violates the sexual dichotomy (heterosexual – homosexual), but also gender norms, namely, social expectations about male and female roles and their gender expressions (Tauches, 2006).

Research has shown that mental health professionals are not immune from negative attitudes towards sexual minorities but, far from this, they clearly show a positive bias for heterosexuals (Bartlett, Smith, & King, 2009; Lingiardi & Capozzi, 2003, 2004). Among sexual minorities, trans people might be more exposed to prejudice than gay or lesbians, even in mental health settings. European surveys show that healthcare services might put trans people at risk for experiences of discrimination, with about one quarter of respondents

reporting ever being discriminated against because of being trans (Prunas et al., 2016). A very large study across European countries that included over 6.000 participants shed light on another problem connected to healthcare services: practitioners seem to lack information on transgender experience (FRA - European Union Agency for Fundamental Rights, 2014). The EU-wide Transgender Eurostudy reported that up to 30% of gender nonconforming people found themselves in situations in which practitioners, in spite of their wish to help, lacked very basic information about trans issues (Whittle, Turner, Coombs & Rhodes, 2008). This lack of information might lead TGNC people to have to educate providers about their own healthcare needs (Grant et al., 2011; Mizock & Lundquist, 2016).

As pointed out in the study by Mizock and Lundquist (2016), TGNC individuals often report other negative experiences in clinical settings, beyond "education burdening". They may feel that the main focus of ongoing therapy is on gender identity, neglecting other relevant aspects of their lives, or on the contrary, avoiding to talk about gender at all; sometimes TGNC patients may perceive that the therapist is trying to fix their "problem" with gender identity or that they approach it as a mental illness (Mizock & Lundquist, 2016).

In Western countries, overt forms of discrimination against TGCN people have increasingly become less accepted and socially desirable (Pettigrew & Meertens, 1995), leaving space for more subtle forms of discrimination. Nadal (2012, 2013) introduced the construct of microaggression to explore the

experiences of transgender people (see Chapter 3). Although microaggressions may appear minimal and harmless when compared to harassment or other direct forms of discrimination, the cumulative effect of several microaggressive experiences can lead to significant psychological distress (Sue, 2010). Also, when microaggressions are perpetrated by helping professionals, whether in mental health, social or healthcare services, this can hinder the establishment of a therapeutic alliance (Sue, 2010). The studies on the attitudes of mental health practitioners towards TGCN people were recently reviewed by Brown, Kucharska and Marczak (2018). Overall, the results of the thirteen reviewed studies seem to suggest positive attitudes towards transgender clients (Brown, Kucharska, & Marczak, 2018). As for the demographic variables that impact attitudes among therapists, most studies report that women have significantly less negative attitudes compared to men (Ali, Fleisher & Erickson, 2016; Bowers, Lewandowski, Savage & Woitaszewski, 2015; Brown et al., 2018; Riggs & Sion, 2016). Furthermore, religiosity and conservative political ideology are negatively correlated with positive attitudes towards transgender clients (Ali et al., 2015; Bowers et al., 2015; Brown et al., 2018). As noted by Brown et al. (2018) in their review, if compared to colleagues from conservative regions, mental health practitioners living in progressive regions or holding liberal political ideology show more positive attitudes towards transgender minorities, they are more prone to support their rights and to receive training on transgender needs (Johnson & Federman, 2014).

The aforementioned recent strand of research mainly focused on health practitioners' explicit attitudes towards transgender people (for instance assessing bias through the Genderism Transphobia Scale, the Transgender Attitudes and Beliefs, the Attitude Towards Transgender Individual Scale; see Brown et al., 2018), thus leaving more subtle effects of prejudice and stereotypes unexplored. Filling this gap, the aim of the present study was to assess the extent to which mental health professionals are biased against transgender clients in the psychological assessment process. To this end, a case description of a fictitious transgender (vs. cisgender) patient was proposed to a large sample of licensed psychotherapists, whose Right-Wing Authoritarianism (RWA; Altemeyer, 1981) was also assessed. The effects of the experimental manipulation on the therapists' clinical evaluations were then investigated. To our knowledge, this approach has never been applied to investigate anti-transgender bias among mental health professionals.

We predicted that transgender patients would be rated as more severe in psychopathology than their cisgender counterparts. We also hypothesized that transgender women would be rated as more severe in psychopathology than transgender men and cisgender patients, as they are subject to a double bias: gender bias and transgender bias. As shown in previous studies, transwomen are more exposed to negative experiences of discrimination and harassment than transmen (Bockting et al., 2013; Grossman, D'Augelli, Salter & Hubbard, 2005; Seelman, 2014). Nevertheless, there is no direct evidence of greater prejudice

towards transwomen than transmen, as the assessment instruments available so far (i.e., Hill & Willoughby, 2005; Nagoshi, Adams, Terrel, Brzuzy & Nagoshi, 2008; Walch, Ngamake, Francisco, Stitt & Shingler, 2012) mainly focus on trans people as a whole group (Worthen, 2013), not allowing to specifically assess attitudes towards transmen and transwomen. When confronted with a cisgender or transgender patient, we expect that, as in every social interaction, therapists will automatically activate stereotypes based on gender as a social category. Stereotype is defined as "a fixed, over-generalized belief about a particular group or class of people" (Cardwell, 1996). Generally, these believes are stable over time and are culturally based (Cardwell, 1996). The automatic activation of stereotypes could have an influence on therapists' clinical evaluation, which not only relies on the overall clinical picture, but also on the stereotypical characteristics of the client's social group. The pernicious and pervasive effects of stereotypes, automatically activated in the presence of relevant behavior or stereotyped-group features, is well-known. The detrimental effect of stereotypes on social perception could trigger a stereotype-consistent behavioral response that is not dependent on an individual's level of prejudice and values (Devine, 1989; Devine & Elliot, 1995). In line with this hypothesis, we expect that transgender women activate negative beliefs about both women and transgender identities, and are thus evaluated more negatively in terms of the severity of their psychopathology. We are interested in a more subtle form of prejudice that cannot be assessed using explicit responses to a questionnaire

measuring anti-transgender attitudes but, rather, could emerge in the biased rating of severity of a fictitious patient. Furthermore, we expect high levels of RWA to moderate the effects of the patient's assigned and experienced gender on the ratings of psychopathological severity. The rationale behind the use of RWA as a moderating variable lays on two reasons. First, the RWA has been shown to be one of the main variables underlying prejudice against minorities, as it measures the individuals' moral values in general, rather than their attitudes towards a specific group (Whitley, 1999; Tsang & Rowatt, 2007). People high in RWA have a strong preference for tradition and social order and are negatively inclined toward deviance and behavior that they consider immoral (Altemeyer, 1998). Thus, RWA does not predict a generic prejudice toward minorities but, specifically, negative attitudes towards groups perceived as threating the values or violating mainstream ways of life (Duckitt, 2006; Rios, 2013). Since previous studies have shown that sexual minorities are stereotyped in terms of threat to traditional moral standards and values (Cottrell & Neuberg, 2005; Madon, 1997), the individual's RWA can be considered a reliable predictor of prejudice towards transgender people.

The second reason is that, in the present study, it was not possible to measure the participants' explicit attitudes towards transgender people, as people working in helping professions might be guarded against openly expressing negative attitudes towards minorities. Furthermore, it would have been pointless to measure explicit prejudice after participants were invited to

read and discuss a clinical vignette about a fictitious patient belonging to that target group.

Material and procedure

Participants.

An a-priori power analysis was conducted for sample size estimation, using G*Power 3.1 (Faul, Erdfelder, Lang, & Buchner, 2007). The power analysis (alpha = .05, power = .90, medium effect size = .30) suggested a sample size of approximately N = 216 for a between-participants ANOVA with eight groups. Thus, a total of 218 female licensed psychotherapists aged 29 to 71 years (M = 46.04; SD = 11.26) participated in the experiment. All the participants were self-identified cisgender, White Italian citizens. To avoid the large effects of respondents' gender observed in previous studies, male psychotherapists were excluded from the study (Steffens & Wagner, 2004). All participants provided written informed consent to participate. The procedure was approved by the University Ethics Committee and was in accordance with the ethical standards of the 1964 Declaration of Helsinki. Demographic characteristics of the study sample are summarized in Table1.

Table 1. Demographic characteristics of the study sample N = 218

	%	N
Sexual Orientation		
Asexual	0.9	2
Bisexual	1.8	4
Heterosexual/straigth	83	181
Lesbian	1.8	4

Sexual Attraction		
Exclusively men	72.5	158
Mostly men but also women	10.6	23
Equally men and women	0.9	2
Mostly women but also men	1.4	3
Exclusively women	2.3	5
Neither men nor women	0	0
Post-graduation		
Doctorate	5.5	12
Master	33.6	73
Psychotherapy training	83.5	182
Other	20.7	45
Theoretical orientation		
Cognitive - Behavioral	19.3	42
Cognitive	3.7	8
Systemic	15.6	34
Psychodynamic / Psychoanalytic	32.6	71
Eclectic	6.4	14
Other	17.9	39
Sexology education		
Yes	11.5	25
Years of practice		
1 - 5	40.9	88
6 - 10	19.1	41
11 - 20	13	28
21 +	9.3	20

Clinical vignettes

The vignettes described the clinical picture of a fictitious patient, with symptoms ascribable to a mood disorder (major depression) or an impulse control disorder (intermittent explosive disorder), and included some biographical information and clinical history. The two vignettes were adapted from the DSM-IV-TR casebook (Spitzer et al., 2002). The disorders selected were previously pretested as stereotypical of women (major depression) and men (intermittent explosive disorder). For each of the two disorders, four

clinical vignettes were elaborated, by varying the patient's experienced gender (man vs. woman) and gender identity (cisgender vs. transgender). The clinical vignettes referring to transgender patients presented the following final sentence: "Mrs./Mr. P. was assigned male/female at birth, but she/he successfully underwent gender-affirming surgery over 15 years ago." Apart from this detail, the cisgender and transgender versions of the clinical vignettes were identical.

Thus, the experimental design consisted of a 2 (experienced gender: man vs. woman) X 2 (gender identity: cisgender vs. transgender) X 2 (disorder: depression vs. intermittent explosive disorder) between-participants design. Each participant was randomly assigned to one of the following eight clinical scenarios: transgender man with depression, cisgender man with depression, transgender man with intermittent explosive disorder, cisgender man with intermittent explosive disorder, transgender woman with depression, cisgender woman with depression, transgender woman with intermittent explosive disorder, or cisgender woman with intermittent explosive disorder.

Procedure

The regional boards of psychologists across the Country were contacted to achieve the highest possible visibility of this research project among their members. Female psychotherapists were then contacted by an e-mail presenting the project and asking for their participation. After providing informed consent, participants received a link to an online platform to complete the study. After

reading the clinical vignette carefully, they were asked to rate the psychopathological severity of the patient on a single item, a 10-point Likert scale ranging from 1 (not at all severe) to 10 (extremely severe). Psychopathology severity was further measured by rating the patient's current level of overall functioning using the Global Assessment of Functioning score (APA, 2000). The GAF consists of nine behavioral descriptors ranging from "absent or minimal symptoms (e.g., mild anxiety before an exam) […] no more than everyday problems" to "persistent danger of severely hurting self or others […] or persistent inability to maintain minimal personal hygiene or serious suicidal act with clear expectation of death" (APA, 2000). Patients were rated between 0 (most severe) and 100 (least severe), with each descriptor having a nine-point range.

A similar paradigm and experimental procedure were used in a previous study to investigate homophobic prejudice in a sample of mental health professionals (Prunas, Sacchi & Brambilla, 2017).

Participants were then presented with the Right-wing Authoritarianism Scale (RWA) (Altemeyer, 1981), which measures the degree of willingness to submit to an authority, adherence to societal conventions and norms, and hostility towards people who do not adhere to them (e.g.: "Our country needs free thinkers who have the courage to defy traditional ways, even if this upsets many people"). The scale showed satisfactory internal coherence in the present study (Cronbach's $\alpha = .76$). Each item was scored on a 9-point Likert scale. The

RWA has shown high correlations with transphobic attitudes in previous studies (Warriner, Nagoshi, & Nagoshi, 2013).

At the end of the procedure, participants were thanked and properly debriefed. The debriefing provided information about the purpose of the study and phone number and email address of the principal investigator for participants who had further questions or concerns.

Results

Descriptive statistics and correlations are reported in Table 2. We decided to exclude three participants from the analyses, as they reported severity ratings over |± 2.5| standard deviations above the mean: thus, the final sample comprised 215 participants. As shown in Table 2, severity rating and GAF scores are negatively correlated (r = -.26, p < .01), meaning that the more the patients is judged as severe by the clinician, the lower their global functioning, supporting the reliability of the scales. Then, we computed a series of 2 (expressed gender: man vs. woman) X 2 (gender identity: cisgender vs. transgender) X 2 (disorder: depression vs. anger outbursts) between-participants ANOVAs with the ratings of severity, and the GAF score as dependent variables. The analysis did not yield neither main effects nor interaction effects, Fs (1, 217) < 3.33, ps > .07.

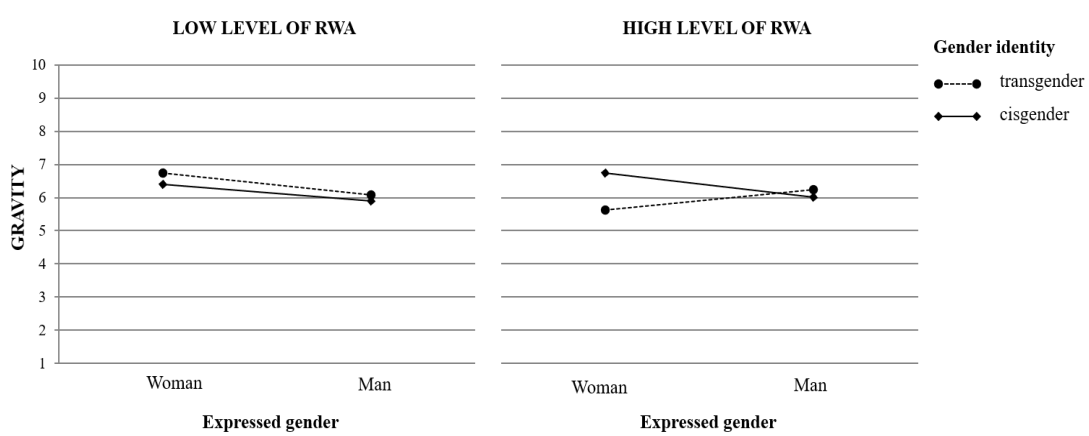
In order to ascertain whether right-wing authoritarianism influenced the severity ratings of transgender and cisgender patients, a series of moderation models was carried out through PROCESS (Hayes, 2013) (model 3, 5000

bootstrap resampling). In all the models, we used gender identity (cisgender = 0, transgender = 1) as independent variable (*X*), the patient's experienced gender (female = 0, male = 1) as the first moderator (*M*), RWA as second continuous moderator (*W*), and severity rating as the dependent variable (*Y*). The model did not consider the independent variable disorder type, since the moderation model tested with disorder type as additional moderator did not yield any significant interaction effect. As showed in Figure 2, the interaction between gender identity, experienced gender and authoritarianism (RWA) on clinical severity ratings was significant (*B* = .53, SE = .24, *t* =2.19, *p* =.03, CI = LL: .05, UL: 1.01). In other words, the interaction effect between gender identity and experienced gender on the ratings of severity was significant (*B* = 1.45, *p* =.007) only when therapists showed high levels of authoritarianism (= 3.82). With high level of authoritarianism, therapists rated a cisgender woman as more severe than a cisgender man (*B* = -.75, SE = .36, *t* =-2.03, *p* =.04, CI = LL: -1.47, UL: -.02). In addition, surprisingly, a cisgender woman was rated as more severe than a transwoman patient (*B* = -1.21, SE = .37, *t* =- 3.22, p =.002, CI = LL: -1.95, UL: -.46); when the patient was transgender, the difference between women and men did not reach significance (*B* = -.69, SE = .38, *t* =1.80, *p* =.07, CI = LL: -.06, UL: 1.46). The last comparison showed no difference in psychopathological severity ratings between transmen and cisgender men (*B* = .23, SE = .38, *t* =.62, *p* =.53, CI = LL: -.50, UL: .98). This

interaction between gender identity and experienced gender is no longer significant (*B* = -.14, *p* =.77) for low levels of the therapist's RWA (= 1.00).

We also controlled for the effect of the therapists' training and the number of years of experience in psychotherapy. We compared the severity ratings of therapist with different theoretical backgrounds (cognitive-behavioral, systemic, psychodynamic/psychoanalytic and others), using the RWA as covariate in the model. We did not obtain any main effects, *Fs* (1, 181) < .26, *ps* < .41, nor any interaction effect *F* (1, 181) = .63, *p* =.59. The same model carried out with the number of years in psychotherapy did not yield any significant main effect, *Fs* (1, 188) < .06, *p* < 61, nor any interaction, *F* (1, 188) = 1, *p* =.41.

Figure 2 Interaction between psychotherapist's RWA, patient's gender identity and patient's expressed gender



General Discussion

The impact and consequences of prejudice against transgender people in mental health professionals are still largely understudied and unknown. Although we anticipated an anti-transgender bias in the assessment of a fictitious patient, our data revealed an unexpected result. The moderation model showed that, for high levels of RWA, cisgender women were considered the most severely psychopathological group. This finding would indicate the occurrence of a gender bias rather than an anti-transgender bias in the patients' clinical evaluation: despite the contents of the clinical vignettes being equal, cisgender women were judged more severely than transgender patients (regardless of their experienced gender) and cisgender men. This difference was not significant for low levels of authoritarianism. As we mentioned before, high levels of RWA are associated with conservative beliefs and negative attitudes towards individuals belonging to groups deviating from social norms. In this perspective, RWA is one of the main variables associated with prejudice towards minority groups, and it could explain the different attributions of severity ratings based on the gender identity and expression of the fictitious patient. We grouped the possible explanations of this unexpected result into two main areas. A cognitive interpretation could be supported by the evidence that women are, in general, more likely than men to report physical and psychological symptoms. Research shows that women are more prone than men to report higher levels of anxiety, depression and poor health in general (Cauce,

et al., 2000; Myers et al., 1984; Nolen-Hoeksema, 1991; Verbrugge, 1989; Macintyre, Hunt & Sweeting, 1996). In that sense, it could be that therapists are more exposed to female patients reporting symptoms than to males, thus biasing their clinical judgement. The second cognitive-motivational interpretation could be ascribed to the activation of a stereotype, according to which women are more pathological than men. The literature reports that at least some psychiatric diagnoses suffer from a gender bias, according to which women are described as more pathological than men under the same symptomatic descriptions (i.e., depression, histrionic personality disorder; see Garb, 1997). It has also been suggested that the Global Assessment of Functioning Scale (GAF) could provide a biased assessment of women's functioning, even when men report deficient living skills (Hintikka, Saarinen, Tanskanen, Koivumaa-Honkanen & Viinamäki, 1998). In some way, the internalization of this stereotype could explain the proneness of women to express more symptoms. Another explanation could comprise a combination of the previous two: on the one hand, therapists are more exposed to female patients, and, on the other, a female sample of psychotherapists might demonstrate internalization of the stereotype.

No difference was observed between the ratings of severity for transmen and transwomen patients. One possible explanation of this unexpected and noteworthy result could be that the psychological and psychopathological characteristics ascribed to a trans person are both feminine and masculine. According to our results, transwomen and transmen were, in fact, located at an

intermediate level of psychopathological severity, between cisgender women and cisgender men. A speculative hypothesis could be ascribed to social categorization: trans people may be not categorized in the same boxes as cisgender men and women, but they could become part of new social categories that combine traits of the stereotypical female and the stereotypical male.

This study suffers from some limitations that should be addressed in future research. First, our sample comprised only female psychotherapists. A large body of research on prejudice and negative attitudes towards minorities shows that women tend to have less heterosexist attitudes than men (Herek, 2002), but that they are more prone to self-stereotyping (Cadinu, Latrofa, & Carnaghi, 2013). Thus, further studies are needed to analyze this bias in both male and female clinicians. Future studies should also better characterize the sample in terms of clinical experience and supervision (in particular with TGNC clients), and educational background (i.e., specific training in gender diversity).

Moreover, we did not include a non-binary identified patient among the transgender identities proposed in the vignettes that we presented to therapists. This issue could make our conclusions not directly applicable to the TGNC population at large. Again, this should be explored and addressed in future studies, as non-binary people are a highly marginalized group, at risk of victimization and discrimination (Richards, Bouman, Seal, Barker, Nieder, & T'Sjoen, 2016).

The evaluation of anti-transgender bias in a sample of professionals with high psychological competence might have induced a mechanism of social desirability: when confronted with a transgender patient, psychotherapists are likely to suppress their transphobic response. For this reason, future studies should assess attitudes towards transgender patients using implicit measures (e.g., the Implicit Association Test). Moreover, future studies should focus on stereotypical symptoms for transgender people, rather than neutral ones. In a previous study on male psychotherapists evaluating a fictitious gay client (Prunas et al., 2017), the authors found that the stereotypicality of the disorder played a crucial role in treatment efficacy expectations. In particular, psychotherapists anticipated fewer benefits from psychotherapy when a gay patient reported a sexual disorder rather than a rage disorder. Exploratory studies are needed to identify psychopathological conditions and disorders that mental health professionals stereotipically associate to being trans and gender nonconforming.

Overall, these findings have relevant implications for clinical practice (Sue, 2010): minorities already experience a relatively high level of stress, higher than that experienced by the average straight white man. Practitioners should keep that in mind and try to control their biases and microaggressions towards this vulnerable population, ensuring a safe and trustworthy environment for everyone. Research shows that competence and knowledge about transgender health and issues, along with familiarity and contact with

gender-variant individuals, are relevant factors affecting positive attitudes among mental health practitioners (Brown, 2018). Trainings on diversity in general and on sexual orientation or specific trainings on gender identities ensure better outcomes in terms of attitudes (Johnson & Federman, 2014; Kidd et al., 2016; Riggs & Bartholomeus, 2015, 2016). Italian training programs for psychologists and medical doctors do not provide specific training on sexual orientation or gender identity. This lack of knowledge could be reflected in behaviors such as inappropriate curiosity around trans bodies and sexualities, ignoring their specific needs, and forcing patients to undergo unnecessary medical or psychological testing (FRA, EU LGBT survey, 2012). The influence of such biases on clinical practice is particularly pernicious if we consider that sexual minorities often call on mental health consultants to help them cope with the stress induced by the prejudiced, hostile and stressful social environment in which they are immersed. Furthermore, transgender people requesting medical treatments (hormone therapy and/or and gender confirming surgeries), are required to receive a psychiatric diagnosis of Gender Dysphoria that implies a psychological (or psychiatric) assessment, or even therapy. Many trans people are thus forced to access healthcare services, a potentially damaging environment for them. This makes it particularly important to secure specialized assistance and training to professionals working at every level of healthcare services for trans people, from nurses to surgeons, from psychologists to physicians.

1.14 Study 2 – Microaggressions Towards Lesbian and Transgender Women in a Clinical Setting: Biased Information Gathering when working alongside Gender And Sexual Minorities In Therapy

Introduction

Health disparities (see Chapter 1) and barriers in accessing care (Seelman, Colón-Diaz, LeCroix, Xavier-Brier & Kattari, 2017) for LGBT individuals are well-documented in literature. Prejudice and bias are sustained by the heterosexist and cisgenderist systems of beliefs, which invalidate or pathologize sexual and gender minorities (Ansara & Hegarty, 2012). The Minority Stress Model (Meyer, 2003) helps explaining the greater risk for negative mental health outcomes in LGBT individuals when compared to the general population. Minority stress theorization posits that individuals with marginalized identities, such as LGBT individuals, experience unique daily stressors based on their marginalized status. Minority stressors may be correlated to external events (distal stressors) or may occur as a consequence of self-identification as a LGBT individual (proximal stressors) (3).

Microaggression theory became part of the conceptual framework offered by minority stress to account for day-to-day insidious discriminations. Microaggressions are described as “brief and commonplace daily verbal, behavioral, and environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative insults to the target person or group” (Torino, Rivera, Capodilupo, Nadal & Sue, 2019). These subtle forms of

prejudice have a detrimental impact on mental health and well-being of LGBT individuals (Owen, Tao & Drinane, 2019).

Despite the elevated mental health disparities among LGBT individuals, psychological services are largely ineffective in meeting the needs of this specific population. Furthermore, therapeutic relationships are not immune from societal norms and values that rule sex and gender (Anzani, Prunas, Sacchi, 2019; Prunas, Sacchi, Brambilla, 2018). Thus, although microaggressions in therapy have been recognized as a violation of ethical guidelines (Morris, Lindley & Galupo, in press), counseling interventions with people of marginalized groups often entails that individuals involved in the therapeutic relationship might enact as members of the dominant vs. marginalized social groups, for example when the therapist is have a normative cisgender heterosexual identity and the client have a marginalized sexual identity (Sue & Sue, 2012). Microaggressions perpetrated in a therapeutic context have been found to have a negative impact in terms of outcomes, with a higher risk of drop-out from treatment (Sue & Sue, 2012) and compromised therapeutic alliance (Owen, et al., 2011). Negative experiences in healthcare settings have been linked to decreased treatment satisfaction and reduction of future help-seeking behaviors among transgender individuals (Seelman et al., 2017). In LGB individuals, microaggressions in therapeutic settings were also connected with negative emotional reactions and a change in attitudes towards psychotherapy in general (Shelton & Delgado-Romero, 2011). Thus, further

investigation of gender identity-based microaggressions in therapeutic contexts is warranted.

Although in recent years a burgeoning area of research has been focused on microaggression towards LGBT individuals and barriers in accessing health care, no studies have investigated "in vivo" microaggressions directed to sexual and gender minorities in a sample of experienced clinicians. Studies on microaggressions have mostly focused on the reported experiences of transgender and LGB individuals (Morris et al., *in press;* Shelton & Delgado-Romero, 2011). To our knowledge no study to date has measured the microaggression perpetrated by psychotherapists in a fictitious clinical scenario.

The aim of the present study is to explore types and variables predicting microaggressions when psychotherapists are confronted with a client whose gender or sexual identity belongs to a marginalized group (vs. a normative identity). In particular, we expect clinicians to give more relevance to microaggressive questions when the patient belongs to a sexual or gender minority group, than with a cis straight client presenting with the same clinical concerns and symptoms. We also expect that the self-assessed emotional arousal generated by a patient belonging to a marginalized group moderates the relevance attributed to microaggressive questions in the trans and lesbian condition.

Current Study

Participants

An a priori power analysis was conducted to estimate sample size using G*Power (Faul et al., 2007). The power analysis (alpha = .05, power = .80, effect size $\eta^2_{partial}$ = .25) suggested a sample size of N = 120 for a 3 between-participants X 2 within-participants ANOVA. One-hundred and thirty-five licensed psychotherapists took part in the study. All the participants were self-identified as cisgender, White Italian citizens. The large majority of the sample identified as female (N = 110; 81.5%). Other demographics characteristics of the sample are summarized in Table 2.

Table 2. Demographic characteristics of the sample

Characteristics	Total N = 135 N (%)	Female N = 110 N (%)	Male N = 25 N (%)
Age groups (yrs)			
27-35	32 (23.7)	28 (25.5)	4 (16)
36-45	54 (40)	41 (37.3)	13 (52)
46-55	30 (22.2)	27 (24.5)	3 12)
56-65	14 (10.4)	10 (9.1)	4 (16)
65+	5 (3.7)	4 (3.6)	1 (4)
Relationship status			
Single	45 (33.3)	37 (33.6)	8 (32)
Married	51 (37.8)	42 (38.2)	9 (36)
Divorced	5 (3.7)	4 (3.6)	1 (4)
Widow	2 (1.5)	1 (1.8)	0
Cohabitant	32 (23.7)	25 (22.7)	7 (28)
Sexual Orientation			
Straight	120 (88.9)	101 (91.8)	19 (76)
Gay/Lesbian	4 (3)	0	4 (16)
Bisexual	10 (7.4)	8 (7.3)	2 (8)
Other	1 (0.7)	1 (0.9)	0
Degree			

Psychology	132 (97.8)	107 (97.3)	25 (100)
Medicine	1 (0.7)	1 (0.9)	0
Philosophy	2 (1.5)	2 (1.8)	0
Literature	4 (3)	4 (3.6)	0
Post-grad education			
Master	61 (45.2)	54 (49.1)	7 (28)
Advanced training courses	37 (27.4)	29 (26.4)	8 (32)
Doctorate	8 (5.9)	4 (3.6)	4 (16)
Psychotherapy training	122 (90.4)	98 (89.1)	24 (96)
Sexology training	17 (12.6)	15 (13.6)	2 (8)
Theoretical Orientation			
Cognitive-Behavioural	32 (23.7)	28 (25.5)	4 (16)
Systemic	18 (13.3)	16 (14.5)	2 (8)
Psychodynamic/Psychoanalitic	55 (40.7)	43 (39.1)	12 (48)
Other	30 (22.2)	23 (20.9)	7 (28)
Years of practice			
1-5	49 (36.3)	42 (38.2)	7 (28)
6-10	33 (24.4)	24 (21.8)	9 (36)
11-20	31 (23)	26 (23.6)	5 (20)
21-30	18 (13.3)	15 (13.6)	3 (12)
30+	4 (3)	3 (2.7)	1 (4)

Procedure

The experiment was conducted in accordance with the guidelines defined by the Declaration of Helsinki. It has been approved by the local ethics committee, and informed consent was obtained from all participants. Therapists were contacted by an e-mail briefly presenting the online study and asking to voluntarily participate. Participants were first presented with an audio file of a woman (trans, cis lesbian, or cis heterosexual depending on the condition) introducing herself and the presenting problems during the first session with the

participant. The audio was recorded by a professional actress, who played all the three roles. In order to make the scenes as similar as possible, we edited the audio so that just the first recorded phrase differed in the three conditions. The fictional patient presented herself as a straight (or lesbian, or trans) woman complaining about panic symptoms (see Appendix 1). The procedure was conducted entirely online and participants were randomly assigned to one of the three experimental conditions. After listening carefully to the audio file, therapists were asked to complete a questionnaire. Detailed information about their training and clinical experience were also collected (see Table 2). At the end of the procedure participants were thanked and debriefed.

Measures

Microaggressive and neutral questions. We first asked therapists to evaluate on a scale from 1 (*not relevant at all*) to 7 (*extremely relevant*) the relevance of 10 questions they might have asked the client to get a full clinical picture. The questions reflected both microaggressive and neutral themes. The items were extracted from a pool of questions collected in a pilot study, which involved a sample of 84 early-career psychologists invited to listen to the same audio-file and to produce up to 10 questions they would have asked the client. Participants generated 575 questions, with a mean of 6.8 questions each. Three different raters blind to the hypotheses independently classified each of the questions as non-microaggressive, possibly microaggressive, or microaggressive. 30.9% of

the sample produced at least one microaggressive question (rated as such by at least two out of three raters).

The questions generated in the pilot study were used to build 5 microaggressive (Cronbach's α = .90) and 5 neutral questions (Cronbach's α = .71) for the current study. In general, microaggressive questions were related to the client's sexual identity (i.e., "How was discovering your sexual identity for you?"), whereas neutral questions were about clinical symptoms and complaints, the clinical history and other clinically relevant areas the client mentioned in the presentation (i.e., "How frequent are the panic attacks you described?").

The Positive and Negative Affect Shedule (PANAS). (Terraciano, McCrae & Costa, 2003). 20-item mood scales that comprises both positive and negative affects. The scale was administered right after the listening task. We used the scale to compute a global score of emotional arousal. The Cronbach's alpha for the global scale was α = .78.

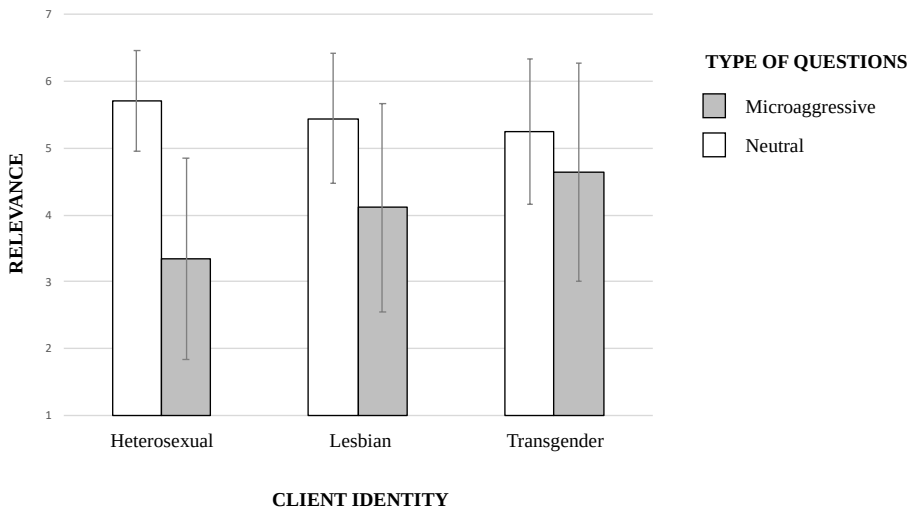
Results

Relevance of microaggressive vs. neutral questions

In order to compare the relevance of microaggressive and neutral questions depending on the sexual identity of the client, we computed a 3 (condition: heterosexual, lesbian, trans) X 2 (type of questions: microaggressive vs. neutral) ANOVA with the first factor between-participants and the second factor within-participants.

The analysis showed a main effect of type of questions, F (1, 132) = 119.36, $p < .001$, $\eta_p^2 = .47$. Independently from the experimental condition, neutral question were considered significantly more relevant (M = 5.44, SD = .98) than microaggressive questions (M = 4.09, SD = 1.63). The ANOVA did not yield a significant main effect of condition, F (1, 132) = 1.76, p = .18, η_p^2 = .03. However, in line with the hypothesis, a significant interaction effect between condition and type of questions emerged, F (2, 132) = 14.56, $p < .001$, $\eta_p^2 = .18$. As displayed in Figure 3, neutral questions were rated as more relevant in the straight client condition (M = 5.70, SD = .75) than in the transgender client condition (M = 5.25, SD = 1.09), t(86)= 2.22, p=.03, d = .48, 95% CI [.05 .90]. The analysis revealed no differences between lesbian (M = 5.44, SD = .98) and transgender conditions, t(95)= .92, p=.36, and between straight and lesbian conditions, t(83)= 1.36, p=.18. The post-hoc comparisons on the relevance of microaggressive questions did no show a difference between lesbian (M = 4.11, SD = 1.59) and transgender condition (M = 4.64, SD = 1.56), t(95)= 1.68, p=.09. Crucially, microaggressive questions were rated as significantly less relevant for the straight client (M = 3.34, SD = 1.50) than for the lesbian client , t(83)= 2.26, p=.03, d = .49, 95% CI [.06 .93], and the transgender one, t(86)= 3.94, p<.001, d = .85, 95% CI [.41 1.29].

Figure 3

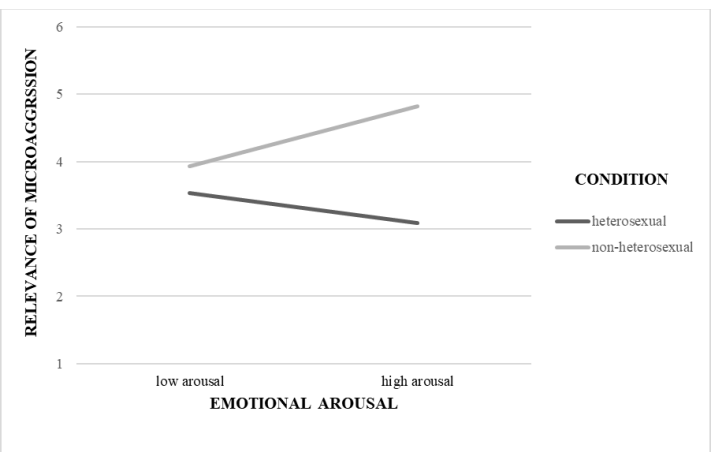


The effect of the Emotional Arousal

In order to ascertain whether emotional arousal influenced the relevance attributed to microaggressive questions, a moderation model was carried out through PROCESS (Hayes, 2018) (model 1, 5000 bootstrap resampling). In the model, we used condition (heterosexual = 0, non-heterosexual = 1) as independent variable (X), the therapist's emotional arousal as moderator (W), and relevance of microaggressive questions as the dependent variable (Y). We chose emotional arousal rather than the valence of emotions for two reasons. A methodological reason relies on the fact that the PANAS showed a good internal consistency ($\alpha = .78$), suggesting that both positive and negative items of the scale measured the same construct. A more theoretical reason is based on the argument that the positive affect and negative affect subscales of the PANAS both measure the latent construct of emotional arousal (Russel, Weiss & Mendelsohn, 1989). We decided to collapse the lesbian client and the transgender

client conditions as the relevance of microaggressive questions did not differ between the two conditions. As showed in Figure 4, the interaction effect between condition and arousal on the relevance of microaggressive questions was significant, B = 1.90, SE = .82, *t* = 2.32, *p* = .02, 95% CI [.28, 3.53]). At high level of arousal (= 2.55), therapists rated microaggressive questions as more relevant for lesbian and trans than heterosexual women (B = 1.74, SE = .43, *t* = 4.04, *p* <.001, 95% CI [.89, 2.59]). At low levels of arousal (=1.85), the difference between non-heterosexual and heterosexual condition was not significant, B = .40, SE = 39, *t* = 1.04, *p* = .30, CI [-.37, 1.17].

Figure 4



Individual differences

In order to ascertain whether therapists' individuals differences would influence their responses we controlled for the effect of therapists' gender and sexual orientation. The first ANOVA did not yield any significant main effect of gender, *F* (1, 129) = .001, *p* =.97, nor any interaction effects with gender, *Fs* < .63, *ps* > .43. The same results were obtained introducing sexual orientation

as independent variable, *Fs* < .95, *ps* > .33. We also controlled for the effect of the therapists' theoretical background (cognitive-behavioral, systemic, psychodynamic or other) and years of practice on relevance evaluations. No interaction effects or a main effect of theoretical background were found, *Fs* < 1.25, *ps* > .29, nor for years of practice, *Fs* < .87, *ps* > .54.

Discussion

The present study aimed at investigating the presence of (micro)aggressive interventions when psychotherapists are confronted with clients with a marginalized sexual or gender identity status (vs. a normative sexual and gender identity). The findings highlighted a bias in evaluating the relevance and usefulness of information while making a psychological assessment of a case. Data showed the effect of the client's sexual identity in rating the relevance of microaggressive questions by the therapists. Such questions were considered less important for the normative straight cisgender client and more important for the less conforming clients, lesbian and transgender respectively. In the opposite direction, asking general questions on symptoms, life events and mental health history was considered less relevant for the assessment in the trans client condition compared to the straight client condition.

Results showed that both lesbian and transgender women were equally target of microaggressions. In addition, only in the transgender condition neutral questions were considered significantly less relevant compared to the

cis-heterosexual condition. This could be explained taking into account the long history of pathologization of trans identities. Once a client is labeled as trans they are immediately "diagnosed" as if the main issue and complaints they are bringing in the consultation fades into the background, and the therapist no longer needs even need additional information.

The bias relies on specific assumptions based on cisgenderism and heteronormativity. In the first place, therapists may be asking more questions on sexual identity to lesbian and transgender clients because they connect the patients' symptoms with the patients' sexual identity (Shelton & Delgado-Romero, 2011). The assumption that sexual identity is the cause of the current symptoms contribute to perpetuate the idea that sexual and gender marginalized identities are inherently wrong and problematic, fostering the internalizations of negative attitudes towards one's own minority identity. The second fundamental assumption that influences therapists to be more prone to ask questions on sexual identity relies on stereotypical beliefs on LGBT experiences. Questions about how sexual identity was "discovered" and how LGBT individuals manage their sexuality in different social and relational contexts are based on stereotypical assumptions. For example, assuming that sexual identity is a discovery (or a choice) that brings troubles to the individuals is a narrative based on a stereotypical representation of LGBT individuals that does not necessarily reflect the experience of every member of the community. Thus, cisgenderist and heterosexist paradigms appear to still have a great

impact in shaping people attitudes towards sexual and gender minorities (Ansara & Hegarty, 2012), including mental health professionals. Furthermore, therapists that were more emotionally aroused were more prone to be microaggressive with a marginalized identity than therapists that showed a low level of arousal. It has been suggested in literature that there is a relationship between emotional arousal and/or anxiety and prejudice and stereotypes (Britt, Boniecki, Vescio, Biernat & Brown, 1996; Vescio & Biernat, 1999). When confronted with a member of a marginalized group, psychotherapists might activate stereotypes that lead to an emotional arousal that is directly detrimental on their judgement. For example, arousal has been showed to reduce the availability of relevant information caused by a narrowed attentional focus (Easterbrook, 1959).

The main guidelines for psychological practice with transgender, gender nonconforming (APA, 2015; Coleman et al., 2011), and LGB (APA, 2012) clients promote understanding, respect, and support, recognizing the existence of minority stress as an important factor affecting the mental health of LGBT individuals (Morris et al., in press). In spite of the guidelines that ensure care and protection for the LGBT population, therapists still express a bias when confronted with a member of the community as a client. As psychologists and psychotherapists our purpose is taking care of our client's mental health and well-being. From this perspective, trying to reduce this bias is crucial in order to be able to fight health barriers and disparities.

A strong proactive strategy can be to endorse a paradigm shift from microaggressions to microaffirmations, clearly helpful in working towards providing real support and affirmation of LGBT identities (Anzani, Morris, Galupo, 2019). The first step in this direction could be made by providing adequate knowledge and competence to therapist on LGBT issues. The Italian educational system does not provide any adequate training on gender, sexual diversity, and sexual or gender minorities needs to healthcare professionals. As a result, it is likely that psychologists, and health care providers in general, are still affected by common thinking and societal paradigms rather than knowledge and skills. A strongly affirmative and supportive practice must be based on adequate and specific trainings. In fact, the microaffirmations model of care recognizes the affirmative practice of cisnormativity acknowledgement and disruption as beneficial (Anzani, Morris, Galupo, 2019). Such practice starts primarily with acknowledging the differences in privileges based on the identities of people involved in the therapeutic relationship with a intersectional perspective.

1.15 Study 3 – From Absence of Microaggressions to Seeing Authentic Gender: Transgender Experiences with Microaffirmations in Therapy[3]

Introduction

The majority of research on transgender health centers on discrimination and stress and the consequences of these experiences for mental health and well-being (e.g., Budge, Andelson & Howard, 2013; Tebbe & Moradi, 2016). This critically relevant line of research is rooted in the Minority Stress Model (Meyer, 2003) and on the construct of cisgenderism (Ansara, 2010; Serano, 2007). Cisgenderism represents the ideology that invalidates or pathologizes gender identities that are different from the ones that were assigned at birth (Ansara & Hegarty, 2012). Although mental health disparities for transgender individuals have been well documented, a number of critical obstacles exist for receiving affirming therapy. Because little is known about transgender individuals' positive therapeutic experiences, the focus of the present study is on describing gender-based microaffirmations received in the context of therapy.

Accessing Care

Although research on transgender health has received increased attention, little is known about the relationship between individual mental

[3] This section consists of the partial reproduction of the article accepted for publication: Anzani A., Morris E.R., Galupo M.P. (in publication). "From Absence of Microaggressions to Seeing Authentic Gender: Transgender Experiences with Microaffirmations in Therapy". *Journal of LGBT Issues in Counseling.*

health care providers and their trans clients. The overall picture based on available data is not encouraging. Eighteen percent of the respondents to the 2015 U.S. Transgender Survey reported that one or more mental health professionals (or religious advisors) tried to stop them from being transgender (James et al., 2016), an experience that is correlated with a higher risk of psychological distress, attempted suicide, homelessness, sex work, and running away from home (James et al., 2016). With regard to health care, 33% of trans people report at least one negative experience in the previous year. Negative experiences include the necessity to educate the healthcare provider about trans health (24%), being asked inappropriate questions (15%), and being refused transition-related treatments (8%; James et al., 2016). The same situation is described in European reports (FRA, EU LGBT Survey, 2014). In particular, openness about being trans increases the risk of being discriminated against in healthcare or social services contexts (FRA, EU LGBT Survey, 2014). The alarming consequences of these experiences are that trans people avoid accessing psychological or medical help for fear of prejudice from care providers (23%) and lack of confidence in services provided (19%; FRA, EU LGBT Survey, 2014). In some ways, the situation is paradoxical in that the vast majority of countries, trans people are required to receive a gender dysphoria diagnosis in order to receive transition-related treatments. This implies a psychological or psychiatric evaluation, and in some cases, even psychotherapy (Anzani, Prunas & Sacchi, 2019). Thus, many trans people are required to

engage within a therapeutic system that is potentially further damaging to their mental health (Anzani et al., 2019). Clearly, there is a need for research that focuses on how to provide affirmative care for those with a transgender identity.

Interpersonal Interactions: From Microaggressions to Microaffirmations

Microaggressions provide a useful model for understanding discrimination and bias within the context of interpersonal interactions. Microaggression theory and research (Sue, 2007) has specifically focused on the way subtle forms of day-to-day interactions affect individuals with marginalized identities. Transgender-based microaggression research has added to our understanding of how transgender individuals of different identities relate on an interpersonal level in a number of relational contexts (Galupo, Davis, & Henise, 2014; Chang & Chung, 2015; Nadal, Rivera, Corpus, 2010). A recent study (Morris, Lindley, & Galupo, *in press*) explored the experiences of trans microaggressions within a therapeutic context as violations of ethical guidelines. The authors identified four main themes that recurred in the participants' narratives: the lack of respect for the client gender identity; a lack of education of mental health professionals; an overemphasis or a minimization of the saliency of gender identity in therapy; and the role of gatekeeping endorsed by some practitioners (Morris et al., *in press*). Mental health care providers often deny the validity and authenticity of the gender identity of their clients, endorsing a cisnormative attitude.

While microaggressions elucidate problems in communication, they do not help to frame how a therapist can interact with trans clients in order to be supportive. The focus on negative experiences has been balanced by the concept of microaffirmations. Research on microaffirmations was introduced by Flanders (2015) who investigated subtle acts that effectively acknowledge bisexual identities. In the last couple of years the construct of microaffirmations has been also applied to transgender experience to describe the validation of an individual's gender identity through intentional or unintentional verbal or behavioral gestures that occur within interpersonal interactions (Galupo, Pulice-Farrow, Clements & Morris, 2018; Pulice-Farrow, Bravo, & Galupo, 2019). Although this research has focused on romantic relationships (Galupo et al., 2018; Pulice-Farrow et al., 2019), microaffirmations could be usefully applied to understanding how small positive gestures may validate an individuals' worthiness within a therapeutic context. The current study is aimed at making a first step in this direction, by examining what transgender clients describe as being affirming in the context of their therapist relationships.

Method

Participants

Participants were 64 transgender adults who endorsed a range of gender identities (see Table 3 for sample demographics). Participants ranged in age from 18 to 65 (M = 30.73, SD = 12.10), and represented 10 countries (Australia, Brazil, Canada, England, Finland, France, Germany, the Netherlands, Scotland,

and the United States) and 21 U.S. states. There was limited racial/ethnic diversity in this sample, with 79.69% of the participants identifying as White (N = 51), and 20.31% as a marginalized racial/ethnic identity (N = 13). To be included in the study participants had to have been currently attending or have attended therapy or counseling within the last five years while identifying as transgender. Participants were recruited online with some posts geared toward specific identities, while others served the transgender community more generally.

Table 3. Participant Demographics	**Total (*N* = 64)**
Age	***M (SD)***
Current Age	30.73 (12.10)
Gender Identity	***N* (%)**
Agender	3 (4.69)
Bigender	3 (4.69)
Gender Non-Conforming	1 (1.56)
Genderqueer/Fluid	7 (10.94)
Man with a Transgender History	4 (6.25)
Transfeminine/Trans Woman	23 (35.94)
Transmasculine/Trans Man	18 (28.13)
Two-Spirit	1 (1.56)
Woman with a Transgender History	5 (7.81)
Socio-Economic Status	***N* (%)**
Working Class	9 (14.1)
Lower-Middle Class	15 (23.4)
Middle Class	19 (29.7)
Upper-Middle Class	12 (18.8)
Upper Class	3 (4.7)
No Answer	6 (9.4)
Race/Ethnicity	***N* (%)**
Asian/Asian-American	3 (4.69)

Biracial/Multiracial	5 (7.81)
Black/African-American	2 (3.13)
Hispanic/Latino	2 (3.13)
Native American/Alaska Native	1 (1.56)
White	51 (79.69)
Other	6(1.30)
Education Level	***N* (%)**
Less Than High School	2 (3.1)
High School Degree/GED	28 (43.7)
Associate's Degree	3 (4.7)
Bachelor's Degree	16 (25.0)
Master's Degree	7 (10.9)
Doctoral Degree	2 (3.1)

Measures

The present study focuses on subtle gender-related microaffirmations experienced during therapy among individuals with a transgender identity. Participants completed an online survey in which they provided demographic information followed by qualitative descriptions of their experiences of microaffirmations from mental health care providers. Participants provided their gender identity as a write-in response, and then selected their primary gender identity from nine discrete options. Participants were asked to respond to the following prompt: "Please provide an example in which your therapist/counselor has communicated subtle positive or supportive messages towards you based on your gender identity that have made you feel supported". Finally, participants were asked to describe the frequency and effect of such microaffirmations on their mental health in an open-response format.

Procedure

The study was approved by the institutional review board (IRB) at Towson University. Participants were recruited using online social networking groups and no incentive was provided for participation. Participants completed an online survey that sought to explore their experiences of microaffirmations from mental health care providers. Responses from a larger dataset on experiences in counseling were considered for the analysis. Participants first provided their gender identity as a write-in response, and then responded to a structured gender identity question in which they were asked to select their primary gender identity from nine discrete options. Participants were then asked to detail experiences in which their mental health care provider subtly affirmed their gender identity. Debriefing and information for support resources were provided at the end of the survey.

Analysis

The research team included a third year doctoral student in Clinical Psychology who identifies as a white heterosexual cisgender woman, a first year M.A. student in Counseling Psychology who identifies as a white queer androgynous person, and a biracial professor of psychology who identifies as a bisexual/pansexual cisgender woman. The diverse composition of our research team allowed for a range of perspectives to be considered throughout the analysis of participant responses.

Participants' qualitative descriptions of their experiences of microaffirmations were evaluated using thematic analysis (Braun & Clarke, 2006). Members of the research team began by independently identifying potential themes of microaffirmations while coding participant responses. The research team then met and agreed upon four overarching themes. Two members of the team then coded the data set into the agreed upon thematic structure, with the third author serving as an external auditor. Two members of the team then independently coded participant responses, resulting in 84% inter-rater reliability. Discrepancies in the categorization of participant responses were resolved via discussion. The authors met several times to determine which quotes best reflected each of the four themes.

Several measures were taken to ensure the validity of our results. First, participants were given the opportunity to provide feedback on how the survey captured (or failed to capture) their unique experiences. Second, two members of the research team independently coded participant responses twice, with the operational definition of all themes being clearly defined. Third, all themes were discussed as a group and final results were unanimously agreed upon by members of the research team. Finally, in order to ensure that our themes resonated with participants of different identities, we conducted a series of chi-square analyses to confirm that there were no significant differences in how frequently themes were expressed across race/ethnicity (White vs. People of color) and gender identity (binary vs. non-binary).

Results and Discussion

Four themes emerged from the data analysis and represented participants' experiences of microaffirmations within the therapeutic relationship. These themes included: 1) absence of microaggressions, 2) acknowledgment of cisnormativity, 3) disrupting cisnormativity, and 4) seeing authentic gender. All participant responses were categorized into at least one of the four themes. Results are presented using illustrative quotes accompanied by participants' gender identity, race/ethnicity, and age. As it is standard for qualitative research, results and discussion are presented in an integrated section (Flick, 2014).

Absence of Microaggressions

Participants often described feeling affirmed by their therapists through the absence of microaggressions. Even though participants were asked to describe their positive experiences, many of their examples were not overtly positive; rather, their examples indicated a lack of negative response. For example, one participant noted feeling affirmed when their therapist was "not responding (to them) with disgust". (Transgender/Trans, Bi/Multiracial, 33)

It has been well documented that transgender people accessing social and healthcare services routinely experience discrimination, rejection, poor treatment, and lack of transgender-specific competence from providers (Austin, Craig, D'Souza, 2018; Stotzer, Silverschanz & Wilson, 2013). It is not surprising, then, that many trans people report an absence of microaggressions

as affirming. For individuals accustomed to mistreatment, something as simple as receiving a phone call after a missed appointment was perceived as affirming.

"(They) called me back when I missed an appointment." (MtF/Genderqueer, White, 63)

Similarly, participants were affirmed by having a therapist who did not judge their viewpoints and did not stand in their way of their transition plan.

"They respected my view of life." (Nonbinary, White, 27)

"My therapist has never discouraged me from transitioning." (Transmasculine, White, 25)

Ultimately, the most basic aspects of therapeutic work, like focusing on the presenting problem, were perceived as affirmative by participants.

"Honestly, I can't remember a single instance where my therapist has actually discussed gender with me, we mostly discuss other things that are on my mind. I think partially for this reason I don't really know where I stand. Although I will say that maybe I'm being ungrateful, because there are some therapists who are outright rejecting. In general, though, my therapist has been super useful in terms of dealing with other things I guess." (Greygender, Asian, 18)

One participant's response illustrated the subtle nuance in which microaggressions and microaffirmations are often communicated.

"This has not, unfortunately, happened. Sometimes overt positivity masked subtle negativity, but little to no subtle positivity was to be found. We both breathed a sigh of relief when they finally agreed to write the necessary letters after stringing me along for 11 months." (Transfeminine, White, 44)

That 26.6% of the participants described absence of microaggressions as supportive highlights how transgender clients may be biased in their perception of what constitutes an authentic affirming practice. This result may be better understood when considering negative experiences of trans individuals in mental health and healthcare settings (Hagen & Galupo, 2014; Grant et al., 2001; Stotzer, Silverschanz & Wilson, 2013). Prior hostile or invalidating experiences have been shown to act as an anchoring point, lowering one's threshold for positivity (Kushner, 2008). This could explain the tendency for trans people to see their therapists' behavior as positive, as they may develop suspicion, skepticism, or hypervigilance towards majority group members in response to discrimination (Sue, 2010). This theme, absence of microaggressions, is particularly relevant to minority stress theory as identity nonaffirmation has been framed in recent literature to be a distal stressor for negative mental health outcomes (Testa, Habarth, Peta, Balsam & Bockting, 2015).

Acknowledgement of Cisnormativity

Beyond the absence of microaggressions, participants described feeling affirmed when mental health providers acknowledged the cisnormative context

(Worthen, 2016) in which their identity was experienced. Participants described feeling supported by their therapists when they were able to acknowledge that a cisnormative society imposes strict rules about how men and women are supposed to behave and appear:

"She often goes out of her way to address concerns of mine like the idea that I may well still dress more masculine. She seems to believe strongly that gender norms are not helpful and do not need to be strict." (Transfeminine, White, 23)

Covert forms of discrimination exist at an institutional level in the form of systemic and environmental microaggressions (Nadal, Skolnik & Wong, 2012). One participant noted that they felt affirmed by their therapist's acknowledgement of the way their official documents reflected their "legal name" and stood in contrast to their gender identity.

"She started using my preferred name right after I told her it. She was apologetic about having to use my legal name in official paper-work." (Transmasculine, White, 26)

Participants described feeling affirmed when therapists demonstrated their understanding that identity disclosure was a process that compromised their safety and was something that they consistently navigated. Previous research has suggested coming out to be an ongoing process rather than an isolated event (Lev, 2004; Nealy, 2017). Participants described feeling affirmed when their therapists understood that disclosure in the context of therapy, did

not automatically translate to disclosure in all situations (Nealy, 2017). One participant noted:

"[My therapist] asked permission to use my chosen name once I disclosed it." (Butch/Multigender/Nonbinary, White, 29)

Another important aspect that emerged from participants' narratives around the acknowledgment of cisnormativity relates to therapists' explicit acknowledgement of their courage. Consistent with the literature on the need to balance an understanding of minority identity with a focus on positive experiences (Budge, 2014), participants felt affirmed when therapists focused on their strength and resilience in the face of difficulties associated with the stigma of being trans:

"I had a different therapist that never messed up on my pronouns and reminded me that transitioning was a very courageous thing to do and to use that strength in other areas of my life." (Transmasculine, Bi/Multiracial, 24)

Disrupting Cisnormativity

Participants described ways that their therapists disrupted cisnormativity. Sometimes affirmation came in the form of simple acts that were both symbolic and went against cisnormative conventions.

"Moved my file to female section." (Transfeminine, White, 18)

Participants described ways that they felt affirmed when therapists encouraged gender exploration and normalized their experiences. Although strongly linked with acknowledging cisnormativity, participants described ways

that their therapists took a more active role in encouraging them to step outside the gender norms (Singh, 2016) and thus disrupt cisnormative conventions. The following two quotes are representative of an active effort on the part of the therapist to assume a more affirmative attitude, showing positive attitudes towards transitioning and celebrating participants' achievements.

"My therapist has shown genuine emotion and excitement multiple times when I've reached milestones in my transition, like surgery, changing my name, starting testosterone." (Male, White, 18)

*"I told them I wanted to come out to people, and they treated this as a positive thing. Importantly, they did *not* make a 'big deal' out of it, and instead reinforced the idea that this would be a natural, healthy choice."* (Nonbinary, White, 21)

Disruption of cissexist norms was described when therapists encouraged clients to explore their gender in a safe and supportive environment and when they framed exploration as a natural and developmentally appropriate process:

"When I came out to my therapist as questioning my identity my therapist said that I should 'explore this as often as I could' and when I changed my name and pronouns was immediately on board." (Nonbinary/Neutrois, White, 28)

"When I asked one of my counselors to help me correct the position of my binder, she helped me with little hesitation and asked if I was thinking about going further in my transition." (Transmasculine, White, 18)

The exploration of one's own gender identity is not confined to therapy or psychological work, but is often worked through via dialogue with other people facing the same issues. Community support is recognized as one of the crucial protective factors in the lives of trans people, even more so when families are not supportive (Bockting, Miner, Swinburne Romine, Hamilton & Coleman, 2013). As such, queer communities or extended networks could represent an important resource of resilience and "life-saving support":

"I have life-saving support from a counselor that works in a LGBTQI counseling center. I don't have to pay for this and so far has been the only person guiding me through the nightmare of all this bureaucracy and giving me ideas for activities and meetings that actually made me feel more empowered. She made me notice that I was dealing with all this struggle alone and put me in contact with people and other nonbinary groups I had no idea of." (Agender, White, 35)

Seeing Authentic Gender

The final theme described by participants centered on the way they felt affirmed when therapists conveyed that their identity was authentic. Acknowledgment of participants' identity served as an empowering message especially when they had previously encountered negative responses with other people or in other contexts. In many cases, participants reported therapists' simple reference to their experienced gender simple and/or their use of stated name and pronouns as affirming.

"Always referred to me as male without needing prompting or reminders, even before I began to medically transition." (Genderfluid, White, 20)

Of participants endorsing the theme of seeing authentic gender, 44% reported the use of correct pronouns as a practice of their therapist, indicating how this simple gesture was experienced as an effective microaffirmation.

Compliments about physical or aesthetic appearance together with phrases that validate and reinforce their affirmed gender identity were also reported by participants as affirming.

"Her telling me that she didn't recognize me in the waiting room, all she saw was a woman." (Transfeminine, White, 59)

"My current therapist defends my fluidity and sees it reaching beyond just my gender. She speaks kindly to my multiplicity and believes me." (Trans nonbinary, White, 28)

Participants also described instances in which their therapist did not unduly focus on their gender identity. Just being treated as "normal" was noted as affirming.

"Affirmative language about gender identity and expression ('Do whatever makes you feel comfortable'), laughing along with my sarcastic humor about being trans, but the most 'subtle' and effective thing is just treating me like a normal person, not a medical patient. Nothing is more positive or supportive than being viewed as a human being rather than an aberration."

(Transfeminine, White, 26)

Participants' perceptions of microaffirmations in therapy were clearly informed against the established history of pathologizing trans individuals in the psychomedical literature (MacKinnon, 2018). This literature has supported a "born in the wrong body" narrative, laying the foundation for the medical regulation (i.e., gatekeeping) of those with a transgender identity (Serano, 2007). When therapists approached participants as whole individuals and without this framework of pathology, they felt affirmed in their gender identity.

Integration of Themes

Table 4 provides the overall thematic structure as well as the frequency of each of the themes. It is important to note that these four themes were not mutually exclusive as participants often expressed more than one theme within the same response. For example, one participant noted:

"I went to a transgender support group for the first time yesterday. My therapist leads the group and suggested I come check it out, he said I could sit next to him if that would make me feel more comfortable. I got up and left midway due to feeling overwhelmed. My therapist followed me and after we spoke, even though I felt better, I decided to leave anyway. My therapist was on his way back to the group when I asked him to apologize and said "tell them the black girl says sorry, they will remember who that is." He replied, "or the black guy." That meant so much." (Bigender, African American, 34)

The above response explicitly highlighted themes of acknowledging cisnormativity, disrupting cisnormativity, and seeing authentic gender (while

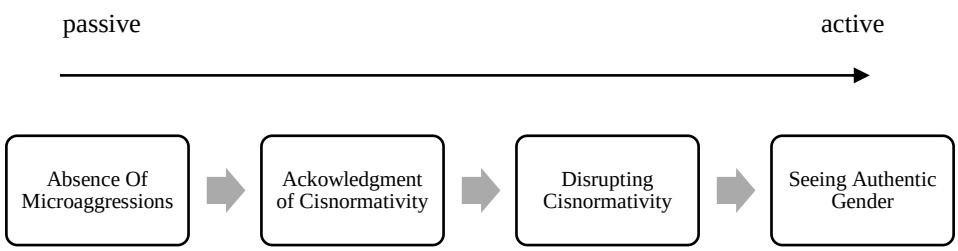
implicitly communicating a lack of microaggressions). The participant felt affirmed by the therapists' acknowledgment of discomfort, their active role in providing support during the group, and their overt assertion of the participant's authentic gender. Participants felt affirmed when therapists understood the complexity of negotiating gender identity and responded to their needs at different levels.

Table 4. Percentage of Participants Endorsing Themes

	Example Quotation	Frequency (%)
Absence of Microaggressions	*"My therapist has never discouraged me from transitioning."*	27.9
Acknowledging of Cisnormativity	*"She seems to believe strongly that gender norms are not helpful and do not need to be strict."*	18.0
Disrupting Cisnormativity	*"My therapist has shown genuine emotion and excitement multiple times when I've reached milestones in my transition, like surgery, changing my name, starting testosterone.*"	26.2
Seeing Authentic Gender	*"My current therapist defends my fluidity and sees it reaching beyond just my gender. She speaks kindly to my multiplicity and believes me.*"	59.0

Conclusion

Figure 5 Thematic Structure



The thematic structure that emerged from the participants' narratives can be understood as representing a linear model consisting of four therapeutic affirmative positions: absence of microaggressions, acknowledgment of cisnormativity, disrupting cisnormativity, and seeing authentic gender. These four positions simultaneously represent increasing levels of affirmation for trans clients and increasing levels of effort and insight for therapists (see Figure 5). Although information builds across these four positions, they are neither fixed nor mutually exclusive (as seen in the ways that these themes were integrated). In addition, it is important to note that these microaffirmations occur alongside gender identity-based microaggressions (Morris et al., *in press*) and together they create a dynamic interpersonal context in which transgender identity is being negotiated.

The model also succeeds in capturing a gradient in psychotherapists' agency. The first two steps represent a more passive way of being affirmative within the relationship with a client, from the basic absence of

microaggressions towards transgender clients to the validation of their experience of discrimination as a social group (acknowledgment of cisnormativity). The last two steps represent a more active role of the psychotherapist in validating a client's experience: the effort to normalize and positively reinforce the exploration of one's own gender identity (disrupting cisnormativity) and the validation of the true self of the client (seeing authentic gender). The last step of the model (seeing authentic gender) corresponds to the most advanced and empowering way to affirm a client's gender identity. This step encompasses both validating the gender identity when it is appropriate and seeing the person in their whole, above and beyond their gender.

Study Limitations and Directions for Future Research

This research would benefit from a more demographically diverse sample. Dillman, Smyth, and Christian (2014) found that studies utilizing online recruitment and survey distribution disproportionally represent white, middle to upper class, and educated individuals, limiting the degree to which the results can be generalized. Thus, future studies should use various recruitment strategies in order to gather a more representative sample.

Previous research has indicated that the perpetuation of gender identity-based microaggressions may vary across identity (Chang & Chung, 2015, Galupo, Henise, & Davis, 2014; Pulice-Farrow, Clements, & Galupo, 2017), and it is within reason that the same findings apply to microaffirmations. An additional limitation of the current study is that participants were recruited

based on their transgender identity. This inclusion criteria may have unintentionally excluded those who are questioning their gender identity or are in the process of forming a transgender identity. The experiences of these individuals, which may have differed due to their developmental identity, were likely unaccounted for in the current study.

Further, participants in the current study endorsed a binary identity (man with a transgender history, transfeminine/trans woman, transmasculine/trans man, and woman with a transgender history) nearly four times as often as a nonbinary identity (agender, bigender, gender non-conforming, genderqueer/fluid, and two-spirit). Although no significant differences were found between those with binary and non-binary identities, future studies with larger sample sizes should attempt to recruit more evenly across identities.

That microaffirmations may be viewed on a linear model encourages practitioners to identify the stage in which they most frequently engage. Future research should be aimed towards the development of interventions targeting skill development at each respective stage, so as to improve the field of gender-affirmative mental health care.

Implications for Counseling

The present study used the construct of transgender microaffirmations (Flanders, 2015; Pulice-Farrow et al., 2019) to investigate the positive experiences of transgender people within the relationships with their therapists. The aim of the study was to fill the gap in the literature regarding the

relationship between psychologists and trans clients, particularly regarding how therapists and counselors can be affirmative in their practice. The model of microaffirmations in trans peoples' therapeutic experiences has important implications for clinical practice.

First, the theme of absence of microaggressions underscores how trans people frame their perception of affirmative practices. This bias may be due to continual exposure to negative experiences that activate an automatic expectation of negative response from the environment. This fits with recent conceptualizations of gender minority stress and resilience (Testa et al., 2015) where identity nonaffirmation is proposed as a distal stressor that then triggers negative internalized attitudes. It is important that mental health professionals offer a safe environment in which trans people have the opportunity to overcome this learned response of hypervigilance (Nadal, Skolnik & Wong, 2012). Although we presented a four-step model of microaffirmations, we hope that the first step might not be necessary in the future. For example, a simple call back by one's therapist or a lack of a disgusted response should be the minimum to expect from ones' own therapist.

Second, the model could serve as useful self-evaluation resource for therapists. As therapists, being aware of the model for gender-based microaffirmations in therapy could be helpful for assessing self-knowledge and present behavior. This information could help therapists reinforce their

affirming practices or help them to move from less passive to a more active role.

Effects of Minority Stress and Social Influences on Transgender Individuals' Psychological Functioning: Clinical implications

This chapter presents studies focused on the consequences of minority stress for the mental health and well-being of transgender individuals. The first study is inherently clinical and will be focused on the investigation of personality patterns of medicalized transgender men and women, by evaluating both the dimensional personality domains proposed by the Alternative Model of Personality Disorders and the categorical DSM-IV personality disorder (PD) diagnoses. Eighty-seven participants (40 transgender women and 47 transgender men; age: 28.10 ± 11.61), voluntarily recruited among those consecutively admitted to a gender clinic, were administered the PID-5 questionnaire and the SCID-II. Transgender women scored lower than cisgender women on two main domains (Negative Affectivity and Psychoticism), and on 7 facets (Submissiveness, Perseveration, Unusual beliefs, Cognitive and Perceptual Dysregulation, Deceitfulness, Irresponsibility and Impulsivity). As for transgender men, lower scores than cisgender men were found on Antagonism and on 5 facets (Restricted affectivity, Intimacy avoidance, Irresponsibility, Impulsivity, Rigid perfectionism). Transgender men scored higher than cisgender men on Depressivity. Nearly 50% of participants showed at least one PD diagnosis, with no gender differences in prevalence.

Borderline PD was the most frequent diagnosis in the overall sample. Self-report measures provide a less maladaptive profile of personality functioning than the clinician-based categorical assessment. Results are interpreted in the light of the Minority Stress Model, and support the need for a multi-method assessment of personality in medicalized transgender people.

The second study will look at the effects of societal gender norms in a different psychological domain, that is sexuality. In particular, the study will focus on sexual imagery and fantasy, that are key aspects of human sexuality as they are associated with sexual arousal and sexual response. A limitation of the existing literature on sexual fantasies is the pervasive focus on cisgender heterosexual individuals, whose behavior is considered normative in a cis-heteronormative society. This research has established the strong influence of gendered sexual scripts on the functioning and content of (presumably) cisgender individuals' sexual fantasies. How these gendered scripts might apply to individuals whose gender identity falls outside the binary is an under-researched area of study. The work is aimed at providing a better understanding of non-binary individuals' sexuality through a qualitative investigation of sexual fantasies in a matched sample of Italian non-binary and cisgender individuals. Results indicated that the sexual fantasies of non-binary individuals were generally comparable to cisgender individuals but were significantly more likely to contain references to non-normative genitals but less likely to refer to themselves as the object of desire. Discussion focuses on how the differences in

non-binary individuals' sexual fantasies affirmed, or were the result of, their gender identity.

1.16 Study 4 – Personality Disorders and Personality Profiles in a Sample of Transgender Clientsrequesting Gender-affirming Treatments

Introduction

Mental health among transgender people is a sensitive topic and the role of mental health professionals in the diagnosis of gender dysphoria and the diagnosis itself are still controversial (Meyer-Balburg, 2010; Dhejne et al., 2016).

Available evidence suggests a higher prevalence of psychopathology in the medicalized transgender population compared to the general population. Transgender people with a diagnosis of gender dysphoria (GD) and attending transgender healthcare services show higher rates of psychiatric disorders, and particularly anxiety and depressive disorders, than the cisgender population (see Dhejne et al., 2016, for a review). Some cross-sectional studies have also evaluated prevalence estimates of personality pathology in the transgender population (Duisin et al., 2014; Fisher et al., 2013; Gomez-Gill et al., 2008; Haraldsen and Dahl, 2000; Hep et al., 2005; Heylens et al., 2014; Madeddu et al., 2009; Meybodi et al., 2014; Miach et al., 2000), although research findings on this topic are still mixed and inconclusive.

Overall, the prevalence of DSM-IV personality disorders (PDs) in samples of medicalized transgender people spreads over a range between 4.3% (Fisher et al., 2013) and 81.4% (Meybodi et al., 2014), with some studies (Fisher et al., 2013) reporting a prevalence rate even inferior to what was found

in large epidemiological samples (Grant et al., 2004). Cluster B PDs, and particularly borderline and narcissistic PDs, were identified as the most frequently diagnosed Axis II disorders in these samples (Bodlund et al., 1993; Bodlund and Armelius, 1994; Cole et al., 1997; Haraldsen and Dahl, 2000; Hepp et al., 2005; Madeddu et al., 2009; Meybodi et al., 2014). Other studies reported a high prevalence of Cluster C disorders (Heylens et al., 2014), in particular avoidant PD (Duisin et al., 2014; Heylens et al., 2014), and of some specific Cluster A disorders, namely paranoid and schizoid PDs (Cole et al., 1997; Duisin et al., 2014; Heylens et al., 2014). No differences seem to emerge when the prevalence of PDs is compared between people in the male and female spectrum (Heylens et al., 2014; Madeddu et al., 2009), nor between gender-dysphoric individuals with early- and late-onset (Heylens et al., 2014).

In spite of its methodological limitations (see Dhejne et al., 2016 for a review) and the relative scarcity of studies on this topic, research on PD prevalence in medicalized transgender people may have a twofold significance.

First of all, research on personality pathology in sexual and gender minority people might be framed within the Minority Stress Model (Hendricks and Testa, 2012; Meyer, 2003), a theoretical framework assessing the role of psychosocial stressors in affecting health and well-being. Indeed, transgender and gender-variant people experience disproportionate rates of stressful life events due to their gender nonconformity or expression, and such stress may

directly or indirectly (i.e., through the action of internalized stigma) affect their mental health (Bockting et al., 2013; Hendrick and Testa, 2012).

Previous studies have linked minority stress to major psychiatric disorders (i.e., mood disorders, anxiety, substance use disorders) (Bockting et al, 2013; Hendricks and Testa, 2012; Pflum et al., 2015; Testa et al., 2015). However, it is plausible to hypothesize that the chronic exposition to minority stress, from the very early years of life, might also favour the development of dysfunctional personality features and interpersonal patterns that mimic the symptoms of PDs. This might be particularly true for transgender people, as opposed to members of other sexual minorities, since their awareness of their experienced gender can appear at a very early age, together with gender non-conforming behaviours and expression, that put them at risk for stigmatization, bullying, harassment and violence (Kosciw et al., 2014; Pizmony-Levy and Kosciw, 2016; Roberts et al., 2013). The impact of minority stress may vary according to the level of trans-negative attitudes in the social and cultural environment. This could be particularly crucial for a country like Italy, where the current study was carried out (Anzani et al., in press; Prunas et al., 2015; Prunas et al., 2018). According to Transgender Europe (Transrespect versus Transphobia Worldwide Research Project, 2017), Italy was the second European country in the overall number of homicides of transgender people perpetrated between 2008 and 2016. The negative attitude toward transgender and gender non-conforming people is largely influenced by the Catholic Church

and the interference that it still exerts on politics and the Italian society at large, which have caused the Country to fall behind with the recognition of fundamental civil rights for all sexual minorities (Lingiardi et al., 2015).

Secondly, personality pathology might also influence the clinical manifestations of GD, as well as the gender transition process. For instance, borderline PD was associated with younger age at the time of application to the gender clinic and tended to be related with greater GD severity (Heylens et al, 2014). Most importantly, a thorough assessment and understanding of the client's personality functioning (in terms of identity stability, self-directedness and interpersonal connections with others) is an important prognostic indicator that might help identify possible hurdles or concerns to be addressed in the gender transition process. As underlined in the Standards of Care of the World Professional Association of Transgender Health (7th version; Coleman et al., 2011), mental health concerns (including PDs) "can be significant sources of distress and, if left untreated, can complicate the process of gender identity exploration and resolution of gender dysphoria" (p.25). Therefore, mental health professionals should screen for both psychopathology and personality pathology during the assessment phase with GD clients, and take it into account when establishing the overall treatment plan. This allows to tailor the treatment to the patient's specific needs, to help them navigate the transition process, to improve their quality of life and, ultimately, to reduce GD.

Although PDs (like any other mental health issue) should never be considered an absolute contraindication for gender transition, hormones or surgery (Coleman et al., 2011), it is reasonable to assume that the presence of any PDs may interfere with the adaptation to the transition process, with compliance with medical treatments and with the post-hormonal and surgical well-being and satisfaction. Bodlund and Kullgren (1996), for example, found that any PD diagnosis and a high number of fulfilled Axis II pathological traits were associated with negative post-surgery outcome. More generally, people with PDs can be difficult medical patients, especially when the condition they are affected with requires long-term medical management (as it is the case with hormonal treatments in medicalized transgender people). For instance, borderline symptoms significantly predicted reduced treatment compliance with several aspects of general healthcare among participants in a primary care population (i.e., conscientiousness with medical treatment, regular dental check-ups, timely completion of laboratory work, following doctor's exercise and nutrition instructions, and remembering to take medications) (Sansone et al., 2015).

In spite of the significant clinical implications, the literature on PDs in medicalized transgender people is scarce.

Dimensional models of personality disorders

Another line of research has explored the personality functioning of transgender people by means of dimensional models of personality, mostly with

inconsistent results. Bozkurt and coll. (2006), for example, used the Eysenck Personality Questionnaire (Eysenck and Eysenck, 1978) to assess three personality dimensions and found higher scores on neuroticism in transwomen compared to cisgender men. Another study (Gómez-Gil et al., 2013) explored the personality profile of people with GD by means of the TCI (Cloninger, 1994), showing that transgender and cisgender people displayed a similar personality profile. Furthermore, the personality profile of transgender individuals resembled more that of the control sample matched by gender identity rather than by gender assigned at birth.

Generally speaking, the results derived from this line of studies provide a fragmented picture because of the different personality measures adopted. Most of these assessment instruments are not directly compatible with a clinical evaluation based on DSM PD criteria, and are not informative in terms of treatment planning.

To our knowledge, no study has yet explored the personality profile of transgender populations according to the new conceptual framework for PDs introduced by the DSM-5 Alternative Model for Personality Disorders (AMPD) (APA, 2013). The model allows to diagnose seven personality disorders, which are all characterized by a moderate or greater impairment in personality functioning and one or more pathological personality traits. The latter are intended as the "tendency to feel, perceive, behave and think in relatively consistent ways across time and across situations" and are grouped in five broad

domains (Negative affectivity, Detachment, Antagonism, Disinhibition and Psychoticism) (APA, 2013, p.762). The multidimensional approach of pathological personality traits is empirically derived (Krueger and Markon, 2014) and has been operationalized in the Personality Inventory for DSM-5 (PID-5) (APA, 2013).

The current study

This study aims to gain a more fine-grained picture of the personality pathology patterns among medicalized transgender men and women, by evaluating both the dimensional personality domains and facets proposed by the AMPD (APA, 2013) and the categorical DSM-IV PD diagnoses.

To this aim, we compared the PID-5 patterns of transgender women and transgender men with those of, respectively, cisgender women and men derived from a large normative sample from the community (Fossati et al., 2013). It is important to note that there are currently no norms for transgender or non-binary people for most personality measures, including the PID-5. This puts psychologists and researchers in the position of having to decide whether to use the gender they were assigned at birth or the gender they identify with as a reference. This choice comes with several implications, as it might lead to over- or underestimating levels of distress or psychopathological symptoms, thus contributing to harm an already vulnerable population (Keo-Meyer et al., 2015; Keo- Meyer and Fitzgerald, 2017). However, the limited number of studies and evidence available seem to suggest that, when scoring psychological assessment

tools, it may be more effective to categorize individuals as their identified gender (Webb et al., 2016).

We also evaluated the prevalence of DSM-IV categorical PD diagnoses in the transgender women and men subsamples. The two subsamples were compared on the overall prevalence of PDs and of any specific PD diagnosis. In line with previous studies (Heylens et al., 2014; Madeddu et al., 2009), we expect to find no difference in the overall PD prevalence, and a predominance of Cluster B diagnoses.

Methods

Participants and procedure

Clients were recruited among those consecutively admitted at the gender clinic at Niguarda Ca' Granda Hospital in Milan, Italy, between January 2017 and July 2018. All clients were referred to the gender clinic for consultation on gender identity issues, gender-affirming hormonal (feminizing or masculinizing treatment) and/or surgical treatments. The criteria for inclusion in the study were a diagnosis of GD (according to DSM-5; APA, 2013), and absence of any current major psychiatric disorders (psychotic disorders, neurocognitive disorders, mental retardation). Inclusion criteria were assessed through at least three individual sessions with an experienced mental health professional.

One-hundred-eight transgender clients accepted to participate in the study, but the final sample included only 87 participants (40 transgender women and 47 transgender men), as 21 participants failed to complete the

questionnaires in their entirety or dropped out after the first assessment session. The PID-5 questionnaire was considered incomplete if responses to more than 25% of the items within each facet were missing.

Participants were first asked to complete a set of self-report questionnaires (including the PID-5 and the SCID-II-PQ), and they were then evaluated with a structured interview for the assessment of personality pathology (SCID-II). Sociodemographic characteristics of the sample are summarized in Table 3. All participants were Italian citizens and the large majority (85%) of them identified as binary. No age difference was found between the two samples (Student's t =0.02, df = 85, $p > 0.05$). Thirteen participants (15% of the whole sample) were already taking masculinizing or feminizing hormones, not necessarily under medical advice.

The study was approved by the Institutional Review Board of the University of Milano-Bicocca and was in accordance with the ethical standards of the 1964 Declaration of Helsinki. All participants provided written informed consent to participate in the study.

Table 5. Participants' demographics

	Transwomen N = 40 N (%)	Transmen N = 47 N (%)
Age	28.21 (SD = 11.8)	28.26 (SD = 11.6)
17	2 (5%)	2 (4.3%)
18-25	20 (50%)	26 (55.3%)
26-35	6 (15%)	7 (14.9%)

36-45	8 (15%)	6 (12.8%)
46-55	2 (5%)	4 (8.5%)
56-65	1 (2.5%)	2 (4.3%)
Non-binary Identity	9 (22.5%)	4 (8.5%)
Hormone treatment	10 (25%)	3 (6,4%)
Educational Level		
Less than high school	7 (17.5%)	17 (36.2%)
High school diploma	24 (60%)	21 (44.7%)
Master's degree	7 (17.5%)	8 (17%)
Other	1 (2.5%)	1 (2.1%)
Civil Status		
Single	31 (77.5%)	39 (83%)
Married	0	1 (2.1%)
Divorced	4 (10%)	1 (2.1%)
Cohabitant	4 (10%)	5 (10.6%)

Measures

The Personality Inventory for DSM-5 (PID-5; Krueger et al., 2012; Fossati et al., 2013) is a self- report questionnaire composed of 220 items, each of which is scored on a 4-point Likert scale (from "0" = "very false or often false" to "3" = "very true or often true"). The questionnaire measures the 25 traits proposed by the alternative model of the DSM-5, Section III. Higher scores reflect higher levels of endorsement of that specific trait and personality pathology. To compute the personality domains and facets score we made use of the algorithm proposed by Krueger and coll. (2011). In the current study Cronbach's α values of .96, .95, .83, .89, .94 were observed respectively for Negative Affectivity, Detachment, Antagonism, Disinhibition, Psychoticism.

As for the facets, Cronbach's α was acceptable (i.e. > .70) for all traits scales and ranged from .72 (Restricted affectivity; Deceitfulness) to .95 (Eccentricity), except for Suspiciousness (α = .64) and Irresponsibility (α = .61).

The Structured Clinical Interview Axis II for DSM-IV (SCID II; First et al., 1997) is a semi-structured interview that allows a categorical assessment of the ten DSM-IV PDs, as well as of PD not otherwise specified and of the adjunctive diagnoses of Depressive and Passive-Aggressive PDs. The SCID-II is preceded by the administration of its self-report screening questionnaire.

Statistical analyses

We first compared the mean scores of each PID-5 facet and domain between transgender clients and the corresponding normative data derived for the Italian general population (Fossati et al., 2015) using one-sample t tests. Transgender women (assigned male at birth) were compared with cisgender women, while transgender men (assigned female at birth) were compared with cisgender men. We next evaluated the prevalence of PDs in the overall sample, and then compared PD rates between transgender women and transgender men using χ^2 test.

Results

PID-5 profiles in the study sample

Table 4 shows PID-5 scores in the transgender women and transgender men samples and their comparison with those of cisgender women and men from the general population.

Transgender women scored lower than cisgender women on two main domains: Negative Affectivity (*t* (39) = -3.94, *p* < .001, 95% CI [-.43, -.14]) and Psychoticism (*t* (39) = -2.83, p < .01, 95% CI [-.31, -.05]). Specifically, they scored lower on two facets of Negative Affectivity, i.e., Submissiveness (*t* (39) = -4.96, *p* < .001, 95% CI [-.51, -.22]) and Perseveration (*t* (39) = -3.35, *p* < .01, , 95% CI [-.43, -.11]) as well as on two facets of Psychoticism, i.e. Unusual beliefs (*t* (39) = -3.66, *p* < .001, 95% CI [-.37, -.11]) and Cognitive and Perceptual Dysregulation (*t* (39) = -3.34, *p* < .01, 95% CI [-.30, -.07]). Further, transgender women scored lower than cisgender women on the Antagonism facet of Deceitfulness (*t* (39) = -2.52, *p* < .05, 95% CI [-.28, -.03]), and on the Disinhibition facets of Irresponsibility (*t* =-1.98, *p* < .05, 95% CI [-.22, .00]) and Impulsivity (*t* (39) = -3.80, *p* < .001, 95% CI [-.52, -.16]).

As for transgender men, lower scores than cisgender men were found on Antagonism (*t* (46) = -7.19, *p* < .001, 95% CI [-.38, -.21]), and specifically on all the facets of this domain, i.e., Manipulativeness (*t* (46) = -4.74, p < .001, 95% CI [-.46, -.18]), Deceitfulness (*t* (46) = -11.56, *p* < .001, 95% CI [-.47,-.33]), Grandiosity (*t* (46) = -8.19, *p* < .001, 95% CI [-.51, -.31]), Attention Seeking (*t* (46) = -2.42, *p* < .05, 95% CI [-.37, -.03]), and Callousness (*t* (46) = -8.38, *p* < .001, 95% CI [-.40, -.25]). Also, transgender men scored lower on the Negative Affectivity facet of Restricted affectivity (*t* (46) = - 2.97, *p* < .01, 95% CI [-.43, -.08]), on the Detachment facet of Intimacy avoidance (*t* (46) = -3.22, *p* < .01, 95% CI [-.45, -.10]), and on the Disinhibition facets of Irresponsibility

(*t* (46) = -4.68, *p* < .001, 95% CI [-.41, -.16]), Impulsivity (*t* (46) = -2.87, *p* < .01, 95% CI [-.51, -.09]) and Rigid perfectionism (*t* (46) = -2.81, *p* < .01, 95% CI [-.44, -.07]). Finally, transgender men scored higher than cisgender men on Depressivity (*t* (46) = 2.28, *p* < .05, 95% CI [.03, .43]), a facet of Negative Affectivity.

DSM-IV personality disorders rates in the study sample

SCID-II results are summarized in Table 5. Ninety-one participants (43 transgender men and 48 transgender women) completed the semi-structured interview out of the initial sample. Fourty-five clients were diagnosed with at least one PD (49.5% of the total sample) and eight clients (8.8%) received more than one PD diagnoses. Cluster B PDs were the most frequent diagnoses, affecting 18.7% of participants in the overall sample. Cluster C PDs were diagnosed in 5 cases (5.5%) and Cluster A PDs in 3 cases (3.3%). Twenty-five patients (27.5%) received a diagnosis of not-otherwise specified (NOS) PD. The specific disorders with the highest prevalence rates were borderline PD (11%), depressive PD (although not included in the official classification) (9.9%) and narcissistic PD (5.5%). Narcissistic PD was more prevalent among transgender women than transgender men. No difference in the prevalence of any other PD was detected between the two subgroups of transgender clients.

Table 6. *PID-5 Descriptive statistics for PID-5 domains and facets and comparisons between transgender and cisgender women and transgender and cisgender men..*

[1] Data derived from the normative sample of the validation study of Italian version of the PID-5 (Fossati et al., 2016)
*p<.05; **p<.01; ***p<.001

	Transmen (N=47) Mean (SD)	**Cisgender Men[1]** Mean	**t**	**Statistical comparison**	**Transwomen (N=40)** Mean (SD)	**Cisgender Women[1]** Mean	**t**	**Statistical comparison**
Negative Affectivity	**0.85 (0.52)**	**0.93**	**-1.11**		**0.75 (0.46)**	**1.04**	**-3.94*** **	**CisW > TW**
Emotional lability	1.12 (0.88)	0.97	1.16		0.98 (0.70)	1.17	-1.73	
Anxiousness	1.17 (0.71)	1.04	1.32		1.01 (0.60)	1.14	-1.30	
Separation insecurity	0.77 (0.77)	0.80	-0.25		0.75 (0.67)	0.82	-0.66	
Submissiveness	0.54 (0.63)	0.70	-1.77		0.34 (0.47)	0.71	-4.96***	CisW > TW

Hostility	0.81 (0.69)	0.97	-1.69		0.82 (0.62)	0.90	-0.86	
Perseveration	0.81 (0.52)	0.94	-1.74		0.69 (0.51)	0.96	-3.35**	CisW > TW
Restricted affectivity	0.73 (0.59)	0.99	-2.97**	CisM > TM	0.69 (0.53)	0.80	-1.26	
Detachment	**0.86 (0.48)**	**0.85**	**0.25**		**0.75 (0.44)**	**0.78**	**-0.54**	
Withdrawal	0.96 (0.63)	0.79	1.90		0.74 (0.61)	0.69	0.56	
Intimacy avoidance	0.54 (0.59)	0.82	-3.22**	CisM > TM	0.66 (0.69)	0.78	-1.11	
Anhedonia	1.01 (0.64)	0.93	0.81		0.82 (0.60)	0.89	-0.67	
Depressivity	0.79 (0.68)	0.56	2.28*	CisM < TM	0.53 (0.52)	0.53	0.09	
Suspiciousness	1.01 (0.54)	1.05	-1.07		0.98 (0.41)	0.99	-0.23	
Antagonism	**0.37 (0.28)**	**0.67**	**-7.19*** **	**CisM > TM**	**0.58 (0.44)**	**0.55**	**0.37**	
Manipulativeness	0.33 (0.47)	0.65	-4.74***	CisM > TM	0.61 (0.56)	0.55	0.68	
Deceitfulness	0.28 (0.24)	0.68	-11.56***	CisM > TM	0.40 (0.39)	0.55	-2.52*	CisW > TW
Grandiosity	0.26 (0.35)	0.67	-8.19***	CisM > TM	0.50 (0.54)	0.55	-0.67	

Attention seeking	0.70 (0.57)	0.90	-2.42*	CisM > TM	1.01 (0.78)	0.84	1.38	
Callousness	0.28 (0.27)	0.61	-8.38***	CisM > TM	0.37 (0.36)	0.43	-1.04	
Disinhibition	**0.77 (0.40)**	**0.87**	**-1.82**		**0.76 (0.36)**	**0.82**	**-0.98**	
Irresponsibility	0.43 (0.42)	0.72	-4.68***	CisM > TM	0.51 (0.35)	0.62	-1.98*	CisW > TW
Impulsivity	0.75 (0.72)	1.05	-2.87**	CisM > TM	0.70 (0.57)	1.05	-3.80***	CisW > TW
Distractibility	0.72 (0.65)	0.85	-1.44		0.65 (0.63)	0.79	-1.33	
Risk taking	1.05 (0.48)	1.10	-0.69		0.90 (0.42)	1.02	-1.79	
Rigid perfectionism	0.89 (0.63)	1.15	-2.81**	CisM > TM	1.05 (0.51)	1.12	-0.85	
Psychoticism	**0.57 (0.53)**	**0.67**	**-1.23**		**0.46 (0.40)**	**0.64**	**-2.83****	**CisW > TW**
Unusual beliefs and experiences	0.50 (0.52)	0.61	-1.44		0.39 (0.41)	0.63	-3.66***	CisW > TW
Eccentricity	0.75 (0.79)	0.86	-0.98		0.64 (0.63)	0.76	-1.22	
Cognitive and perceptual disregulation	0.47 (0.50)	0.53	-0.88		0.34 (0.35)	0.53	-3.34**	CisW > TW

Given the discrepancies between the self-report and clinical assessment of personality functioning, we further evaluated whether the presence of any DSM-IV PD diagnosis was associated with higher scores on the PID-5 domains by means of five ANOVAs with a 2 (gender assigned at birth) x 2 (PD vs No PD) design (dependent variables: PID-5 domain scores).

Transgender participants with at least one PD diagnosis showed higher scores on Negative Affectivity, Detachment, Disinhibition and Psychoticism (*Fs* (1,79) between 9.288 and 17.371, all *ps* $\leq$ .003), while the presence of any PD diagnosis was unrelated with Antagonism scores (F (1,79) = 1.101, $p > 0.05$). Further, assigned males at birth showed higher scores than assigned females on Antagonism (significant main effect of gender assigned at birth: F (1, 79) = 5.944, $p < .05$).

Table 7. SCID-II scores. Prevalence of personality disorders in the two samples.

[1] At least one PD diagnosis belonging to this cluster.
[2] We included here only those individuals who fulfill the general diagnostic criteria for a PD but that do not meet criteria for any specific PD. The prevalence of the PDs not officially included in the classification (depressive and passive-aggressive) are listed separately.

	Transwomen (N = 48)	Transmen (N = 43)	Total (N = 91)	C.C. χ^2 (df = 1), p
At least on PD diagnosis	26 (54.2%)	19 (44.2%)	45 (49.5%)	0.90, N.S.
Cluster A diagnoses[1]	1 (2.1%)	2 (4.6%)	3 (3.3%)	0.47, N.S.
Paranoid PD	1 (2.1%)	0	1 (1.1%)	0.91, N.S.
Schizoid PD	0	1 (2.3%)	1 (1.1%)	1.13, N.S.
Schizotypal PD	0	1 (2.3%)	1 (1.1%)	1.13, N.S.
Cluster B diagnoses[1]	8 (16.7%)	4 (9.3%)	12 (13.2%)	1.07, N.S.
Histrionic PD	1 (2.1%)	0	1 (1.1%)	0.91, N.S.

Narcissistic PD	5 (10.4%)	0	5 (5.5%)	4.74, 0.03
Borderline PD	6 (12.5%)	4 (9.3%)	10 (11%)	.24, N.S.
Antisocial PD	0	1 (2.3%)	1 (1.1%)	1.13, N.S.
Cluster C diagnoses[1]	2 (4.2%)	2 (4.6%)	4 (4,4%)	0.01, N.S.
Avoidant PD	1 (2.1%)	1 (2.3%)	2 (2.2%)	0.01, N.S.
Dependent PD	1 (2.1%)	0	1 (1.1%)	0.91, N.S.
Obsessive-compulsive PD	1 (2.1%)	1 (2.3%)	2 (2.2%)	0.01, N.S.
Not-otherwise specified (NOS) PD[2]	16 (33.3%)	9 (20.9%)	25 (27.5%)	1.75., N.S.
Depressive PD	4 (8.3%)	5 (11.6%)	9 (9.9%)	0.28, N.S.
Passive-aggressive PD	0	0	0	-

Discussion

To our knowledge, this study was the first to investigate the personality profile of medicalized transgender clients by means of both the dimensional DSM-5 Alternative Model for personality traits and the classical DSM-IV categorical approach to PDs.

Two main findings emerged. First, the AMPD dimensional assessment of personality traits indicated that the transgender sample presented, overall, a healthier and less maladaptive personality profile than their cisgender counterparts matched by gender identity. Second, the categorical approach to PDs diagnoses by means of structured clinical interviewing pointed out a considerable prevalence of PDs in our sample: almost half of the included transgender clients exhibited at least one PD diagnosis.

Thus, two different scenarios emerged, with self-report dimensional measures offering a much healthier and less maladaptive view of overall

personality functioning than the clinician-based categorical assessment. These different findings can be attributed to various sources. One hypothesis is that the differences might be connected to method variance. It has been reported that the variance of PD diagnoses explained by PID–5 traits is weak to moderate, ranging between 24% and 49% (Few et al., 2013). Another possible explanation is connected to the peculiarities of the therapeutic relationship and rapport between mental health professionals and transgender clients requesting gender-affirming medical treatments. Transgender clients may perceive the assessment process as a hurdle that must be cleared to achieve their goals, rather than as a useful and helpful clinical tool (Madeddu et al., 2009). The clinician's "gate-keeping" role may thus induce transgender clients to present themselves (especially when confronted with self-report measures) as healthy and well-functioning, denying the presence and clinical relevance of overt psychopathological manifestations. Although current diagnostic manuals (APA 2013; WHO, 2018), clinical guidelines (Hembree et al., 2017) and Standards of Care (Coleman et al., 2011) moved far beyond the "gate-keeping" approach, even nowadays the fear of being denied appropriate treatment may keep trans clients experiencing mental health professionals as "gate keepers" in their transition journey (Nieder et al., 2016). As a consequence, they might show a guarded, defended attitude whenever questions or issues around their mental health are raised in clinical consultation especially, but not only, when access to gender- confirming medical treatment is at stake. It must be noted, however,

that in spite of this possible confounding effect, we were still able to discriminate between the dimensional personality profile of transgender clients with and without any PD diagnosis, with transgender clients with PDs showing a more dysfunctional and maladaptive profile than those without any personality diagnosis.

It is plausible to read the less maladaptive profiles through the lens of the Minority Stress Model, specifically in terms of resilience. There is evidence that transgender individuals use adaptive strategies to buffer the effects of stigma on health, exercising resilience to contrast societal stigma and promoting social adjustment (Meyer, 2015). Resilience in transgender people involves a self-generated definition of self and embraces self-worth (Singh et al., 2014), thus promoting wellbeing and health and representing a strong protective factor against mental disorders (Scandurra et al., 2018).

Personality facets and domains according to the Alternative Model of Personality Disorders Transgender men scored lower than cisgender men on every trait included in the Antagonism domain. Antagonism, juxtaposed to Agreeableness, is defined as "behaviours that put the individual at odds with other people, including an exaggerated sense of self-importance and a concomitant expectation of special treatment, as well as a callous antipathy towards others, encompassing both unawareness of others' needs and feelings and a readiness to use others in the service of self-enhancement" (APA, 2013, p.780). The Antagonism domain has been reported to show marked gender

differences, with men scoring consistently higher than women (Bastianes et al., 2016; Fossati et al., 2015). Manipulativeness, Deceitfulness, Grandiosity, Attention-seeking, Callousness and Hostility, as facets included in the Antagonism domain, seem therefore to be less characteristic of the personality functioning of transgender men as opposed to cisgender men. One speculative explanation for this result could be ascribed to a lower propensity of transmen to a sense of entitlement and self- assertiveness, as they navigate a world in which they are more exposed to aggressions, microaggressions, harassment and violence than cisgender men (Nadal at al., 2012; Prunas et al., 2018; Shires and Jaffee, 2015). Instead, they might need to be more vigilant and attuned to other people's feelings and needs, in order to understand their intentions and attitudes. The low scores in the Antagonism domain in the sample of transgender men are in line with the low prevalence, in this sample, of narcissistic PD, of which Antagonism is a crucial clinical correlate (APA, 2013). Moreover, it must be noted that transgender men lived part of their lives in a female role and were socialized as women. Women are socially expected to be more agreeable than men, and generally report higher levels of agreeableness across most cultures around the world (Schmitt et al., 2008). Also, on average females report to be more nurturing, warm, affiliative than males, as well as less aggressive, impulsive, dominant, sensation-seeking and risk-taking (Mealey et al., 2000). Lower scores on the traits included in the Antagonism domain (together with lower scores on other traits like Restricted affectivity, Intimacy

avoidance, Irresponsibility and Impulsivity) could be ascribed to the fact that transmen were encouraged, during their early years, to express their feelings and build intimate relationships, as well as being empathetic, attuned to the needs of others and altruistic.

The same explanation can apply to the finding that transgender women show lower scores than cisgender women on Negative Affectivity, and specifically on Submissiveness and Perseveration. Being socialized as male might lead transgender woman to exhibit a reduced tendency to experience "frequent and intense experiences of high levels of a wide range of negative emotions and their behavioral and interpersonal manifestations" (APA, 2013, p. 779). Several studies have shown gender differences in emotion expressions in Western cultures (Chaplin, 2015). In particular women show greater emotional expression overall (Chaplin, 2015; Kring and Gordon, 1998) and a wider range of positive (LaFrance et al., 2003) and internalizing negative emotions (Allen and Haccoun, 1976). It could be argued that a masculine socialization encourages the adoption of a pattern of emotional expression that is consistent with the stereotypical gender role (i.e., emotional restraint). Transmen scored higher than cisgender men only on Depressivity, a facet denoting "feelings of being down, miserable and/or helpless; pessimism about the future; pervasive shame and/or guilt; feelings of inferior self-worth; thought of suicide and suicidal behaviour" (APA, 2013, p. 779). This result is also supported by the

relatively high prevalence of Depressive PD (approaching 12%) in the sample of transgender men.

The validity of Depressive PD as a discrete diagnostic entity has been criticized on several grounds (Ryder et al., 2002), including the large diagnostic overlap with mood disorder diagnoses, dysthymia in particular (Bagby et al., 2003). Such critiques have led to the exclusion of Depressive PD from the DSM-5 (APA, 2013). The high endorsement of Depressivity in transgender men suggests that attention should be paid to signs of depression, not only in the form of a full-blown mood disorder, but also as a personality disposition. Although several studies have underlined the role of minority stress in increasing the risk for mood disorders in sexual minorities, only a few focused specifically on the transgender population (Bockting et al., 2013; Hoy-Ellis et al., 2017), and none on the impact of minority stress in shaping long-lasting, and stable depressive personality traits (i.e. pessimism, shame, low self-esteem, lack of motivation, guilt-proneness), which seem to be pervasively characteristic of transgender people (Giordano, 2018).

Categorical diagnoses of personality disorders

The nearly 50% prevalence rate of any PD diagnosis in the current sample is consistent with previous findings on a sample of transgender clients with DSM-IV "gender identity disorder". For example, in the study by Madeddu and coll. (2009), using the SCID-II, an overall prevalence of PDs of 52% was found, with 22% prevalence of Cluster B PDs (with narcissistic PD

showing the highest prevalence in the overall sample), 12% of Cluster A PDs, 2% of Cluster C PDs and a 16% prevalence of Not Otherwise Specified PD.

In line with previous studies (Heylens et al., 2014; Madeddu et al., 2009), transgender women and men did not differ in terms of PD rates, and borderline PD was the most frequent diagnosis in the overall sample (Cole et al., 1997), again with no differences in prevalence between the two subsamples. As the prevalence of PDs in the general population has been estimated around 15% in large epidemiological studies (Grant et al., 2004), it may be argued that transgender clients are at a higher risk of developing PDs than the general population. However, the complex relationship between the development of PDs and GD is still far from being elucidated, and several factors may contribute to the high PD rates detected among transgender samples, as compared to general norms. Although PDs and GD may well be independent conditions, it might be difficult to ascertain the presence and clinical relevance of PD traits during the assessment process with transgender clients. The diagnosis of PDs often requires a longer clinical observation than that of GD, and every personality trait or interpersonal pattern assessed in transgender people should be carefully considered in the light of the specific phase of the transition process the client is going through. For instance, ideas of reference or suspiciousness might be quite common in transgender clients, especially at the beginning of their social transition (Bodlund et al., 1993). Furthermore, these personality traits and patterns can be even adaptive at early stages, given the

risks and threats (in terms of violence and interpersonal rejection) connected to the exoticization and ridicule of transgender bodies within a trans-negative cultural environment (Pfeffer, 2016).

Moreover, as the onset of PDs and often that of GD can be traced back to adolescence/early adulthood (and sometimes even childhood), it might be argued that PDs (or maladaptive personality traits) may evolve as a dysfunctional way of coping with GD (Bockting et al., 2006). For example, transgender people might handle intense dysphoric feelings through social isolation, avoidance of interactions with others, self-harm and self-mutilation, anger outbursts, preoccupation with grandiose fantasies, envy of others, all of which constitute characteristic patterns of definite PDs.

Another possible explanation could be linked to the Minority Stress Model (Meyer, 2003), according to which the high prevalence rate of PDs and maladaptive personality traits in people belonging to minorities might result from the discriminative and stigmatizing environment in which they were raised and live. Transgender and gender non-conforming people are more likely than cisgender people to experience physical, psychological and sexual violence, discrimination, harassment, rejection from friends and family (Grossman and D'Augelli, 2007; Mizock and Lewis, 2008), even the more so than people belonging to other sexual minorities (i.e. lesbian, gay and bisexual people). Such negative experiences can impact on transgender people from the very early years of life. Over time, such negative experiences of discrimination end

up conveying to the transgender person the message that their identity and their core self are unacceptable, representing an unremitting form of invalidation. Although to our knowledge no previous study has explored the long-term impact of minority stress on personality traits and disorders, there is some preliminary evidence derived from studies carried out in large samples of LGB people. For example, in a study on teenagers from the community (Reuter et al., 2016), non-heterosexual participants were found to score higher on measures of borderline PD features than their straight counterparts, and the results remained significant even after controlling for measures of depression and anxiety. The authors argue that the association between a non- heterosexual orientation and borderline PD features can be explained as the result of an emotionally invalidating environment which, according to some theoretical models of borderline PD, plays a central role in the development of borderline PD (Linehan, 1993). Children at risk for developing BPD later in life are assumed to be born with a biological predisposition toward strong emotional responses that, in an interaction with the environment, are more likely to be invalidated. Over time, chronic invalidation leads to self-invalidation, as the capacity to accept and therefore manage one's own emotional, cognitive, and behavioural experiences and responses is disturbed. This pattern is thought to lead to the emotional dysregulation at the core of borderline PD. The same considerations can be extended to transgender clients to explain the high prevalence of

borderline PD and traits assessed in the current study, as well as previous ones (Cole et al., 1997).

Limitations

Transgender clients who seek medical treatments are not representative of the transgender and gender-nonconforming population at large, so the current results cannot be generalized to the entire transgender population. In fact, the prevalence of people in the general population that identify as gender-variant or gender-nonconforming is much larger than that referred to gender clinics (van Caenegem et al., 2015).

Also, we sampled participants at different stages of treatment and social transition: some people included in the sample were already taking hormonal therapies (not necessarily under medical advice), some others were already living in their experienced gender, while some others could be at an earlier stage of social transition. The different stage of transition might have influenced the response patterns to self-administered tests and clinician-administered interviews.

Longitudinal studies are needed to clarify the impact of personality pathology on long-term outcomes of medicalized transgender clients. To our knowledge, this relationship was only evaluated with respect to satisfaction with gender-affirming surgery (Bodlund and Kullgren, 1996). More studies are necessary to ascertain whether, in this specific population, the presence of any PDs traits or diagnosis (and borderline PD in particular) (Sansone et al., 2015)

can interfere with compliance with medical treatments and lead to worse general health outcomes (i.e., regular endocrinological check-ups, laboratory testing, following doctor's instructions).

Finally, in the current study, we compared the dimensional personality profile of transgender men and women with cisgender controls matched by gender identity. The lack of a consistent method for categorizing the gender of persons who identify differently than the gender they were assigned at birth presents a significant limitation to researchers attempting to study gender minority populations (Webb et al., 2016). It is advisable that improvements in deriving assessment norms are made, due to the growing visibility and acceptance of transgender people in the general public.

Conclusions

Our results call for the importance of an accurate assessment of personality pathology and maladaptive traits in transgender clients referred to gender clinics, by means of both categorical and dimensional assessment tools, in order to tailor the gender-affirming treatment to the client's specific needs and vulnerabilities.

Also, the presence of specific vulnerabilities in terms of personality functioning might be useful to anticipate potential difficulties that might be experienced in the following phases of the transition, especially, but not only, in the interpersonal and social domains.

The presence of a full-blown PD diagnosis should be addressed with ad-hoc treatments in order to improve the client's overall functioning.

1.17 Study 5 - Sexual Fantasy Across Gender Identity: A qualitative investigation of differences between cisgender and non-binary people's imagery

Introduction

Sexual imagery and fantasy are a key aspect in human sexuality as they are associated with sexual arousal and response (Morin, 1995). Leithenberg and Henning define sexual fantasies as "any mental imagery that is sexually arousing for the individual" (1995, p. 470). What people fantasize about can enhance (or inhibit) their sexual responsivity. Thus, sexual fantasies play a fundamental role in sexual functioning, where the erotic mind can produce and intensify sexual desire and arousal (Lehmiller, 2018; Morin, 1995). However, this association is not necessarily unidirectional, fantasies can stimulate sexual arousal as well as sexual arousal can stimulate fantasies (Leitenberg & Henning, 1995). The situational context for, and the contents of, sexual fantasies differ considerably among individuals and across identities. In fact, sexual fantasies might vary from more realistic imagery to completely unrealistic. They might involve more romantic and emotional images or be explicitly and strictly focused on sexual activity. They might occur during masturbation, sexual activities with partner(s), or without engaging in any sexual activity. Lastly, sexual fantasies might be spontaneous or intentional (Leitenberg & Henning, 1995; Wilson, 1978). In sex therapy, sexual imagery is often used as a channel to access individuals' eroticism and could be used as a powerful tool in working with clients (Morin, 1995). Despite the pivotal role of

fantasies in sexual functioning, literature on this topic is quite outdated and limited.

The original research within the area of sexual fantasies often focused on gender differences in sexual imagery, arguing that men engage more frequently in sexual fantasies than women (Jones & Barlow, 1990; Leitenberg & Henning, 1995), men are more prone than women to experience spontaneous sexual fantasies (Jones & Barlow, 1990), and that there are gender differences in the content of sexual fantasies. Men's fantasies were described as more visual and graphic in details; involving an active role in the sexual interaction; and often including specific sexual acts, group sex, description of the partner's body parts, and a greater variety of partners. On the other hand, women's fantasies were more focused on emotions and intimate connections, involved a passive sexual role, included a current or past partner, and named romantic thoughts (Sue, 1979; Zurbriggen & Yost, 2004).

More recently, Bogaert, Visser and Pozzebon (2015) argued that there is another fundamental difference between men and women's fantasies. The authors introduced the construct of object of desire self-consciousness (Bogaert & Brotto, 2014) to describe the fantasies in which individuals imagine themselves as the object of others' attraction. In these fantasies, individuals described using their body, their appearance, or their action to attract their sexual partner (Bogaert et al., 2015) with women being reported to be more prone than men in engaging in this type of fantasy. In other words, men would

focus on women's appearance in their fantasies and women would focus on men's interest in their appearance. The authors argue that being the object of others' desire is more relevant in the sociosexual functioning of individuals raised to be women (Bogaert & Brotto, 2014) because of the repeated indoctrination to the idea that women are the sum other their parts and that their sexual attraction stems from their appearance (Fredrickson & Roberts, 1997). Whereas men's sexuality is more visual (elicited by physical appearance) and proactive than women's, and thus they are less likely to view themselves as the object of someone else's desires (Bogaert & Brotto, 2014; Meana, 2010).

A limitation of the existing literature is the pervasive focus on cisgender heterosexual individuals, whose behavior is considered normative in a cis-heteronormative society. Conceptualizations of sexuality in psychological and sex research have been predominantly cis-heteronormative; however, cisgenderism depletes the reality of complex gender identities reducing it to two opposite and essentialist categories of woman vs. man, where cisgender is assumed to be the norm and is linguistically unmarked (Ansara & Hegarty, 2014). Cisgenderism entails a conceptualization of sexuality based on binary assumptions, in which gender identity and sexual orientation are largely perceived as fixed and immutable (van Anders, 2015). When acknowledging individuals who have identities outside of the binary constraints of cisgender and heterosexual identities, the essentialist and gendered conclusions of prior studies may fail to align with their lived experiences. Thus, it is important for

sexual research to resist cis-sexists' assumptions and ideology and to instead acknowledge the lived experience of those living outside of the binary constraints of the larger cis-heteronormative society.

Non-binary Experiences

As acknowledged, the literature on gender and sexual fantasies has focused almost exclusively on the cisgender experience. This research has established the strong influence of gendered sexual scripts on the functioning and content of (presumably) cisgender individuals' sexual fantasies. How these gendered scripts might apply to individuals whose gender identity falls outside the binary is an under-researched area of study.

A burgeoning area of research has been in gaining an understanding of the experiences of individuals who self-identify with the label's non-binary or genderqueer. Non-binary or genderqueer genders are umbrella terms which refer to individuals whose identities do align exclusively with woman or man categories (Webb, Matsuno, Budge, Krishnan & Balsam, 2017). Non-binary individuals may be fluid and move between genders or identify with a third gender other than woman and man (Richards et al., 2016). Despite the diversity among these identities, non-binary individuals share the same critical opposition for rigid gender binaries that do not reflect their experiences of gender (Bradford et al., 2018; Monro, 2019; Webb et al., 2017).

Although non-binary and genderqueer individuals are included within the broader identity group of transgender, research has found significant

differences in the experiences of binary vs. non-binary transgender individuals (Richards et al., 2016; Catalpa et al., 2019; Monro, 2019). A recent study by Catalpa and colleagues (2019) identified four identity dimensions that were able to strongly predict the differences between binary transgender, non-binary, and cisgender sexual minorities. In particular, non-binary individuals scored higher than binary transgender individuals on interpersonal scales, such as challenging the gender binary and gender fluidity (Catalpa et al., 2019). The two groups were comparable on the intra-psychic dimensions of identity (i.e., the theoretical understanding of gender and social construction of gender; Catalpa et al., 2019). Whereas, sexual minority individuals (i.e., lesbian, gay, and bisexual) scored lower than their transgender (binary and non-binary) counterparts on all four dimensions, highlighting their different experiences in terms of conceptualization of gender (Catalpa et al., 2019). These differences in experience and understanding of gender, both within the transgender spectrum and across sexual and gender minoritized identities, emphasizes the need for greater attention towards the unique experiences of non-binary individuals.

Research on the topic of sexual fantasies of non-binary individuals is scarce. The only resource available on this topic describes the sexual fantasies of self-identified non-binary people as being different from cisgender fantasy on several aspects (Lehmiller, 2019). Non-binary individuals were more prone to fantasize about kinky sex, forced sex, anal sex, the use of sex toys during intercourse, polyamorous relationships, and being someone else (i.e., an adult

baby, a furry, or body exchange). In the on-line blog of the author, Lehmiller (2019) discusses the proneness of non-binary individuals to imagine changing their body as another relevant element in non-binary fantasy. Compared to cisgender people, non-binary individuals are more likely to imagine changing their body, genitals, or personalities in their fantasies. Nonetheless, the author concludes that "the prevailing themes that appeared in people's sexual fantasies were pretty similar. In other words, there's far more that unites us than divides us in our fantasy worlds" (Lehmiller, 2019).

Aside from sexual fantasy, the scientific literature on non-binary sexuality from a wider perspective does not offer much. The only data available on non-binary sexuality regards the experiences of non-binary youths (Eisenberg et al., 2017; Kattari et al., 2019). Literature reports how transgender and non-binary youths seem to have a precocious sexuality in terms of the first experience and number of partners when compared to their cisgender peers (Eisenberg et al., 2017). Early experiences and increased number of partners were correlated with experiencing depression, suicidal ideation and cyberbullying (Kattari et al., 2019). Again, this lack of research acknowledges the need for investigations into the unique sexual experiences of non-binary individuals.

Current Study

The present work is aimed at providing a better understanding of non-binary individuals' sexuality. This objective was achieved through a qualitative

investigation of sexual fantasies in a matched sample of Italian non-binary and cisgender individuals. The following research question was examined: *In what ways do individuals with a non-binary identity differ in their descriptions of their personal sexual fantasies?*

Method

Participants

The current study is part of a larger mixed-method research study investigating sexual fantasies of transgender people who identify as non-binary (vs. cisgender). The study was conducted in Italy and consisted of two parts. The first quantitative part of the study counted a total sample of 273 (45 self-identified non-binary individuals, 147 cisgender women, and 81 cisgender men). A subgroup of the sample completed the second qualitative part of the study. The 48.9% of non-binary people (n = 22) and 64% of cisgender people (n = 146) answered an optional open-ended question regarding their sexual imagery. Given the imbalance of the sample, 22 cisgender participants matched by age with the non-binary participants' subgroup were randomly extracted to make the comparisons.

To be included in the study participants had to be at least 18 years old. The mean age of the final sample (n = 44) was 26.68, SD = 5.90, with no age differences between the cisgender and non-binary groups t (42) = -.10, p =.92. All participants identified as Italian. Additionally, 59.1% (n = 13) of cisgender

and 81.8% (n = 18) of non-binary participants identified themselves as assigned female at birth.

Procedure

Participants were recruited online through notices on various Facebook feeds. The study was approved by the Institutional Review Board of the University of Milano – Bicocca and was in accordance with the ethical standards of the 1964 Declaration of Helsinki.

The present study focuses on the sexual fantasies experienced by non-binary and cisgender individuals. After completing the first part of the study, participants were asked to respond to the following questions: "Most people experience sexual fantasies. Please, take a moment to imagine a sexual fantasy that you find particularly arousing and pleasurable. Describe the fantasy including your feelings, desires, and activities at each stage of the fantasy. For example, what events and feelings led up to the encounter and what events and feelings occurred during the encounter? Please include any and all information that is important in making your fantasy sexually arousing. Just remember: your responses are completely anonymous. Take your time". The question was adapted from a study conducted by Bogaert, Visser & Pozzebon (2015).

Analysis

All sexual fantasies were translated into English by the second author, who is a native Italian speaker. Possible discrepancies in the use of sexually-connoted words, largely culturally driven, were resolved via discussion.

Participants' descriptions of their sexual fantasy were analyzed via content analysis (Mayring, 2004). The rationale behind the choice of content analysis among other qualitative methodologies was the co-presence of multiple layers of themes in the vast majority of the sexual fantasies. The content analysis allowed us to capture the complexity of the written material produced without losing information. After a first read of the all the sexual fantasies, the members of the research team agreed upon a coding scheme, including 27 codes. The codes were not mutually exclusive, with participants possibly endorsing several codes within the same theme (i.e., being dominant and being submissive could be relevant within the same sexual fantasy).The fantasies were coded blinded, with participant demographics, such as gender identity, hidden during the coding process. Definition of the codes are provided in Table 1. Once the definitions were set, all three members of the research team independently coded the sexual fantasies. The coding team then met again and went through each response line by line and discussed discrepancies in coding, arriving at consensus around codes.

To understand the impact of gender identity on sexual fantasies, statistical analysis of the codes was completed to determine if significant differences in sexual fantasies across gender identity were present. Each code was identified within a binary set of 1 present and 0 absent. Chi-square test for independence were utilized to compare: 1) differences in the frequency of codes for cisgender and non-binary individuals and 2) differences in the frequency of

codes for cisgender women and men. When the expected cell count for comparisons where less than five Fisher's exact test (1-sided) was used. For those codes were a significant difference was found, post-hoc comparisons were conducted to further denote the differences in sexual fantasies across gender identities.

Positionality

The coding team included a second-year M.A. student in clinical psychology who identifies as a white queer trans man, a third-year doctoral-level student in clinical psychology who identifies as an Italian cisgender woman, and a professor of psychology who identifies as a biracial bisexual/pansexual cisgender woman. All members of the research team have been trained in qualitative research methods and transgender studies. Due to the range of our collective experiences across gender and race, we brought into the coding discussions different perspectives. Additionally, at each coding session we actively reflected on our personal reactions to the data to allow for a processing of personal biases and to engage in bracketing. This acknowledgement of reactions increased the rigor of our process and the trustworthiness of our results (Morrow, 2005; Tufford & Newman, 2012).

Results and Discussion

Participants were asked to describe in detail a particularly arousing sexual fantasy. Sexual fantasies represent individual wishes and desires about sexual encounters (Leitenberg & Henning, 1995) and as such each participant

described unique scenarios depicting their fantasy. The content analysis revealed five overarching themes of the participant's sexual fantasies: 1) narrative structure, 2) context, 3) sexual role, 4) relational role, and 5) non-normative identities/genitals; with several codes falling within each theme (see Table 6). The results are described using direct quotes from participants and are positioned with the participants' gender identity and age. Results are presented using portions of participants' quotes relevant to the code being discussed. The presence of … indicates were extraneous words have been removed while preserving the meaning of the quote. As is standard for qualitative research, an integrated results and discussion section is presented (Flick, 2014).

Narrative structure

Participants approached their descriptions of sexual fantasies from different narrative vantage points, captured by seven different codes. The narrative structure theme represented the overall description of the sexual fantasies with focus given to the sexual and emotional aspects. The narrative structure codes included: broad, specific, sexual, graphic, emotional, holistic, and sensory (see Table 6).

Participants in the current study fell into one of two overarching categories representing the details of their fantasy. The sexual fantasies were described either broadly, without much emphasis placed on the events or environment or in specific ways, such as an order of sexual actions or a detailed

description of the location. Participants (38.6%) who described their sexual fantasies broadly provided only a general description of their fantasy.

> *"A porn-star comes to my home and she gives it [sex] to me because I'm beautiful and clever." (cisgender man, 26 years old)*

Other participants described their fantasy in specific ways, with 61.4% of the participants providing details about who, how, and where the sexual encounter would take place.

> *"I casually run into a sexy colleague in a bar. We already know each other, and we already had a chat at the office. We chat digging more deeply into our stories, knowing more intimately each other. I'm attracted by her way of thinking out of the box, her figure and because she doesn't show off about her appearance or her values. . . Later on, she offers me a drive home. I accept. I'm happy but also nervous. I fear that something could go wrong. Down the street near my house, my cheek touches hers for a greeting, but we find each other kissing, touching and making love. The day after, there is a bit of embarrassment at the workplace, but by night we will talk again about what happened and we will see each other again." (cisgender woman, 22 year-old)*

Participants' sexual fantasies also tended to fall into categories of either sexual, graphic, or emotional descriptions. Often participants (65.9%) stated that at least one sexual act would take place. Cisgender men (100%) were

significantly more likely to note a sexual act than cisgender women (61.5%), *p* =.049, fishers exact test, r = 0.45 [95% CI: 0.04, 0.73], with no significant difference between non-binary and cisgender individuals (see Table 2).

> *"If a woman that I like takes the initiative and it involves sexual intercourse." (cisgender man, 19 years old)*

Additionally, when explaining their sexual fantasy, 38.6% of participants described graphic or explicit details of the sexual act within their fantasy.

> *"A double penetration by two very muscular men." (non-binary, 22 years old)*

Although participants were prompted to describe both the emotional and physical components of their sexual fantasy, few participants (11.4%) described emotional aspects in their sexual fantasies.

> *" I enjoy telling them nice things because they are sweet and sensitive, and it makes them happy. We like to take our time and talk." (non-binary, 27 years old)*

Slightly more participants (22.7%) answered the prompt fully by describing a holistic fantasy which included both sexual and emotional aspects (22.7%).

> *"My sexual fantasy would be to play with erotic objects with my partner; that could happen only after we have been together for a long time and after a deep sentimental acquaintance." (non-binary, 21 years old)*

When detailing their fantasy, participants' (54.5%) descriptions frequently involved at least one of the five senses with touch (43.2%) being the highest endorsed sense and smell being the least (2.3%).

> *"I touch their skin with my finger, my lips, my tongue, my teeth and a scalpel. I can taste them. I can feel their skin crawl." (non-binary, 38 years old)*

> *"I'm in a bookstore. I adore the smell of books." (cisgender woman, 22 years old)*

Since sexual fantasies, by definition, involve sexual acts, prior studies have found that individuals often describe at least some sexually explicit content in their fantasies (Godley, Avery, & van Anders, 2014; Zurbriggen & Yost, 2004). Additionally, researchers have noted that gendered scripts of behavior effect sexual fantasies. Women's fantasies generally contain more emotional references (Gil, 1990) which is hypothesized to be the result of the gender scripts for women which includes an emphasis on nurturance and warmth (Godley et al., 2014); men's sexual fantasies generally contain more sexually explicit content (Zurbriggen & Yost, 2004). Contrary to the expectation set by prior research, there was not a significant difference between non-binary and cisgender individuals across any of the elements of the narrative structure, and only one significant difference between cisgender women and men's descriptions of their sexual fantasies (see Table 7). Thus, within this

sample non-binary participants did not report descriptions of sexual fantasies that ascribed to either gender role/expectation and cisgender women were no more likely than cisgender men to describe emotional aspects or abstain from graphic details.

Context

Participants also described their sexual fantasies in ways that highlight different contextual settings. Four codes emerged within the context of sexual fantasies: realistic, unrealistic, forbidden, and public (see Table 1). Participants' (72.7%) responses often described sexual fantasies that could realistically happen outside of their imagination, frequently reminiscing about past sexual experiences.

> *"I often resort to two main sexual fantasies, all of them start from real lived situations. Sometimes they are distorted and sometimes they are quite stuck to reality (although, in real life I did not have any orgasm in any situation)." (cisgender woman, 29 years old)*

> *"We are three. Two men and me. I like when they touch me everywhere and they tell me that I am beautiful and that they want me. I like when I feel that other people desire me." (cisgender woman, 28 years old)*

Conversely, 22.7% of participants described fantasies which were unlikely to exist in reality, such as those involving famous individuals, situations which are rare, or involving death.

"I sit on a throne made of corpses of my enemies whom I consider unworthy; I bathe in their blood and their guts." (non-binary, 39 yeras old)

While there was not a significant difference between non-binary and cisgender individuals within this code (see Table 2); of the non-binary participants who described unrealistic sexual fantasies, most mentioned either having both genitals or the genitals of someone else.

"Then because it is a fantasy, I would get involved having both a penis and a vagina. So, in addition to being fucked, I imagine having a penis and fucking a FTM [female-to-male] muscular guy and I feel very dominant." (non-binary, 22 years old)

"A recurring fantasy is to have a penis and having sex with somebody, being active during the intercourse." (non-binary, 22 years old)

Lehmiller (2019) notes in the only publication on non-binary individuals' sexual fantasies that non-binary individuals are more likely to fantasize about becoming someone else or trading bodies with someone else. This idea of having both or different genitals is consistent with the concept of a non-binary identity in which individuals may view themselves as being both or neither woman or man, or of being a different gender (Galupo, Pulice-Farrow, & Ramirez, 2017; Richards et al., 2016). Thus, fantasizing about different genitals may serve to affirm our participants' non-binary identities.

Sexual fantasies which were taboo or forbidden, such as cheating on a partner or having sex with a coworker, where described by 29.5% of the participants.

> *"My current erotic fantasy is to have sex with a man, this man is real in the sense that I met him during a job and I immediately found him very attractive. I then knew that he was sexually attracted to me too. Now we are keeping in touch mainly on WhatsApp, but both of us have stable partners and we do not want to betray them. But in my imagination, that I'm building with him, we meet in a hotel and after a sexy dinner, in which we drink a glass or maybe more, we start to get aroused a lot. We go to the room and we spend a hot night together where he takes me in all possible and unimaginable ways, even in an anal intercourse, that I've never done before!" (cisgender woman, 34 years old)*

Additionally, some participants' sexual fantasies took place in public space (27.3%).

> *"I would like to have sex with a partner and his girlfriend in his terrace in Centocelle during the night." (non-binary, 34 years old)*

> *"I'm am dressed as a sexy teacher, wearing a short skirt, a low-cut blouse with a padded bra and very high heels. I am wearing a different than usual make-up, much more provocative. I see myself near my desk looking at the only man who is sitting in the classroom. I feel very sexy*

and I cannot wait to tease him. I tease him in various way. I have control and he is so turned on that he takes me there, in the classroom, on my desk." (cisgender woman, 22 years old).

Previous qualitative and quantitative studies have shown that fantasies of public sex are common in cisgender men and women (Joyal, Cossette, & Lapierre, 2015). While there was not a significant difference between non-binary and cisgender participants endorsement of this code; cisgender women (46.2%) were more likely to describe a sexual fantasy involving public sex with none of the men's fantasies taking place in public, p =.046, *fishers exact test, r = 0.51* [95% CI: 0.10, 0.77] (see Table 2). Women may be more likely to endorse a fantasy of public sex as it relates to submitting to the passion of the moment and being overwhelmed with sexual desire; which prior researchers have theorized to be a component of women's sexual fantasies (Leitenberg & Henning, 1995).

Sexual Role

Participants described themselves in various roles within their reported sexual fantasies. The sexual role described how the participant performed sexually within their fantasy. This included: 1) receiver, 2) giver, 3) explicit consent, 4) explicit non-consent, 5) power, 6) being dominant, and 7) being submissive (see Table 1). Being the receiver of sexual pleasure in the fantasies was described by 52.3% of participants in the current study.

"She [partner] smiles at me flirtatiously and activates the vibrating panties that I'm wearing. . . from here on I just feel an immense pleasure caused by her touch and her use of sex toys." (non-binary, 21 years old)

Giving sexual pleasure and performing sexual acts on the target was described in 40.9% of participants fantasies.

"I start to put my hands under her t-shirt, and I'm about to go crazy with desire. I touch her back making her chill [goose bumps]. I am aroused by seeing her facial expression and hearing her moaning, then I touch her just over her butt and I go up towards her breasts, caressing her hips. I love to tease her without cutting to the chase. . . Then I would put my hand in her panties, and I would start to masturbate her until she asks me to undress her. . . While I touch and stimulate her breasts and nipples, and sometimes grabbing her ass to facilitate the push, I would penetrate, we would both orgasm. It is important that in the end we are both satisfied. What is exciting the most is hearing her moaning of pleasure and seeing her expression." (cisgender woman, 26 years old)

Gendered scripts have been found to affect how an individual view's themselves performing within their sexual fantasy. Due to societal expectations that men actively seek out women to have sex with, research has shown that men tend to have an active role in their sexual fantasies and to be the giver of pleasure whereas women envision themselves as the receiver of pleasure (Leitenberg & Henning, 1995). Despite the gender expectations of who would

endorse being the giver or receiver in participants' sexual fantasies, within this sample there were no significant differences between non-binary and cisgender individuals or between cisgender women and men (see Table 2).

Present within the sexual role codes were themes relative to control in the sexual action. The subject of consent was explicitly mentioned by seven participants with three (6.8%) expressing a need for consent within their sexual fantasies.

> *"My fantasies are more about BDSM themes than sex itself. I am turned on by the tightness of the rope, being put on a leash, being put in a cage, blindfolded, without knowing what is about to happen to me. The unknown turns me on, knowing that I am completely in the hand of another person. With consent of course." (non-binary, 26 years old)*

While four (9.1%) sexual fantasies involved explicit non-consent from the target.

> *"I move my penis into her anus. She asks me to be gentle. I penetrate her and we make love like that at first very slowly and then with force. She discovers that it is not painful, she has another orgasm. Stimulated by its contractions, I feel I can no longer resist. I go out of her anus and I get up to come on her face. My surprise when she pushes my penis into her throat and swallows my cum is equal only to her in noticing for the first time, moving the bandage that covers her eyes, the video camera that has taken over our act." (cisgender man, 31 years old)*

Power is a frequent code within prior reports of sexual fantasies of both cisgender women and men (Zurbriggen & Yost, 2004). Participants in the current study (36.4%) also described some form of power imbalance in their sexual fantasies, such as having sex with a boss or teacher.

> *"The second fantasy is in a restaurant in which I used to work. Often during the service my boss used to make very explicit jokes until at the end of the evening I would gave myself to him. One night, I did not want to do it and I told him so. He said he was willing to pay me just to lick me. I accepted and I remember that in the restaurant storage he asked me to suck it [his penis] first; I did it without resistance. After a few minutes he laid me down on the table and began to lick me for a long time until I was extremely excited. He got me up, I turned, and asked him to penetrate me from behind. It turns me on to think of how assertive I was in that moment, of how uninhibited I was, for the first time I played freely with my body and I made myself desirable. Although I was theoretically subdued because of the money, I felt I was dominating the desire." (cisgender woman, 29 years old)*

> *"Fucking my ex-boss's ex without any affection and ejaculate on her face or her tits, and doing it again, and again, and again." (cisgender man, 27 years old)*

Finally, being dominant over the target was endorsed by 25.0% of participants.

"In my fantasy my partner wears a 19th century corset with garters and a very thin thong that reveals female genitalia. She is wearing her hair back with a 40-50s' style, so that I will be able to unleash it and pull it during the intercourse. The ideal position of the act is doggy style so that I have a chance to dominate during the intercourse, grabbing her hair and her breast with my hands. My partner must scream and revel, and to a small extent I would also like that she feels a little pain from the hair pulling." (cisgender man, 21 years old)

Whereas a submissive role was described by 29.5% of participants.

"I would keep talking with the other people dining while caressing his crotch. Feeling his erection under my fingers would fill me with expectation and (sexual) excitement. At some point I stop, we look at each other, horny and unsatisfied at the same time. Once we arrive at home I would like to be punished for my behavior, being taken with vigor on the floor or on the table, feeling desired." (non-binary, 19 years old)

Sexual fantasies of submission are quite frequent among women and are hypothesized to be in part the result of societal influences that women should abstain from sex. Thus, through fantasizing about forced sexual encounters, a woman can be freed from her guilt and shame (Zurbriggen & Yost, 2004). Conversely, the theme of sexual force and dominance is more frequent among men and theorized to be the result of the male societal gender role of dominance

(Leitenberg & Henning, 1995). Lehmiller (2019) reported that non-binary individuals in his sample were more likely than binary individuals to fantasize about forced sex but did not provide a rational or a definition of forced sex. Contrary to the gender expectations set by prior research, within this sample we found no significant differences in power, dominance, or submission between non-binary and cisgender participants or between cisgender women and men (see Table 2).

Relational Role

Apart from how the participant behaved sexually in their fantasy; they also described their familiarity with the target and if the participant or the target was the more desirable person in the fantasy. This relational role included: known, unknown/specific, or unknown/general target; self, other, or mutual/couple focus; and to be desired (see Table 1). Within the categorization of targets, an individual the participants knew in their real life was described by 40.9% participants as being the target of their sexual fantasy.

> *"What I think about when I want to get aroused is recalling the moments in which I make love to my boyfriend." (non-binary, 26 years old)*

While not actually knowing the target, 22.7% of participants described a specific type of person (i.e. a person with specific bodily features or personality characteristic) with whom they envisioned their sexual fantasy.

> *"I tend to imagine or conjure up persons that I admire and that seem to be distant, restrained, or very competent, people with a dominant personality. . . The woman I imagine gives me a series of very reassuring sensations: she is strong, competent and independent, and she desires me, she is able to protect me." (non-binary, 34 years old)*

Whereas the remaining participants (36.4%) described a general unknown individual in their sexual fantasy and did not detail any distinguishing features about the target.

> *"Of all the sexual fantasies, I find seducing or being seduced by girls or women to be very exciting. That could focus on friends or other people they have around, but they prefer me, especially if they are friends of my girlfriend. I also imagine walking around and going into shops or pubs and that shop assistants, clients, bystanders [all female words in Italian] etc. would be so into me that we would end up together." (cisgender man, 27 years old)*

There were no significant differences between non-binary and cisgender individuals or cisgender women and men descriptions of targets (see Table 2). Participants were equally likely to describe any category of target.

Participants' sexual fantasies were also described with differential attention given to various targets. This attention or focus was either given to the self, other, or to the participant and others equally. Frequently participants

(63.6%) detailed sexual fantasies in which they were the focus of attention and sexual interaction.

> *"The fantasy that I have found most exciting in the recent months is to have a penis to masturbate or to use in interactions with my partner or other people, which could be oral sex or hand stimulation. There are no specific events or emotions that trigger the [sexual] encounter, nor follow. My fantasy starts with my erect penis and ends when it ejaculates." (non-binary, 31 years old)*

Less often endorsed were sexual fantasies in which the focus was placed on another individual (22.7%).

> *"After so many months, my lover calls me and tells me he wants to see me. I already feel from his voice how much he desires me and has missed me. . . I prepare for the meeting by dressing as I know he likes and doing the body treatments he particularly enjoys. I see him, his eyes burn with desire." (Cisgender woman, 41 years old)*

Finally, the least described were sexual fantasies in which the focus was that of the participant and their target(s), such as them as a couple (9.1%).

> *"What makes me feel emotional is not only the physical contact but also the empathic engagement: coming when she has an orgasm or intuit what he is feeling while the three of us are together." (non-binary, 34 years old)*

Who was to be desired within the fantasy was also noted by participants, with some (45.5%) participants depicting sexual fantasies in which their target found the participant to be very attractive and desirable.

> *"He tells me all the time that I drive him crazy, and he's constantly excited at the sight of my body and my breast. He literally tears up my underwear because he cannot resist me. I let myself do everything, I'm at his mercy." (cisgender woman, 36 years old)*

Consistent with the findings of Anzani & Prunas (*in preparation*), non-binary participants were significantly less likely to endorse a fantasy in which they were the object of another's desire, $\chi^2(1) = 9.17$, $p = .002$, $r = 0.46$ [95% CI: 0.17, 0.67], with 22.7% of non-binary participants endorsing this code versus 68.2% of cisgender participants. Non-binary individuals report high levels of body dissatisfaction (McGuire, Doty, Catalpa, & Ola, 2016) and may engage in bypassing to elevate sexual dysfunction that is positively related to body dissatisfaction (Pascoal, Narciso, & Pereira, 2012; Pujols, Meston, & Seal, 2010). Kaplan (1979) defines bypassing as blocking out negative thoughts and emotions about oneself and fantasizing on positive traits of oneself or others. Transgender and non-binary individuals have reported they internalize messages from society that they are "freaks", "monsters" and, "undesirable" as partners (Rood et al., 2017, p. 421). These internal messages in combination with bypassing could explain why non-binary individuals are significantly less likely to be the object of desire in their sexual fantasies.

Non-normative presentations

While infrequent, some participants characterized sexual fantasies which discussed non-normative identities or genitals (see Table 1). Both were rare in the context of sexual fantasies with 13.6% of participants describing their or a target's non-normative identity, such as asexuality or a transgender identity.

> *"Having sex with a mulatto [Italian term for an individual with one white and one black parent] MTF [male-to-female] transwoman, that has not had the surgery [gender affirmation surgery]." (non-binary, 33 years old)*

Additionally, 15.9% of participants described having or desiring non-normative genitals, or using their genitals in non-normative ways.

> *"Another fantasy of mine is to find an androgynous and a little masculine woman who calls herself a woman or an intersex or an androgynous woman, who has a hypertrophic [enlarged] clitoris that I find irresistible." (cisgender woman, 33 years old)*

> *"What must not be missing is that he has to come in my mouth or on my belly, I'm waiting for them to prescribe me hormones, until I have breasts. It would also arouse me that he would come here [on their breasts]. In fact, sometimes I make him nut on my chest." (non-binary, 26 years old)*

Non-binary participants (27.3%) were significantly more likely to include details about non-normative genitals than were cisgender participant (4.5%), *p* =.047, *fishers exact test*, *r* = 0.31 [95% CI: 0.02, 0.56], and there was no significant difference between cisgender women and men (see Table 2). While there were no significant differences between non-binary and cisgender participants or cisgender men and women who endorsed the non-normative identities (See Table 2); the qualitative content of their sexual fantasy differed. When cisgender participants spoke of non-normative identities it was to highlight a desire to have sex with individuals who had these identities or genitals; whereas non-binary individuals described both a desire and a presence within themselves of these codes. Thus, it is possible that for the cisgender participants, endorsement of these codes reflects a fetishization of transgender identities and a general reduction of transgender individuals to their body parts (Tompkins, 2014).

Conclusions

The present study is unique in exploring the sexual fantasies of cisgender and non-binary individuals, highlighting their similarities and differences. Non-binary individuals represent a unique group who actively challenge or negate the gender binary (Iantaffi & Barker, 2019). As such, non-binary individuals do not follow traditional gender scripts of what are appropriate and socially sanctioned behaviors for women and men (Bradford et al., 2018). Instead, non-binary individuals redefine what is acceptable gender

practice by increasing the flexibility of gender roles, combining gender roles, or through creating ambiguity (Richards et al., 2016). This redefinition is evident in our participants' expression of sexual fantasies which subscribed to neither of the binary gender expectations. Sexual script theory (Simon & Gagnon, 2003), as well as prior research on sexual fantasies, dictate that (presumably cisgender) women and men will differ in the content of their fantasies due to the belief that men are dominant, and woman are submissive. The results of our study showed that non-binary individuals' sexual fantasies did not fall in line with either binary gender expectation. This affirms that non-binary individuals are redefining how to do gender and creating expressions that are outside of binary understandings.

Comparisons of Non-binary and Cisgender Individuals

By allowing for a comparison, similarities and differences between non-binary and cisgender individuals' sexual fantasies could be examined. This comparison showed that non-binary participants' sexual fantasies rarely differed from those of cisgender participants. While the majority of studies that investigated sexual fantasies were focused on differences between cisgender women and men's preferences (Jones & Barlow 1990; Leitenberg & Henning, 1995; Sue, 1979; Zurbriggen & Yost, 2004; Bogaert & Brotto, 2015), little is known about transgender and non-binary individuals. The current study is the first to show that the sexual fantasies of cisgender and non-binary individuals share similar content and overall themes.

When non-binary participants did differ from cisgender participants, they did so in ways that affirmed, or were salient to, their gender identity. Non-binary participants described having a desire for different or both genitals which would allow the participant to engage differently in sexual activity[4]; a desire which may serve to affirm their identity. Similarly, non-binary participants talked about their or a target's non-normative identities or genitals differently than did their cisgender counterparts. Cisgender participants spoke of a desire to have sex with transgender individuals, reducing them to their bodies or genitals (Mauk, Perry, Muñoz-Laboy, 2013); whereas non-binary participants spoke of how they used their genitals in non-normative ways or how their non-normative identities impacted their sexual fantasies.

Finally, when non-binary participants described their sexual fantasies, they were significantly less likely to describe themselves as the object of another's desire. This could be the result of internalized transphobia (which is not shared by cisgender individuals) where transgender individuals sometimes experience a discomfort with their transgender identity due to the negative views the larger society holds towards transgender individuals (Bockting, 2015). As noted earlier, internalized transphobia combined with high levels of body dissatisfaction (McGuire, Doty, Catalpa, & Ola, 2016) could lead non-

[4] Participants were not aroused simply by the thought of themselves as another gender, but rather in how their affirmed bodies could be used sexually. Therefore, the presence of a desire for different or both genitals should not be confused for autogynephilia or autoandrophilia.

binary individuals to be less likely to fantasize about being another individuals object of desire. Additionally, cisgenderist conceptualizations of sex, which are pervasive in the assumptions of sexuality and sexual practice (Blumer, Ansara, & Watson, 2013), could influence non-binary individuals' view of their sexual desirability. Non-binary individuals may not be able to find reflections of societal sexual attraction towards non-binary identities and internalize this to mean that they, themselves, are not sexually desirable. Future research should investigate the extent that internalized transphobia and cisgenderism affect non-binary individuals' self-image and self-sexual attractiveness.

Future studies should also investigate how non-binary individuals navigate gendered expectations when actively engaging in sexual activities. Because sexual fantasies consist of both past experiences and imagination (Leitenberg & Henning, 1995) it maybe that the eschewing of gender seen within non-binary individuals fantasies maybe not be possible when confronted with real situations with real individuals. Therefore, it is important to understand how non-binary individuals redefine gender within sexual spaces.

Comparisons Across Cisgender Women and Men

Additionally, the current study found limited differences between the sexual fantasies of cisgender women and men. The majority of the literature on sexual fantasies took place 20 to 30 years ago and, as such, relies on dated assumptions that men will be dominant and focused on sexual pleasure whereas women will be submissive and emotionally focused (Leitenberg & Henning,

1995). The current results show that the women in our study were equally likely to be the giver of sexual pleasure or the dominant partner and men were just as likely to describe emotional aspects in their sexual fantasies. As such, the results highlight the need to reinvestigate sexual research which relies on outdated gender scripts which might not align with our modern society.

Limitations

The present study is not without limitations. First, the utilization of a small sample participants from Italy means the results should be interpreted within this context and additional research is needed to extend these results to more diverse ethnic identities. Second, because sexual fantasies constitute a deeply intimate subject, participant responses were recorded anonymously via an online survey to promote honesty in response. This anonymity however does not allow for participants to provide direct feedback of our analyses which limits the trustworthiness of the interpretation of participants' responses. To address this potential concern each participant's response was read several times by the entire research team to ensure complete understanding of the participant's sexual fantasy. Finally, because participants initially responded in Italian and their responses were translated to English prior to coding, it is possible that the meaning of some phrases was lost or translated incorrectly. To decrease this potential negative result, the coding team discussed what particular words meant in Italian and what similar phrases could capture the same meaning. The coding team additionally consisted of individuals

representing a variety of gender identities and sexual orientations which helped in the translation process.

Clinical Implications

Through the investigation of sexual fantasies, the current study provides necessary information for clinicians working with non-binary individuals. First, this study centered the lived experiences of non-binary individuals by asking them to describe their personal sexual fantasies. Thus, allowing for their experiences to be acknowledged rather than a reliance on clinical assumptions (Leitenberg & Henning, 1995) that were found to be generally inapplicable to this population.

Second, this study provides clinicians with information about the sexual fantasies of non-binary individuals. As Riggs and Bartholomaeus (2018) point out, the dearth of research on the sexual experiences of transgender individuals leads to a deficit in sexual education and by extension therapy aimed at helping transgender individuals navigate sexuality. Therefore, this study allows clinicians to gain a basic understanding of how a non-binary identity may impact a clients' sexuality. This is particularly important as the sexuality of transgender and gender-nonconforming individuals has historically been pathologized by mental health professionals and sex therapists (Prunas, 2019), and the contents of their sexual fantasies (i.e. autogynephilia or autoandrophilia) were mostly explored to identify indications and contraindications for medical gender-affirmative treatments.

Third, the results of the current study shed light on how non-binary individuals' gender identity and sexuality interact to affirm each other. This exploratory analysis revealed that non-binary participants' sexual fantasies often contain references to non-normative genitals and identities which are described as desirable and stimulating. Clinicians could work with non-binary clients to create sexual fantasies in which their identities are desired by others, thus serving to affirm their identity and possibly decrease their experience of dysphoria.

Finally, it is extremely important that therapists keep in mind how attraction towards transgender expressions is not fully legitimized within sexualities and orientations in Western societies (Lenihan, Kainth & Dundas, 2015; Pulice-Farrow, McNary, & Galupo, 2018). This has an impact not only on how non-binary individuals enact their gendered sexuality, but also on their cisgender partners. Sexual attraction to non-normative gender presentation is often considered fetishistic or a less preferable 'alternative' to those who present in a normative gender role (Blair & Hoskin, 2018; Lenihan et al., 2015). Therapists must be aware of the privileges and/or disadvantages of the identities involved in the romantic or sexual relationships and how they may impact the individuals functioning within sexual space.

Table 8. **Coding structure.**

	Code	Description
Narrative	Broad	Participant provides a very general description of the events occurring in the fantasy.
	Specific	Participant provides a very detailed description of the events occurring in the fantasy.
	Sexual	Participant describes sexual acts.
	Graphic	Participant provides specific details about sexual activities.
	Emotional	Participant describes emotions or emotional connectivity.
	Holistic	Participant describes both emotional and sexual aspects.
	Sensory	Participant mentions sensory perception(s).
Context	Realistic	Scenario of the fantasy is possible.
	Unrealistic	Scenario of the fantasy is impossible.
	Forbidden	Scenario of the fantasy or its component(s) are considered transgressive or taboo.
	Public	Scenario of the fantasy existed within the view of other(s) or in public spaces.
Sexual Role	Receiver	Description is focused on receiving pleasure from other(s).
	Giver	Description is focused on giving pleasure to other(s).
	Explicit consent	Participant mentions receiving consent before the sexual act.
	Explicit non-consent	Participant mentions not receiving consent before the sexual act.
	Power	Participant describes a power dynamic.
	Being dominant	Participant describes being the dominant partner in the scene.
	Being submissive	Participant describes being the submissive partner in the scene.
Relational Role	Known target	Individual(s) involved in the fantasy were known by the participant.
	Unknown specific target	Individual(s) involved in the fantasy were an ideal type of person not known by the participant.
	Unknown general target	Individual(s) involved in the fantasy were not known by the participant.
	Self-focus	Description is centered on the participant’s experience.

	Other-focus	Description is c entered on other individual(s) involved in the fantasy.
	Mutual-focus	Description is centered on the mutual involvement in the fantasy, of both the participant and other individual(s).
	To be desired	Description is focused on being the object of desire of the other(s) involved.
Non-Normative	Non-normative identities	Participant describes a scene involving individuals outside the norms on gender and sexuality.
	Non-normative genitals	Participant describes a scene involving bodies outside the gender binary.

Table 9. **Chi-Square Analysis**

			Non-binary v. Cisgender			Cisgender Women v. Cisgender Men		
		Overall (%)	Non-binary (%)	Cisgender (%)	χ^2	Women (%)	Men (%)	χ^2
Narrative	Broad	38.6	45.5	31.8	0.86	23.1	44.4	1.12
	Specific	61.4	54.5	68.2	0.86	76.9	55.6	1.12
	Sexual	65.9	54.5	77.3	2.53	61.5	100	4.48*
	Graphic	38.6	40.9	36.4	0.10	30.8	44.4	0.43
	Emotional	11.4	18.2	4.5	2.03	7.7	0	0.73
	Holistic	22.7	31.8	13.6	2.07	23.1	0	2.41
	Sensory	54.5	54.5	54.5	0.00	69.2	33.3	2.76
Context	Realistic	72.7	68.2	77.3	0.46	84.6	66.7	0.98
	Unrealistic	22.7	22.7	22.7	0.00	15.4	33.3	0.98
	Forbidden	29.5	22.7	36.4	0.98	46.2	22.2	1.32
	Public	27.3	27.3	27.3	0.00	46.2	0	5.71*
Sexual Role	Receiver	52.3	45.5	59.1	0.82	69.2	44.4	1.35
	Giver	40.9	40.9	40.9	0.00	30.8	55.6	1.35
	Explicit consent	6.8	9.1	4.5	0.36	0	11.1	1.51
	Explicit non-consent	9.1	9.1	9.1	0.00	7.7	11.1	0.06
	Power	36.4	36.4	36.4	0.00	30.8	44.4	0.43
	Being dominant	25.0	27.3	22.7	0.12	15.4	33.3	0.98
	Being submissive	29.5	31.8	27.3	0.11	30.8	22.2	0.20

Relational Role	Known target	40.9	31.8	50.0	1.50	61.5	33.3	1.69
	Unknown specific target	22.7	27.3	18.2	0.52	15.4	22.2	0.17
	Unknown general target	36.4	36.4	36.4	0.00	30.8	44.4	0.43
	Self-focus	63.6	68.2	59.1	0.39	69.2	44.4	1.35
	Other-focus	22.7	31.8	13.6	2.07	15.4	55.6	3.96
	Mutual-focus	9.1	13.6	4.5	1.10	7.7	0	0.73
	To be desired	45.5	22.7	68.2	9.17**	84.6	44.4	3.96
Non-Normative								
	Non-normative identities	13.6	22.7	4.5	3.09	7.7	0	0.73
	Non-normative genitals	15.9	27.3	4.5	4.25*	7.7	0	0.73

* $p < .05$, ** $p < .01$

6. General Discussion

The present work aimed at providing a better understanding of how societal norms may impact both interpersonal relationships, in our case with a therapist, and the mental health and well-being of transgender and gender-variant individuals. The research studies that approached this issue from a social perspective have proved that psychologists and psychotherapists are not immune to biases towards marginalized sexual identities (see Chapter 4). Cisgenderist and heterosexist norms in Western society seem to impact the way transgender individuals experience psychotherapy: Studies 1 and 2 showed that when psychotherapists are confronted with gender or sexual diverse identities they may be biased in their clinical evaluation of the case. Instead, Study 3 accounts for the direct experiences of transgender people who accessed psychotherapeutic services. In order to avoid focusing exclusivelyon the negative aspects of the interaction between transgender clients and professionals, the study aimed at investigating the circumstances in which transgender individuals felt affirmed within the relationship with their therapists.

On the other hand, the studies that addressed mental health and well-being issues highlighted the effects of societal norms on transgender individuals' functioning (see Chapter 5). In terms of mental health, Study 4 described personality functioning in a sample of transgender individuals that

were evaluated with two different clinical instruments for personality assessment. Whereas, Study 5 focused on the effects of cis-heteronormativity on sexual functioning, particularly on sexual fantasies.

Taken together, the results of the studies presented in this thesis have several clinical and training implications for the work with transgender individuals. As highlighted throughout the thesis, the transgender population is disproportionately in need for counseling and psychotherapy, as this population reports higher rates of psychological distress (see § 2.1), but paradoxically transgender individuals accessing health care services find themselves in a hostile environment.

When talking about the clinical work with transgender individuals few essential premises are needed to frame the discourse. First of all, we cannot disregard the fact that transgender individuals have undergone a long history of pathologization, that characterized both research and professional practice (Kelleher, 2009). In the past, gender identity disorder diagnosis constituted the privileged way to look at transgender mental health issues. This led to a pathologizing of the individual's singular psychosocial experiences, thus limiting therapeutic responses and treatment options (Alegría, 2010). In the past few years several steps towards depathologizing gender diversity have been made. To begin with, the DSM-5 (APA, 2013) made a first step in trying to reduce the stigma associated with the diagnosis of Gender Identity Disorder.

The term Gender Dysphoria replaced the old diagnosis, that has also been placed in a different chapter in the DSM-5. The diagnostic criteria underwent numerous changes, including a shift from a gender binary to a gender diversity perspective and, most importantly, the core of the diagnosis have became the distress caused by dysphoria and not gender non-conformity itself (Lev, 2013). Very recently, the World Health Organization with the last edition of the International Classification of Diseases (ICD – 11) also implemented important changes following the trend towards the recognition of gender diversity as a non-pathological condition (Özer, de Grift, Gijs, 2018). Gender Incongruence is classified in the ICD – 11 within the chapter of conditions related to sexual health and is defined as "a marked and persistent incongruence between an individual's experienced gender and the assigned sex" (WHO, 2019). Although important adjustments have been made in order to reduce stigma associated with a gender diverse condition, negative overt and subtle discriminative episodes are still experienced by transgender people in health care contexts, as some of the studies I presented tried to highlight (see Chapter 3).

Secondly, a relevant issue about the clinical work with transgender clients regards the role of the gatekeeper, that is strictly related to the aforementioned history of pathologization. As any other cisgender clients, transgender individuals may seek psychotherapy for a large variety of reasons (Budge, 2015; Rachlin, 2002). People who identify as transgender may be: 1) clients who desire

medical interventions and need a letter from two health care provider (Budge, 2015; Coleman et al., 2012) and, 2) people dealing with minority stress. In the first case, psychotherapists may find themselves in the role of a gatekeeper. In the past, therapists had the power to decide (and authorize) the transition process on behalf of transgender clients, and their decisions were often based on assumptions about gender that did not always apply to the lived experience of transgender persons (Shultz, 2018). More recently both researchers and clinicians are trying to view the transgender experience more broadly, thinking about transgender lives and bodies as diverse. This entails challenging the narrative of "internal distress" (Shultz, 2018). The diagnosis of gender dysphoria shifted the problem of the transgender condition from the gender diverse identity to distress caused by being trans, however the DSM-5 diagnosis still fails to recognize that the distress reported by transgender individuals may be not related to internal struggles but to societal discrimination and minority stress (Shultz, 2018).

Thirdly, mental health services are reported to be ineffective in meeting the needs of the trans population (Budge, Israel, & Merrill, 2017; Israel, Gorcheva, Walther, Sulzner, & Cohen, 2008; Sperber, Landers, & Lawrence, 2005). The studies that investigated the overall quality of mental health services for transgender individuals report it to be poor and lacking options around appropriate treatments resulting in unmet needs (McCann & Sharek, 2016; Sperber et al., 2005). In spite of the fact that a large part of the transgender

population desires to discuss about gender identity or transition with a therapist at some point in their life, only a subgroup of transgender individuals receives such services (James et al., 2016). Furthermore, non-binary individuals are even less likely than binary transgender individuals to attend a psychological service even though they report higher rates of psychological distress (Morris et al., *in press*). Contributing to the perceived inefficacy of mental health professionals is a lack of training in working with transgender clients and more generally with gender and sexual diversity (Israel, Ketz, Detrie, Burke, & Shulman, 2003; Morris et all., *in press*; Walinsky & Whitcomb, 2010; Willging, Salvador, & Kano, 2006). The gap between need and services is particularly noticeable for non-binary individuals (Budge et al., 2017). Perception of rejection and discrimination may also constitute a barrier in seeking mental health treatments, that may lead to avoidance behaviors or strategies like not openly declare one's identity during assistance (Aylagas-Crespillo, García-Barbero & Rodríguez-Martín, 2018; FRA, 2014). In the study conducted by James and coll. (2016), one in five respondents reported that the therapist they were seeing attempted to stop them from being transgender, "an experience that increase the likelihood of attempting suicide by 149%" (Morris et al., *in press*). Negative biases and hostility, also in the form of microaggressions, may detrimentally impact the therapy outcomes for LGB and queer individuals (Garnets, Hancock, Cochran, Goodchilds, & Peplau, 1991; Morris et al., *in press*; Sue & Capodilupo, 2007)

and it has been hypothesized that these conclusions may extent also to transgender individuals (Morris et al., *in press*). Finally, research has shown that non affirmative approaches have a significant and long-lasting impact on the well-being and mental health of trans people. A recent study carried out on a large sample of transgender individuals across the Unites States (Turban et al., 2019) has shown that reported exposure to gender identity conversion efforts (by secular professionals vs religious advisors) in their lifetime was associated with severe psychological distress during the previous month, Associations were found between recalled lifetime exposure and higher odds of lifetime suicide attempts and recalled exposure before the age of 10 years and increased odds of lifetime suicide attempts.

As a matter of fact, Studies 1 and 2 are consistent with the literature reporting how psychotherapists may be biased in working with clients with marginalized identities. Microaggressions towards transgender identities in therapy have been interpreted as a violation of ethical guidelines (Morris et al., *in press*). Basic principles as the respect for people's right and dignity, unfair discrimination, knowing one's competence boundaries, and, maintaining adequate competence, are often violated when a therapist shows no respect for the client's identity (i.e., denying their identity), when there are not prepared on gender and sexual identity issues, or when they act as gatekeepers (Morris et al., *in press*). Study 3 shows how avoiding microaggressions constitutes just the first

step in being affirmative and propose a more active acknowledgment of minority stress and more active ways to validate a client's gender identity. The clinical implications of the study suggests the use of affirmative practices with transgender clients accessing mental health services and in particular in therapeutic settings. Affirmation starting from the use of pronouns that are congruent with a client's gender identity regardless of the gender that the client was assigned at birth (Knutson, Koch & Goldbach, 2019).

Lastly, a pivotal element to keep in mind when working with diversity in general is intersectionality. When working with a marginalized identity it is important to keep clearly in mind that both of the individuals involved in the therapeutic relationship have multiple identities, that not all of the identities are salient in the same way at the same time, and that some of these identities may belong to a marginalized or (a privileged) social group (i.e., identifying as an immigrant, black person and/or disabled). These social identities may also be in conflict, for example when a strong religiosity intersect with a homosexual and/or transgender identity.

All the critical points that I made apply to the clinical work with transgender clients, but this may be extended to diverse individuals in general, lead to an important conclusion that also sum up what this work is all about: clinical psychology must be informed by social psychology about the causes and the effects that intergroup relationships may have on individuals (see Study 4 and

5). It is important to highlight that societal norms and demands are so pervasive in our culture that sometimes we can also be (micro)aggressive unintentionally, without being aware of the harm we are causing. Mental health professionals working alongside gender diverse individuals, but also sexual minorities, are being called upon to being aware of how their attitudes and their knowledge about gender identity and expression may affect the quality of care for transgender individuals (Guideline 4), to acknowledge how stigma, prejudice and discrimination may affect health and well-being of transgender individuals (Guideline 5) and recognize the institutional barriers that transgender people may encounter (Guideline 6) (APA, 2015). Briefly, clinical interventions with LGBT minorities cannot disregard also a social perspective with several applicative implications. In this sense, Minority Stress Theory and Microaggression Theory may represent overarching theories that should inform the clinical work of all clinical psychologists and mental health professionals, regardless of their educational background and theoretical orientation. In fact, psychologists may be required to advocate on a number of different levels when working alongside transgender individuals. With transgender youth this may consist in consulting with teachers and school counselors, or providing resources and information to students and/or school personnel. Also, mental health professionals may be summoned to ensure that their clients are situated in safe and welcoming environments. And they are also encouraged to "inform public policy to reduce

negative systemic impact on transgender people and promote positive social change" (APA, 2015). Clinicians have the responsibility to acknowledge in which power dynamic position they found themselves in the therapeutic relationship with a client, and guarantee a safe and non-judgmental space to explore and ill with.

References

Alegría, C. A. (2016). Gender nonconforming and transgender children/youth: Family, community, and implications for practice. Journal of the American Association of Nurse Practitioners, 28(10), 521-527. doi: 10.1002/2327-6924.12363.

Ali, N., Fleisher, W., & Erickson, J. (2016). Psychiatrists' and psychiatry residents' attitudes toward transgender people. *Academic Psychiatry, 40*, 268–273. doi:10.1007/s40596-015-0308-y.

Allen, J. G., Haccoun, D.M, 1976. Sex differences in emotionality: A multidimensional approach. *Human Relations, 29*, 711–722. doi: 10.1177/001872677602900 80.

Altemeyer, B. (1981). *Right-wing authoritarianism*. Manitoba: University of Manitoba press.

American Psychiatric Association (2013). *Diagnostic and Statistical Manual of Mental Disorders, 5th ed.* Arlington, VA: American Psychiatric Publishing.

American Psychiatric Association (APA). (1987). *Diagnostic and statistical manual of mental disorders. 3rd ed., revised*. Washington, DC: American Psychiatric Association.

American Psychiatric Association (APA). (2000). *Diagnostic and Statistical Manual of Mental Disorders: DSM-IV-TR*. Washington, DC: American Psychiatric Association.

American Psychological Association (2015). Guidelines for psychological practice with transgender and gender nonconforming people. *American Psychologist, 70*, 832-864. doi: 10.1037/a0039906.

American Psychological Association. (2012). Guidelines for psychological practice with lesbian, gay, and bisexual clients. American Psychologist, 67, 10–42. doi:/10.1037/a0024659.

Ansara, Y. G. (2010). Beyond cisgenderism: Counselling people with non-assigned gender identities. In L. Moon (Ed.), *Counselling ideologies: Queer challenges to heteronormativity* (pp. 167–200). Aldershot: Ashgate.

Ansara, Y. G., & Hegarty, P. (2012). Cisgenderism in psychology: Pathologising and misgendering children from 1999 to 2008. *Psychology & Sexuality, 3,* 137-160. doi: 10.1080/19419899.2011.576696.

Ansara, Y. G., & Hegarty, P. (2014). Methodologies of misgendering: Recommendations for reducing cisgenderism in psychological research. *Feminism & Psychology, 24,* 259-270. doi : 10.1177/0959353514526217.

Anzani, A., Di Sarno, M., Sacchi, S., Prunas, A. (2018). Maladaptive personality traits, defense mechanisms, and trans-negative attitudes. *International Journal of Transgenderism, 19,* 456-465. doi: 10.1080/15532739.2018.1478759

Anzani, A., Morris, E. R., & Galupo, M. P. (2019). From Absence of Microaggressions to Seeing Authentic Gender: Transgender experiences with microaffirmations in therapy. *Journal of LGBT Issues in Counseling*. doi: 10.1080/15538605.2019.1662359.

Anzani, A., Prunas, A., Sacchi, S. (2019). Facing Transgender and Cisgender Patients: the Influence of the Client's Experienced Gender and Gender Identity on Clinical Evaluation. *Sexuality Research and Social Policy,*1- 9. doi: 10.1007/s13178-019-00382-4

Asch, S. (1955). *Social Psychology*. Englewood Cliffs, N.J.: Prentice Hall.

Austin, A., & Goodman, R. (2017). The impact of social connectedness and internalized transphobic stigma on self-esteem among transgender and gender non-conforming adults. *Journal of Homosexuality, 64,* 825–841. doi: 10.1080/00918369.2016.1236587.

Austin, A., Craig, S. L., & D'Souza, S. A. (2018). An AFFIRMative Cognitive Behavioral Intervention for Transgender Youth: Preliminary Effectiveness. *Professional Psychology: Research and Practice, 49,* 1. doi: 10.1037/pro0000154.

Bagby, R., Ryder, M. A. G., Schuller, D. R., 2003. Depressive personality disorder: A critical overview. *Current Psychiatry Reports, 5,* 16–22. doi:/10.1007/s11920-003-0004-6.

Bartlett, A., Smith, G., & King, M. (2009). The response of mental health professionals to clients seeking help to change or redirect same-sex sexual orientation. BMC Psychiatry, 9, 11. doi:10.1186/1471-244X-9-11

Bastiaens, T., Claes, L., Smits, D., De Clercq, B., De Fruyt, F., Rossi, G., Vanwalleghem, D., Vermote, R., Lowyck, B., Claes, S., De Hert, M., De Hert, M. (2016). The construct validity of the Dutch Personality Inventory for DSM-5 personality disorders (PID-5) in a clinical sample. *Assessment. 23,* 42-51. doi:10.1177/1073191115575069.

Baumeister, R. F., & Leary, M. R. (1995). The need to belong: desire for interpersonal attachments as a fundamental human motivation. *Psychological bulletin, 117,* 497. doi: 10.1037/0033-2909.117.3.497.

Blair, K. L., & Hoskin, R. A. (2019). Transgender exclusion from the world of dating: Patterns of acceptance and rejection of hypothetical trans dating partners as a function of sexual and gender identity. *Journal of Social and Personal Relationships, 36*, 2074-2095. doi: 10.1177/0265407518779139.

Blumer, M. L., Ansara, Y. G, & Watson, C. M. (2013). Cisgenderism in family therapy: How everyday clinical practices can delegitimize people's gender self-designations. *Journal of Family Psychotherapy, 24*, 267-285. doi: 10.1080/08975353.2013.849551.

Bockting, W. (2015). Internalized transphobia. In P. Whelehan & A. Bolin (Eds.), *The International Encyclopedia of Human Sexuality*, (pp. 583-625). Hoboken, NJ: Wiley.

Bockting, W. O., Miner, M. H., Swinburne Romine, R. E., Hamilton, A., & Coleman, E. (2013). Stigma, mental health, and resilience in an online sample of the US transgender population. *American Journal of Public Health, 103*, 943-951. doi: 10.2105/AJPH.2013.301241.

Bockting, W., Knudson, G., Goldberg, J. M. (2006). *Counselling and mental health care of transgender adults and loved ones. Vancouver coastal health, transcend transgender support and education society, and the Canadian rainbow health coalition*. Retrieved from: http://lgbtqpn.ca/wp-content/uploads/woocommerce_uploads/2014/08/Guidelines-mentalhealth.pdf (accessed 21 January 2019).

Bodlund, O., Armelius, K. (1994). Self-image and personality traits in gender identity disorders: An empirical study. *Journal of Sexual and Marital Therapy, 20*, 303–317. doi: https://doi.org/10.1080/00926239408404380.

Bodlund, O., Kullgren, G. (1996). Transsexualism- general outcome and prognostic factors: A five- year follow-up study of nineteen transsexuals in the process of changing sex. *Archives of Sexual Behavior, 25*, 303. doi: 10.1007/BF02438167.

Bodlund, O., Kullgren, G., Sundbom, E., Höjerback, T. (1993). Personality traits and disorders among transsexuals. *Acta Psychiatrica Scandinavica, 88*, 322–327. doi:10.1111/j.1600- 0447.1993.tb03467.x.

Bogaert, A. F., & Brotto, L. A. (2014). Object of desire self-consciousness theory. *Journal of Sex & Marital Therapy, 40*, 323-338. doi: 10.1080/0092623X.2012.756841.

Bogaert, A. F., Visser, B. A., & Pozzebon, J. A. (2015). Gender differences in object of desire self-consciousness sexual fantasies. *Archives of Sexual Behavior, 44*, 2299-2310. doi: 10.1007/s10508-014-0456-2.

Bowers, S., Lewandowski, J., Savage, T. A., & Woitaszewski, S.A. (2015). School psychologists' attitudes toward transgender students. *Journal of LGBT Youth, 12*, 1–18. doi:10.1080/19361653.2014.930370.

Bozkurt, A., Isikli, H., Demir, F., Ozmenler, K. N., Gulcat, Z., Karlidere, T., Aydin, H., 2006. Body image and personality traits of male-to-female transsexuals and homosexuals. *Social Behavior and Personality: An International Journal, 34*, 927-938. doi: 10.2224/sbp.2006.34.8.927.

Bradford, N. J., Rider, G. N., Catalpa, J. M., Morrow, Q. J., Berg, D. R., Spencer, K. G., & McGuire, J. K. (2018). Creating gender: A thematic analysis of genderqueer narratives. *International Journal of Transgenderism, 20*, 155-168. doi: 10.1080/15532739.2018.1474516.

Breslow, A. S., Brewster, M. E., Velez, B. L., Wong, S., Geiger, E., & Soderstrom, B. (2015). Resilience and collective action: Exploring buffers against minority stress for transgender individuals. *Psychology of Sexual Orientation and Gender Diversity, 2*, 253–265. doi:10.1037/sgd0000117.

Britt, T. W., Boniecki, K. A., Vescio, T. K., Biernat, M. & Brown, L. (1996). Intergroup anxiety: A person situational approach. *Personality and Social Psychology Bulletin, 22*, 1177±1188. 10.1177/01461672962211008.

Brown, S., Kucharska, J., & Marczak, M. (2018). Mental health practitioners' attitudes towards transgender people: A systematic review of the literature. *International Journal of Transgenderism, 19*, 4-24. doi: 10.1080/15532739.2017.1374227.

Browne, K., & Lim, J. (2008). *Count Me In Too: LGBT Lives in Brighton and Hove. Trans people: additional findings report.* Brighton: University of Brighton. Retrieved from: http://www.brighton.ac.uk/cupp/images/stories/projects/c-k-e/LGBTU/CMIT_Safety_Report_Final_Feb08.pdf

Budge, S. L. (2014). Navigating the balance between positivity and minority stress for LGBTQ clients who are coming out. *Psychology of Sexual Orientation and Gender Diversity, 1*, 350. doi: 10.1037/sgd0000077.

Budge, S. L. (2015). Psychotherapists as gatekeepers: An evidence-based case study highlighting the role and process of letter writing for transgender clients. *Psychotherapy, 52*(3), 287. doi: 10.1037/pst0000034.

Budge, S. L., Adelson, J. L., & Howard, K. A. S. (2013). Anxiety and depression in transgender individuals: The roles of transition status, loss, social support,

and coping. *Journal of consulting and clinical psychology, 81*, 545-557. doi:10.1037/a0031774.

Budge, S. L., Israel, T., & Merrill, C. R. S. (2017). Improving the lives of sexual and gender minorities: The promise of psychotherapy research. *Journal of Counseling Psychology, 64*, 376–384. doi:10.1037/cou0000215.

Burgard, S. A., Cochran, S. D., & Mays, V. M. (2005). Alcohol and tobacco use patterns among heterosexually and homosexually experienced California women. *Drug & Alcohol Dependence, 77*, 61-70. doi: 10.1016/j.drugalcdep.2004.07.007.

Butler, J. (2004). *Undoing gender.* London: Routledge.

Cabaj , R. P. (2014). Substance use issues among gay, lesbian, bisexual, and transgender people. In M. Galanter , H.D. Kleber , & K.T. Brady (Eds.), *Textbook of substance abuse treatment*. Washington, DC: American Psychiatric Association.

Cadinu, M., Latrofa, M., & Carnaghi, A. (2013). Comparing self-stereotyping with in-group-stereotyping and out-group-stereotyping in unequal-status groups: The case of gender. *Self and Identity, 12*, 582-596. doi: 10.1080/15298868.2012.712753.

Capozzi, P., & Lingiardi, V. (2003). Happy Italy? The Mediterranean experience of homosexuality, psychoanalysis, and the mental health professions. *Journal of Gay & Lesbian Psychotherapy, 7*, 93-116. doi:10.1300/J236v07n01_07.

Cardwell, M. (1996). Dictionary of Psychology. Chicago IL: Fitzroy Dearborn.

Catalpa, J. M., McGuire, J. K., Berg, D., Fish, J. N., Rider, G. N., & Bradford N. (2019). Predictive validity of the Genderqueer Identity Scale (GQI): Differences between genderqueer, transgender and cisgender sexual minority individuals. *International Journal of Transgenderism, 20,* 305-314. doi: 10.1080/15532739.2018.1528196.

Cauce, A. M., Paradise, M., Ginzler, J. A., Embry, L., Morgan, C. J., Lohr, Y., & Theofelis, J. (2000). The characteristics and mental health of homeless adolescents: Age and gender differences. *Journal of Emotional and Behavioral Disorders, 8,* 230-239. doi: 10.1177/106342660000800403.

Chang, T. K., & Chung, Y. B. (2015). Transgender microaggressions: Complexity of the heterogeneity of transgender identities. *Journal of LGBT Issues in Counseling, 9,* 217-234. doi: 10.1080/15538605.2015.1068146.

Chaplin, T. M., 2015. Gender and emotion expression: A developmental contextual perspective. *Emotion Review, 7,* 14-21. doi: 10.1177/1754073914544408.

Claes, L., Bouman, W.P., Witcomb, G., Thurston, M., Fernandez- Aranda, F., & Arcelus, J. (2015). Non- suicidal self- injury in trans people: Associations with psychological symptoms, victimization, interpersonal functioning, and perceived social support. *Journal of Sexual Medicine, 12,* 168 – 179. doi:10.1111/ jsm.12711.

Cloninger, C. R., Przybeck, T. R., Svrakic, D. M., & Wetzel, R. D. (1994). The Temperament and Character Inventory (TCI): A guide to its development and use. St. Louis, MO: Center for Psychobiology of Personality.

Cochran, S. D. (2001). Emerging issues in research on lesbians' and gay men's mental health: Does sexual orientation really matter? *American Psychologist, 56*, 931. doi: 10.1037/0003-066x.56.11.931.

Cohen, S., & Wills, T. A. (1985). Stress, social support, and the buffering hypothesis. *Psychological bulletin, 98*, 310. doi: 10.1037/0033-2909.98.2.310.

Cohn, T. J., Casazza S. P., Cottrell E. M. (2018). The Mental Health of Gender and Sexual Minority Groups in Context. In K.B. Smalley, J.C. Warren, K.N. Barefoot (Eds). *LGBT HEALTH. Meeting the Needs of Gender and Sexual Minorities.* New York, NY: Springer Publishing Company.

Cole, C. M., O'Boyle, M., Emory, L. E., Meyer, W. J. (1997). Comorbidity of gender dysphoria and other major psychiatric diagnoses. *Archives of Sexual Behavior, 26*, 13–26. doi: 10.1023/A:1024517302481.

Cole, E. R. (2009). Intersectionality and research in psychology. *American Psychologist, 64*, 170–180. doi: 10.1037/a0014564.

Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J.,...Zucker, K. (2012). Standards of care for the health of transsexual, transgender, and gender-nonconforming people, Version 7. *International Journal of Transgenderism, 13*,165–232. doi: 10.1080/15532739.2011.700873.

Davey, A., Arcelus, J., Meyer, C., & Bouman, W. P. (2015). Self- injury among trans individuals and matched controls: Prevalence and associated factors. *Health & Social Care in the Community, 24*, 485-494 . doi:10.1111/ hsc.12239.

Devine, P. G. (1989). Stereotypes and prejudice: Their automatic and controlled components. *Journal of Personality and Social Psychology, 56,* 5. doi: 10.1037/0022-3514.56.1.5.

Devine, P. G., & Elliot, A. J. (1995). Are racial stereotypes really fading? The Princeton trilogy revisited. *Personality and Social Psychology Bulletin, 21,* 1139-1150. doi: 10.1177/01461672952111002.

Dhejne, C., Van Vlerken , R., Heylens , G., & Arcelus, J. (2016). Mental health and gender dysphoria: A review of the literature. *International Review of Psychiatry, 28,* 44 – 57. doi:10.3109/ 09540261.2015.1115753.

Diamond, M. (2002). Sex and Gender are Different: Sexual Identity and Gender Identity are Different. *Clinical Child Psychology and Psychiatry, 7,* 320–334. doi: 10.1177/1359104502007003002

dickey, l. m., Reisner, S.L., & Juntunen, C.L. (2015). Non- suicidal self- injury in a large online sample of transgender adults. *Professional Psychology: Research and Practice, 46,* 3-11 . doi: 10.1037/ a0038803.

Duisin, D., Batinić, B., Barisic, J.V., Djordjevic, M.L., Vujović, S., Bizic, M.R., 2014. Personality disorders in persons with gender identity disorder. *The Scientific World Journal*. doi: 10.1155/2014/809058.

Durkheim, E. (1951). *Suicide*. New York: Free Press.

Easterbrook, J. A. (1959). The effect of emotion on cue utilization and the organization of behavior. Psychological Review, 66, 183±201. doi: 10.1037/h0047707.

Eisenberg, M. E., Gower, A. L., McMorris, B. J., Rider, G. N., Shea, G., & Coleman, E. (2017). Risk and protective factors in the lives of transgender/gender nonconforming adolescents. *Journal of Adolescent Health, 61*, 521-526. https://doi.org/10.1016/j.jadohealth.2017.04.014

Eisenberger, N. I., Lieberman, M. D., & Williams, K. D. (2003). Does rejection hurt? An fMRI study of social exclusion. *Science, 302*, 290-292. doi: 10.1126/science.1089134.

Eysenck, H. J., Eysenck, S. B. G. (1978). *Manual of Eysenck Personality Questionnaire*. London: Hodder and Stoughton Ltd.

Faul, F., Erdfelder, E., Lang, A. G., & Buchner, A. (2007). G* Power 3: A flexible statistical power analysis program for the social, behavioral, and biomedical sciences. *Behavior Research Methods, 39*, 175-191. doi: 10.3758/BF03193146

Fernández-Rouco, N., Fernández-Fuertes, A. A., Carcedo, R. J., Lázaro-Visa, S., & Gómez-Pérez, E. (2017). Sexual violence history and welfare in transgender people. *Journal of Interpersonal Violence, 32*, 2885-2907. doi: 10.1177/0886260516657911

Few, L. R., Miller, J. D., Rothbaum, A. O., Meller, S., Maples, J., Terry, D. P., Collins, B., MacKillop, J. (2013). Examination of the Section III DSM–5 diagnostic system for personality disorders in an outpatient clinical sample. *Journal of Abnormal Psychology. 122*, 1057–1069. http://dx.doi.org/10.1037/a0034878

First, M. B., Gibbon, M., Spitzer, R.L., Williams, W., Benjamin, L.S. (1997*). Structured Clinical Interview for DSM-IV Axis II Personality Disorders* (SCID-II). Washington, DC: American Psychiatric Publishing.

Fisher, A. D., Bandini, E., Casale, H., Ferruccio, N., Meriggiola, M. C., Gualerzi, A., Manieri, C., Jannini, E., Mannucci, E., Monami, M., Stomaci, N. Delle Rose, A., Susini, T., Ricca, V. Maggi, M. (2013). Sociodemographic and clinical features of gender identity disorder: An Italian multicentric evaluation. *Journal of Sexual Medicine, 10,* 408–19. doi: 10.1111/j.1743-6109.2012.03006.x.

Flanders, C. F. (2015). Bisexual health: A daily dairy analysis of stress and anxiety. *Basic and Applied Social Psychology, 37,* 319–335. doi:10.1080/01973533.2015.1079202.

Flick, U. (2014). *An introduction to qualitative research.* London: Sage.

Fossati, A., Borroni, S., Somma, A., 2015. *PID-5 Adulti. Manuale d'Uso della Versione Italiana*. Milano, Italy: Raffaello Cortina Editore.

Fossati, A., Krueger, R.F., Markon, K.E., Borroni, S., Maffei, C. (2013). Reliability and validity of the Personality Inventory for DSM-5 (PID-5): Predicting DSM-IV personality disorders and psychopathy in community-dwelling Italian adults. *Assessment, 20,* 689–708. doi: 10.1177/1073191113504984.

FRA – European Union Agency for Fundamental Rights (2014). *EU LGBT survey - European Union lesbian, gay, bisexual and transgender survey - Results at a glance.* Retrieved from:

http://fra.europa.eu/en/publication/2013/eu-lgbt-survey-european-union-lesbian-gay-bisexual-and-transgender-survey-results

Fredrickson, B. L., & Roberts, T. A. (1997). Objectification theory: Toward understanding women's lived experiences and mental health risks. *Psychology of Women Quarterly*, *21*, 173–206. doi: 10.1111/j.1471-6402.1997.tb00108.x

Galupo, M. P., Henise, S. B., and Davis, K. S. (2014). Transgender microaggressions in the context of friendship: Patterns of experience across friends' sexual orientation and gender identity. *Psychology of Sexual Orientation and Gender Diversity, 1*, 461. doi: 10.1037/sgd0000075.

Galupo, M. P., Pulice-Farrow, L. K., & Ramirez, J. L. (2017). "Like a constantly flowing river": Gender identity flexibility among non-binary transgender individuals. In Sinnott, J. D. (Ed). *Identity Flexibility During Adulthood: Perspectives in Adult* Development. Springer. pp 163-177

Garb, H. N. (1997). Race bias, social class bias, and gender bias in clinical judgment. *Clinical Psychology: Science and Practice, 4*, 99-120. doi: 10.1111/j.1468-2850.1997.tb00104.x

Gil, V. E. (1990). Sexual fantasy experiences and guilt among conservative Christians: An exploratory study. *Journal of Sex Research, 27*, 629-638. doi:10.1080/00224499009551584.

Giordano, S., 2018. Understanding the emotion of shame in transgender individuals - some insight from Kafka. Life Sciences. *Society and Policy, 14*, 23. doi: 10.1186/s40504-018-0085- y.

Goldey, K. L., Avery, L. R., & van Anders, S. M. (2014). Sexual fantasies and gender/sex: A multimethod approach with quantitative content analysis and hormonal responses. *The Journal of Sex Research, 51*, 917-931. doi: 10.1080/00224499.2013.798611.

Golub, S. A., Walker, J. J., Longmire-Avital, B., Bimbi, D. S., & Parsons, J. T. (2010). The role of religiosity, social support, and stress-related growth in protecting against HIV risk among transgender women. *Journal of Health Psychology*, 15, 1135–1144. doi: 10.1177/1359105310364169.

Gómez-Gil, E., Gutiérrez, F., Cañizares, S., Zubiaurre-Elorza, L., Monràs, M., Esteva de Antonio, I., Salamero, M., Guillamón, A., 2013. Temperament and character in transsexuals. *Psychiatry Research. 210*, 969-74. doi: 10.1016/j.psychres.2013.07.040.

Grant, B. F., Hasin, D. S., Stinson, F. S., Dawson, D. A., Chou, S. P., Ruan, W. J., Pickering, R. P. (2004). Prevalence, correlates, and disability of personality disorders in the United States: results from the National Epidemiologic Survey on Alcohol and Related Conditions. *Journal of Clinical Psychiatry, 65*, 948-58. doi: 10.4088/JCP.v65n0711.

Grant, J. M., Mottet, L. A., Tanis, J., Harrison, J., Herman, J. L., & Keisling, M. (2011). *Injustice at every turn: A report of the National Transgender Discrimination Survey.* Washington, DC: National Center for Transgender Equality and the National Gay and Lesbian Task Force. Retrieved from: http://transequality.org/PDFs/NTDS_Report.pdf.

Grossman, A. H., D'Augelli, A. R. (2007). Transgender youth and life-threatening behaviors. *Suicide and Life-Threatening Behavior, 37*, 527–537. doi: 10.1521/suli.2007.37.5.527.

Grossman, A., D'Augelli, A., Salter, N., & Hubbard, S. (2005). Comparing gender expression, gender nonconformity, and parents' responses of female-to-male and male-to-female transgender youth: Implications for counseling. *Journal of LGBT Issues in Counseling, 1*, 41–59. doi:10.1300/J462v01n01_04.

Haas , A. P., Rodgers, P. L., & Herman, J. L. (2014). *Suicide attempts among transgender and gender non- conforming adults: Findings of the national transgender discrimination survey*. Retrieved from http:// williamsinstitute.law.ucla.edu/ wp- content/ uploads/AFSP- Williams- Suicide- Report- Final.pdf

Haraldsen, I. R., Dahl, A. A. (2000). Symptom profiles of gender dysphoric patients of transsexual type compared to patients with personality disorders and healthy adults. *Acta Psychiatrica Scandinavica, 102*, 276–81. doi: 10.1034/j.1600-0447.2000.102004276.x.

Harper, G. W., & Schneider, M. (2003). Oppression and discrimination among lesbian, gay, bisexual, and transgendered people and communities: A challenge for community psychology. *American journal of community psychology, 31*, 243-252. doi: 10.1023/A:1023906620085.

Harvey, M. R. (2007). Towards an ecological understanding of resilience in trauma survivors: Implications for theory, research, and practice. In. M. R. Harvey & P. Tummala-Narra (Eds.), *Sources and expression of resilience in trauma survivors: Ecological theory, multicultural perspectives.* Birmingham, NY: Haworth. doi:10.1300/J146v14n01_02.

Hatzenbuehler, M. L. (2011). The social environment and suicide attempts in lesbian, gay, and bisexual youth. *Pediatrics, 127*, 896-903. doi: 10.1542/ peds.2010- 3020.

Hatzenbuehler, M. L., Nolen-Hoeksema, S., & Erickson, S. J. (2008). Minority stress predictors of HIV risk behavior, substance use, and depressive symptoms: results from a prospective study of bereaved gay men. *Health Psychology, 27*, 455. doi: 10.1037/0278-6133.27.4.455.

Hayes, A. F. (2013). Introduction to Mediation, Moderation, and Conditional Process Analysis. A Regression-Based Approach. New York: Guilford.

Hayes, A. F. (2018). Introduction to Mediation, Moderation, and Conditional Process Analysis (2nd Ed). New York: Guilford.

Hembree, W. C., Cohen-Kettenis, P. T., Gooren, L., Hannema, S. E., Meyer, W. J., Murad, M. H., Rosenthal, S. M., Safer, J. D., Tangpricha, V., T'Sjoen, G. G. (2017). Endocrine treatment of gender- dysphoric/gender-incongruent persons: An Endocrine Society Clinical Practice Guideline. *The Journal of Clinical Endocrinology and Metabolism, 102*, 3869–3903. doi: 10.1210/jc.2017-01658.

Hendricks, M. L., Testa, R. J. (2012). A conceptual framework for clinical work with transgender and gender nonconforming clients: An adaptation of the minority stress model. *Professional Psychology: Research and Practice, 43*. doi: 10.1037/a0029597.

Hepp, U., Kraemer, B., Schnyder, U., Miller, N., Delsignore, A., 2005. Psychiatric comorbidity in gender identity disorder. *Journal of Psychosomatic Research, 58*, 259–261. doi: 10.1016/j.jpsychores.2004.08.010.

Herek G. M, Chopp R., and Strohl D. (2007) Sexual Stigma: Putting Sexual Minority Health Issues in Context. In I.H. Meyer & M.E. Northridge (Eds) *The Health of Sexual Minorities. Public Health Perspectives on Lesbian, Gay, Bisexual and Transgender Populations.* New York, NY: Springer.

Herek, G. M. (2002). Gender gaps in public opinion about lesbians and gay men. *Public Opinion Quarterly, 66,* 40-66. doi:10.1086/338409.

Herek, G. M., Gillis, J. R., & Cogan, J. C. (2015). Internalized stigma among sexual minority adults: Insights from a social psychological perspective. *Stigma and Health, 1*, 18–34. doi:10.1037/2376-6972.1.S.18.

Heylens, G., Elaut, E., Kreukels, B. P. C., Paap, M. C. S., Cerwenka, S., Richter-Appelt, H., Cohen- Kettenis, P. T., Haraldsen, I. R., De Cuypere, G. (2014). Psychiatric characteristics in transsexual individuals: multicentre study in four European countries. *British Journal of Psychiatry, 204,* 151–6. doi: 10.1192/bjp.bp.112.121954.

Hintikka, J., Saarinen, P., Tanskanen, A., Koivumaa-Honkanen, H., & Viinamäki, H. (1999). Gender differences in living skills and global assessment of functioning among outpatients with schizophrenia. *Australian & New Zealand Journal of Psychiatry, 33,* 226-231. doi: 10.1046/j.1440-1614.1999.00538.x.

Hoy-Ellis, C. P., Fredriksen-Goldsen, K. I. (2017). Depression among transgender older adults: General and minority stress. *American Journal of Community Psychology, 59,* 295-305. doi: 10.1002/ajcp.12138.

Iantaffi, A., & Barker, M. J. (2019). *Life Isn't Binary: On Being Both, Beyond, and In-Between*. London, England: Jessica Kingsley Publishers.

Israel, T., Gorcheva, R., Walther, W. A., Sulzner, J. M., & Cohen, J. (2008). Therapists' helpful and unhelpful situations with LGBT clients: An exploratory study. *Professional Psychology: Research and Practice*, *39*, 361–368. doi:10.1037/0735-7028.39.3.361

James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). *The Report of the 2015 U.S. Transgender Survey*. Washington, DC: National Center for Transgender Equality.

Jones, J. C., & Barlow, D. H. (1990). Self-reported frequency of sexual urges, fantasies, and masturbatory fantasies in heterosexual males and females. *Archives of Sexual Behavior, 19*, 269-279. http://dx.doi.org/10.1007/BF01541552.

Joyal, C. C., Cossette, A., & Lapierre, V. (2015). What exactly is an unusual sexual fantasy?. *The Journal Of Sexual Medicine*, *12*(2), 328-340.

Kaplan, H. S. (1979). *Disorders of sexual desire and other new concepts and techniques in sex therapy* (Vol. 2). New York, NY: Simon & Schuster.

Kattari, S. K., Atteberry-Ash, B., Walls, N. E., Rusow, J., Klemmer, C., & Kattari, L. (2019). Differential sexual behavior experiences of LGBT and transgender/nonbinary young people in Colorado. *Youth & Society*,. doi: 10.1177/0044118X19854783

Kawachi, I., & Berkman, L. F. (2001). Social ties and mental health. *Journal of Urban health, 78*, 458-467. doi: 10.1093/jurban/78.3.458.

Kelleher, C. (2009) Minority stress and health: Implications for lesbian, gay, bisexual, transgender, and questioning (LGBTQ) young people. *Counselling Psychology Quarterly, 22*, 373-379. doi: 10.1080/09515070903334995.

Keo-Meier, C .L., Herman, L. I., Reisner, S. L., Pardo, S. T., Sharp, C., Babcock, J. C. (2015). Testosterone treatment and MMPI–2 improvement in transgender

men: A prospective controlled study. *Journal of Consulting and Clinical Psychology, 83*, 143-156. doi: 10.1037/a0037599

Keo-Meier, C. L., Fitzgerald, K. M. (2017). Affirmative psychological testing and neurocognitive assessment with transgender adults. *Psychiatric Clinics of North America, 40,* 51–64. doi: 10.1016/j.psc.2016.10.011

Keuroghlian, A. S., Reisner, S. L., White, J. M., & Weiss, R. D. (2015). Substance use and treatment of substance use disorders in a community sample of transgender adults. *Drug and Alcohol Dependence, 152,* 139-146. doi:10.1016/ j.drugalcdep.2015.04.008

Knutson, D., Koch, J. M., & Goldbach, C. (2019). Recommended terminology, pronouns, and documentation for work with transgender and non-binary populations. Practice Innovations, 4(4), 214.

Kosciw, J. G., Greytak, E. A., Palmer, N. A., Boesen, M. J. (2014). *The 2013 National School Climate Survey: The Experiences of Lesbian, Gay, Bisexual and Transgender Youth in our Nation's Schools*. New York: Gay, Lesbian, & Straight Education Network.

Kosciw, J. G., Greytak,E. A., Bartkiewicz, M. J., Boesen,M. J., & Palmer, N. A. (2011). *The 2011 National School Climate Survey: The Experiences Of Lesbian, Gay, Bisexual And Transgender Youth In Our Nation's Schools*. New York: Gay, Lesbian, & Straight Education Network.

Kring, A. M., Gordon, A. H. (1998). Sex differences in emotion: Expression, experience, and physiology. *Journal of Personality and Social Psychology, 74*, 686–703. doi: 10.1037/0022–3514.74.3.686

Krueger, R. F., Derringer, J., Markon, K. E., Watson, D., Skodol, A. E. (2012). Initial construction of a maladaptive personality trait model and inventory for DSM-5. *Psychological Medicine, 42,* 1879-90. doi: 10.1017/S0033291711002674

Krueger, R. F., Eaton, N. R., Derringer, J., Markon, K. E., Watson, D., Skodol, A. E. (2011). Personality in DSM-5: Helping delineate personality disorder content and framing the metastructure. *Journal of Personality Assessment, 93,* 325-331. doi: 10.1080/00223891.2011.577478

Krueger, R. F., Markon, K. E. (2014). The role of the DSM-5 personality trait model in moving toward a quantitative and empirically based approach to classifying personality and psychopathology. *Annual Review of Clinical Psychology, 10,* 477–501. doi: 10.1146/annurev-clinpsy- 032813-153732

Kushner, L. H. (2008). *Contrasts in judgements of mental health. Unpublished master's thesis*. American University, Washington, D.C.

LaFrance, M., Hecht, M. A., Levy Paluck, E. L. (2003). The contingent smile: A meta-analysis of sex differences in smiling. *Psychological Bulletin, 129,* 305–334. doi:10.1037/0033– 2909.129.2.305.

Langenderfer-Magruder, L., Whitfield, D. L., Walls, N. E., Kattari, S. K., & Ramos, D. (2016). Experiences of intimate partner violence and subsequent police reporting among lesbian, gay, bisexual, transgender, and queer adults in Colorado: Comparing rates of cisgender and transgender victimization. Journal of Interpersonal Violence, 31, 855-871. doi: 10.1177/0886260514556767.

Lehavot, K., & Simoni, J. M. (2011). The impact of minority stress on mental health and substance use among sexual minority women. *Journal of Consulting and Clinical Psychology, 79*, 159. doi:10.1037/a0022839

Lehmiller, J. J. (2018). *Tell me what you want: The science of sexual desire and how it can help you improve your sex life.* New York: Da Capo Lifelong Books.

Lehmiller, J. J. (2019, April 8).The sexual fantasies of people with non-binary gender identities [Blog post]. Retrieved from: https://www.lehmiller.com/blog/2019/4/8/what-do-gender-non-binary-people-fantasize-about

Leitenberg, H., & Henning, K. (1995). Sexual fantasy. *Psychological Bulletin, 117*, 469-496. doi: 10.1037/0033-2909.117.3.469

Lenihan, P., Kainth, T., & Dundas, R. (2015). Trans Sexualities. In C. Richards and M. J. Barker (Eds.), *The palgrave handbook of the psychology of sexuality and gender.* New York, NY: Palgrave Macmillan.

Lev, A. I. (2004). *Transgender emergence: Therapeutic guidelines for working with gender-variant people and their families*. New York, NY: Haworth.

Linehan, M. (1993). *Cognitive-Behavioral Treatment of Borderline Personality Disorder*. The Guilford Press, New York.

Lingiardi, V., & Capozzi, P. (2004). Psychoanalytic attitudes towards homosexuality: An empirical research. *The International Journal of Psychoanalysis, 85*, 137-157. doi: 10.1516/AAFK-H7N2-YVCA-27MC.

Lingiardi, V., Nardelli, N., Tripodi, E. (2015). Reparative attitudes of Italian psychologists toward lesbian and gay clients: Theoretical, clinical and social

implications. *Professional Psychology: Research and Practice, 46*, 132–139. doi: 10.1037/pro0000016.

Macintyre, S., Hunt, K., & Sweeting, H. (1996). Gender differences in health: are things really as simple as they seem?. *Social Science & Medicine, 42*, 617-624. doi: 10.1016/0277-9536(95)00335-5

MacKinnon, K. R. (2018). Pathologising trans people: Exploring the roles of patients and medical personnel. *Theory in Action, 11*, 74-96. doi: 10.3798/tia.1937-0237.182

Madeddu, F., Prunas, A., Hartmann, D. (2009). Prevalence of Axis II Disorders in a sample of clients undertaking psychiatric evaluation for sex reassignment surgery. *Psychiatric Quarterly, 80*, 261-7. doi: 10.1007/s11126-009-9114-6.

Marshall, E., Claes, L., Bouman, W. P., Witcomb, G. L., & Arcelus, J. (2016). Non- suicidal self-injury and suicidality in trans people: A systematic review of the literature. *International Review of Psychiatry, 28*, 58-69. doi: 10.3109/ 09540261.2015.1073143.

Mauk, D., Perry, A., & Muñoz-Laboy, M. (2013). Exploring the desires and sexual culture of men who have sex with male-to-female transgender women. *Archives of Sexual Behavior, 42*, 793-803. doi: 10.1007/s10508-013-0079-z

Mayring, P. (2004). Qualitative content analysis. In I. Steinke, U. Flick, & E. von Kardoff (Eds.), *A Companion to qualitative research* . Thousand Oaks, CA: Sage Publications.

Mays, V. M., & Cochran, S. D. (2001). Mental health correlates of perceived discrimination among lesbian, gay, and bisexual adults in the United States. *American Journal of Public Health, 91*, 1869-1876. doi: 10.2105/AJPH.91.11.1869

McCann, E., & Sharek, D. (2016). Mental health needs of people who identify as transgender: A review of the literature. *Archives of Psychiatric Nursing, 30*(2), 280-285. doi: 10.1016/j.apnu.2015.07.003.

McGuire, J. K., Doty, J. L., Catalpa, J. M., & Ola, C. (2016). Body image in transgender young people: Findings from a qualitative, community based study. *Body Image, 18,* 96-107. doi: 10.1016/j.bodyim.2016.06.004.

McManama O'Brien, K. H., Liu, R. T., Putney, J. M., Burke, T. A. & Aguinaldo, L. D. (2018). Suicide and Self-injury in Gender and Sexual Minority Populations. In: K.B. Smalley, J.C. Warren and K.N. Barefoot (Eds). *LGBT HEALTH. Meeting the Needs of Gender and Sexual Minorities.* New York, NY: Springer Publishing Company.

Mealey, L., 2000. *Sex Differences: Development and Evolutionary Strategies*. San Diego: Academic Press.

Meana, M. (2010). Elucidating women's (hetero) sexual desire: Definitional challenges and content expansion. *Journal of Sex Research, 47*, 104–122. doi: 10.1080/00224490903402546.

Meybodi, A. M., Hajebi, A., Jolfaei, A. G. (2014). The frequency of personality disorders in patients with gender identity disorder. *Medical Journal of the Islamic Republic of Iran, 28*, 9-0.

Meyer I. H. (2007). Prejudice and Discrimination as Social Stressors. In I.H. Meyer & M.E. Northridge (Eds) *The Health of Sexual Minorities. Public Health Perspectives on Lesbian, Gay, Bisexual and Transgender Populations*. New York, NY: Springer.

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. *Psychological Bulletin, 129*, 674. doi: 10.1037/0033-2909.129.5.674.

Meyer, I. H. (2015). Resilience in the study of minority stress and health of sexual and gender minorities. *Psychology of Sexual Orientation and Gender Diversity, 2*, 209–213. doi: 10.1037/sgd0000132.

Meyer-Bahlburg, H. F. (2010). From mental disorder to iatrogenic hypogonadism: Dilemmas in conceptualizing gender identity variants as psychiatric conditions. *Archives of Sexual Behavior, 39*, 461-476. doi: 10.1007/s10508-009-9532-4.

Miach, P. P., Berah, E. F., Butcher, J. N., Rouse, S., 2000. Utility of the MMPI-2 in assessing gender dysphoric patients. *Journal of Personality Assessment, 75*, 268–79. doi: 10.1207/S15327752JPA7502_7.

Mizock, L., & Mueser, K. T. (2014). Employment, mental health, internalized stigma, and coping with transphobia among transgender individuals. *Psychology of Sexual Orientation and Gender Diversity, 1*, 146–158. doi:10.1037/sgd0000029.

Mizock, L., Lewis, T. K. (2008). Trauma in transgender populations: Risk, resilience, and clinical care. *Journal of Emotional Abuse, 8*, 335–354. doi: 10.1080/10926790802262523.

Monro, S. (2019). Non-binary and genderqueer: An overview of the field. *International Journal of Transgenderism, 20*(2-3), 126-131. doi: 10.1080/15532739.2018.1538841.

Morin, J. (1995) *The erotic mind.* London: Headline.

Morris, E. R., Lindley, L., & Galupo, M. P. (in press). Better issues to focus on": Transgender microaggressions as ethical violations in therapy. *The Counseling Psychologist*.

Morrow, S. L. (2005). Quality and trustworthiness in qualitative research in counseling psychology. *Journal of Counseling Psychology, 52*, 250–260. doi:/10.1037/0022-0167.52.2.250

Myers, J. K., Weissman, M. M., Tischler, G. L., Holzer, C. E., Leaf, P. J., Orvaschel, H., ... & Stoltzman, R. (1984). Six-month prevalence of psychiatric disorders in three communities: 1980 to 1982. *Archives of General Psychiatry, 41*, 959-967. doi:10.1001/archpsyc.1984.01790210041006

Nadal K. L., Skolnik A., & Wong Y. (2012). Interpersonal and systemic microaggressions toward transgender people: Implications for counseling. *Journal of LGBT Issues in Counseling, 6*, 55-82. doi: 10.1080/15538605.2012.648583

Nadal, K. L. (2013). *That's so gay! Microaggressions and the lesbian, gay, bisexual, and transgender community*. Washington, DC: American Psychological Association.

Nadal, K. L., Davidoff, K. C., Davis, L. S., & Wong, Y. (2014). Emotional, behavioral, and cognitive reactions to microaggressions: Transgender

perspectives. *Psychology of Sexual Orientation and Gender Diversity, 1,* 72–81. doi: 10.1037/sgd0000011.

Nadal, K. L., Davidoff, K. C., Davis, L. S., Wong, Y., Marshall, D., & McKenzie, V. (2015). A qualitative approach to intersectional microaggressions: Understanding influences of race, ethnicity, gender, sexuality, and religion. *Qualitative Psychology, 2*, 147-163. doi: 10.1037/qup0000026.

Nadal, K. L., Rivera, D. P., and Corpus, M. J. H. (2010). Sexual orientation and transgender microaggressions: Implications for mental health and counseling. In D. W. Sue (Ed.), *Microaggressions and marginality: Manifestation, dynamics, and impact*. Hoboken, NJ, US: John Wiley and Sons Inc.

Nadal, K. L., Whitman, C. N., Davis, L. S., Erazo, T., and Davidson, K. C. (2016). Microaggressions toward lesbian, gay, bisexual, transgender, queer, and genderqueer people: A review of the literature. *Journal of Sex Research, 53,* 488–508. doi: 10.1080/00224499.2016.1142495.

Nagoshi, J. L., Adams, K. A., Terrell, H. K., Hill, E. D., Brzuzy, S., & Nagoshi, C. T. (2008). Gender differences in correlates of homophobia and transphobia. Sex roles, 59, 521. doi: 10.1007/s11199-008-9458-7.

Nealy, E. C. (2017). *Transgender Children and Youth: Cultivating Pride and Joy With Families In Transition*. New York, NY: WW Norton and Company.

Nemoto, T., Bödeker, B., & Iwamoto, M. (2011). Social support, exposure to violence and transphobia, and correlates of depression among male-to-female transgender women with a history of sex work. *American Journal of Public Health, 101*, 1980–1988. doi: 10.2105/AJPH.2010.197285.

Nemoto, T., Operario, D., Keatley, J., & Villegas, D. (2004). Social context of HIV risk behaviours among male-to-female transgenders of colour. *AIDS Care, 16*, 724–735. doi:10.1080/09540120413331269567.

Nieder, T. O., Elaut, E., Richards, C., Dekker, A. (2016). Sexual orientation of trans adults is not linked to outcome of transition-related health care, but worth asking. *International Review of Psychiatry, 28*, 103–111. doi: 10.3109/09540261.2015.1102127.

Nock, M. K., Borges, G., Bromet, E. J., Alonso, J., Angermeyer, M., Beautrais, A., . . . Williams, D. (2008). Cross- national prevalence and risk factors for suicidal ideation, plans and attempts. *The British Journal of Psychiatry, 192*, 98-105 . doi:10.1192/ bjp.bp.107.040113.

Nolen-Hoeksema, S. (1991). Responses to depression and their effects on the duration of depressive episodes. Journal of Abnormal Psychology, 100, 569. doi: 10.1037/0021-843X.100.4.569.

Nuttbrock, L., Bockting, W., Rosenblum, A., Hwahng, S., Mason, M., Macri, M., & Becker, J. (2014). Gender abuse, depressive symptoms, and substance use among transgender women: A 3- year prospective study. *American Journal of Public Health, 104*, 2199-2206. doi:10.2105/AJPH.2014.302106.

Owen, J., Imel, Z., Tao, K. W., Wampold, B., Smith, A., & Rodolfa, E. (2011). Cultural ruptures in short-term therapy: Working alliance as a mediator between clients' perceptions of microaggressions and therapy outcomes. *Counselling and Psychotherapy Research, 11*, 204-212. doi:10.1080/14733145.2010.491551

Owen, J., Tao, K. W. and Drinane, J. M. (2019). Clinical Impact and Psychological Harm. In G.C. Torino, D.P. Rivera, C.M. Capodilupo, K.L.

Nadal, and D.W. Sue (Eds.). *Microaggression Theory: Influence And Implications*. Hoboken, NJ: John Wiley and Sons.

Pachankis, J. E. (2007). The psychological implications of concealing a stigma: A cognitive-affective-behavioral model. *Psychological Bulletin, 133*, 328–345. doi: 10.1037/0033-2909.133.2.328.

Pascoal, P., Narciso, I., & Pereira, N. M. (2012). Predictors of body appearance cognitive distraction during sexual activity in men and women. *The Journal of Sexual Medicine, 9*, 2849-2860. https://doi.org/10.1111/j.1743-6109.2012.02893.x

Perez-Brumer, A., Hatzenbuehler, M. L., Oldenburg, C. E., & Bockting, W. (2015). Individual- and structural-level risk factors for suicide attempts among transgender adults. *Behavioral Medicine, 41*, 164–171. doi:10.1080/ 08964289.2015.1028322

Pfeffer, C. A. (2016). Transgender sexualities, In Goldberg, A.E. (Ed.), *The SAGE Encyclopedia of LGBTQ Studies*. New York, NY: Sage.

Pflum, S. R., Testa, R. J., Balsam, K. F., Goldblum, P. B., & Bongar, B. (2015). Social support, trans community connectedness, and mental health symptoms among transgender and gender nonconforming adults. *Psychology of Sexual Orientation and Gender Diversity, 2*, 281-286. doi:10.1037/sgd0000122.

Pichler, S., & Ruggs, E.N. (2015). LGBT workers. *Oxford handbook of workplace discrimination*, 665-701.

Pierce, C. M. (1970). Offensive mechanisms. In F. B. Barbour (Ed.), *The black '70's*. Boston: Porter Sargent.

Pinto, R. M., Melendez, R. M., & Spector, A. Y. (2008). Male-to-female transgender individuals building social support and capital from within a gender-focused network. *Journal of Gay and Lesbian Social Services, 20*, 203-220. doi:10.1080/10538720802235179.

Pizmony-Levy, O., Kosciw, J.G., 2016. School climate and the experience of LGBT students: A comparison of the United States and Israel. *Journal of LGBT Youth, 13*, 46-66. doi: 10.1080/19361653.2015.1108258.

Prunas, A. (2019). The pathologization of trans-sexuality: Historical roots and implications for sex counselling with transgender clients. *Sexologies, 28*, 135-141.

Prunas, A., Bandini, E., Fisher, A. D., Maggi, M., Pace, V., Quagliarella, L., ... & Bini, M. (2016). Experiences of discrimination, harassment, and violence in a sample of Italian transsexuals who have undergone sex-reassignment surgery. *Journal of Interpersonal Violence, 33*, 2225-2240. doi: 10.1177/0886260515624233

Prunas, A., Clerici, C. A., Gentile, G., Muccino, E., Veneroni, L., & Zoja, R. (2015). Transphobic murders in Italy: an overview of homicides in Milan (Italy) in the past two decades (1993-2012). *Journal of interpersonal violence, 30*, 2872-2885. doi: 10.1177/0886260514554293.

Prunas, A., Sacchi, S., & Brambilla, M. (2018). The Insidious Effects of Sexual Stereotypes in Clinical Practice. *The Journal of Sex Research, 55*, 642-653. doi: 10.1080/00224499.2017.1337866.

Pujols, Y., Meston, C. M., & Seal, B. N. (2010). The association between sexual satisfaction and body image in women. *The Journal of Sexual Medicine, 7*, 905-916. doi: 10.1111/j.1743-6109.2009.01604.x.

Pulice-Farrow, L., Clements, Z. A., and Galupo, M. P. (2017). Patterns of transgender microaggressions in friendship: The role of gender identity. *Psychology and Sexuality, 8*, 189-207. doi: 10.1080/19419899.2017.1343745.

Pulice-Farrow, L., McNary, S. B., & Galupo, M. P. (2019). "Bigender is just a Tumblr thing": Microaggressions in the romantic relationships of gender non-conforming and agender transgender individuals. *Sexual and Relationship Therapy*, advanced online publication. doi: 10.1080/14681994.2018.1533245.

Rachlin, K. (2002). Transgender individuals' experiences of psychotherapy. *International Journal of Transgenderism, 6*, 1–19. Retrieved from: http://www.symposion.com/ijt/ijtvo06no01_03.htm.

Reback, C., & Larkins, S. (2006). *Once in a blue moon: Toward a better understanding of heterosexually identified men who have sex with men and/or preoperative transgender*. Retrieved from: https://www.friendscommunitycenter.org/s/BlueMoon_Reback.pdf

Reisner, S. L., Perkovich, B., & Mimiaga, M. J. (2010). Mixed methods study of the sexual health needs of New England transmen who have sex with non-transgender men. *AIDS Patient Care and STDs, 2*, 501–513. doi:10.1089/apc.2010.0059

Reuter, T. R., Sharp, C., Kalpakci, A. H., Choi, H. J., Temple, J. R. (2016). Sexual orientation and borderline personality disorder features in a community

sample of adolescents. *Journal of Personality Disorders, 30,* 694-707. doi: 10.1521/pedi_2015_29_224.

Richards, C. (2017). Psychology. In C. Richards, W.P. Bouman, and M-J. Barker (Eds) *Genderqueer and Non-Binary Genders*. London: Palgrave.

Richards, C., Bouman, W. P., Seal, L., Barker, M. J., Nieder, T. O., & T'Sjoen, G. (2016). Non-binary or genderqueer genders. *International Review of Psychiatry, 28,* 95-102. doi: 10.3109/09540261.2015.1106446.

Riggs, D. W., & Bartholomaeus, C. (2018). Transgender young people's narratives of intimacy and sexual health: implications for sexuality education. *Sex Education, 18,* 376-390. doi: 10.1080/14681811.2017.1355299.

Riggs, D. W., & Sion, R. (2016). Gender differences in cisgender psychologists' and trainees' attitudes toward transgender people. *Psychology of Men & Masculinity, 18,* 187–190. doi: 10.1037/men0000047.

Roberts, A. L., Rosario, M., Slopen, N., Calzo, J.P., Austin, S.B., 2013. Childhood gender nonconformity, bullying victimization, and depressive symptoms across adolescence and early adulthood: an 11-year longitudinal study. *Journal of the American Academy of Child and Adolescent Psychiatry, 52,* 143-152. doi: 10.1016/j.jaac.2012.11.006.

Rodríguez-Madera, S. L., Padilla, M., Varas-Díaz, N., Neilands, T., Vasques Guzzi, A. C., Florenciani, E. J., & Ramos-Pibernus, A. (2017). Experiences of violence among transgender women in Puerto Rico: an underestimated problem. *Journal of Homosexuality, 64*, 209-217. doi: 10.1080/00918369.2016.1174026.

Rood, B. A., Maroney, M. R., Puckett, J. A., Berman, A. K., Reisner, S. L., & Pantalone, D. W. (2017). Identity concealment in transgender adults: A qualitative assessment of minority stress and gender affirmation. *American Journal of Orthopsychiatry, 87,* 704. doi: 10.1037/ort0000303

Rood, B. A., Reisner, S. L., Puckett, J. A., Surace, F. I., Berman, A. K., & Pantalone, D. W. (2017). Internalized transphobia: Exploring perceptions of social messages in transgender and gender-nonconforming adults. *International Journal of Transgenderism, 18,* 411-426.doi: 10.1080/15532739.2017.1329048

Rood, B. A., Reisner, S. L., Surace, F. I., Puckett, J. A., Maroney, M. R., & Pantalone, D. W. (2016). Expecting rejection: Understanding the minority stress experiences of transgender and gender-nonconforming individuals. *Transgender Health, 1*, 151-164. doi: 10.1089/trgh.2016.0012.

Rotondi, N. K. (2012). Depression in trans people: A review of the risk factors. *International Journal of Transgenderism, 13*, 104-116. doi: 10.1080/15532739.2011.663243.

Rotondi, N. K., Bauer, G. R., Travers, R., Travers, A., Scanlon, K., & Kaay, M. (2012). Depression in male-to-female transgender Ontarians: results from the Trans PULSE Project. *Canadian Journal of Community Mental Health*, 30, 113-133. doi: 10.7870/cjcmh-2011-0020.

Russell, J. A., Weiss, A., & Mendelsohn, G. A. (1989). Affect grid: a single-item scale of pleasure and arousal. *Journal of personality and social psychology, 57*, 493. doi: 10.1037/0022-3514.57.3.493

Ryder, A. G., Bagby, R. M., Schuller, D. R. (2002). The overlap of depressive personality disorder and dysthymia: a categorical problem with a dimensional

solution. Harvard Review of Psychiatry. 10(6), 337-52. doi: 10.1080/10673220216230.

Sánchez, F. J., & Vilain, E. (2009). Collective self-esteem as a coping resource for male-to-female transsexuals. *Journal of Counseling Psychology, 56,* 202–209. doi: 10.1037/a0014573.

Sansone, R. A., Bohinc, R. J., Wiederman, M. W. (2015). Borderline personality symptomatology and compliance with general health care among internal medicine outpatients. International Journal of Psychiatry in Clinical Practice. 19, 132–136. doi: 10.3109/13651501.2014.988269.

Scandurra, C., Amodeo, A. L., Valerio, P., Bochicchio, V., & Frost, D. M. (2017). Minority stress, resilience, and mental health: A study of Italian transgender people. *Journal of Social Issues, 73*, 563-585. doi: 10.1111/josi.12232

Scandurra, C., Bochicchio, V., Amodeo, A. L., Esposito, C., Valerio, P., Maldonato, N. M., Bacchini, D., Vitelli, R., 2018. Internalized transphobia, resilience, and mental health: Applying the Psychological Mediation Framework to Italian transgender individuals. *International Journal of Environmental Research and Public Health, 15,* 508e. doi: 10.3390/ijerph15030508.

Schmitt, D.P., Realo, A., Voracek, M., Allik, J. (2008). Why can't a man be more like a woman? Sex differences in Big Five personality traits across 55 cultures. *Journal of Personality and Social Psychology, 94,* 168. doi: 10.1037/a0014651

Schulz, S. L. (2018). The informed consent model of transgender care: An alternative to the diagnosis of gender dysphoria. *Journal of humanistic psychology, 58*, 72-92. doi: 10.1177/0022167817745217.

Seelman, K. L. (2014). Transgender individuals' access to college housing and bathrooms: Findings from the National Transgender Discrimination Survey. *Journal of Gay & Lesbian Social Services, 26*, 186-206. Retrieved from: http://scholarworks.gsu.edu/ssw_facpub/57.

Seelman, K. L., Colón-Diaz, M. J., LeCroix, R. H., Xavier-Brier, M., & Kattari, L. (2017). Transgender noninclusive healthcare and delaying care because of fear: connections to general health and mental health among transgender adults. *Transgender health, 2,* 17-28. doi: 10.1089/trgh.2016.0024.

Serano, J. (2007). *Whipping girl: A transsexual woman on sexism and the scapegoating of femininity*. Berkeley, CA: Seal Press.

Shelton, K., & Delgado-Romero, E. A. (2011). Sexual orientation microaggressions: The experience of lesbian, gay, bisexual, and queer clients in psychotherapy. *Journal of Counseling Psychology, 58*, 210. doi: 10.1037/a0022251.

Shires, D. A., Jaffee, K. (2015). Factors associated with health care discrimination experiences among a national sample of female-to-male transgender individuals. *Health and Social Work, 40*, 134-141. doi: 10.1093/hsw/hlv025

Shively, M. G., & De Cecco, J. P. (1977). Components of sexual identity. *Journal of homosexuality, 3*, 41-48. doi: 10.1300/J082v03n01_04

Simon, W., & Gagnon, J. H. (2003). Sexual scripts: Origins, influences and changes. *Qualitative sociology, 26,* 491-497. doi: 10. 1111/j.1743-6109.2009.01604.x

Singh, A. A., Hays, D. G., & Watson, L. S. (2011). Strength in the face of adversity: Resilience strategies of transgender individuals. *Journal of Counseling and Development, 89,* 20–27. doi:10.1002/j.1556-6678.2011.tb00057.x.

Singh, A.A. (2016). Moving From Affirmation to Liberation in Psychological Practice with Transgender and Gender Nonconforming Clients. *American Psychologist, 71*¸755-762. doi: 10.1037/amp0000106.

Singh, A.A., Meng, S.E., Hansen, A.W. (2014). "I am my own gender": Resilience strategies of trans youth. *Journal of Counseling and Development, 92,* 208–218. doi: 10.1002/j.15566676.2014.00150.x.

Sperber, J., Landers, S., & Lawrence, S. (2005). Access to health care for transgendered persons: Results of a needs assessment in Boston. *International Journal of Transgenderism, 8,* 75–91. doi:/10.1300/J485v08n02_08

Spitzer, R. L., Gibbon, M. E., Skodol, A. E., Williams, J. B., & First, M. B. (2002). *DSM-IV-TR casebook: A learning companion to the diagnostic and statistical manual of mental disorders, text rev*. Arlington, VA: American Psychiatric Publishing, Inc.

Steffens, M. C., & Wagner, C. (2004). Attitudes toward lesbians, gay men, bisexual women, and bisexual men in Germany. *Journal of Sex Research, 41,* 137-149. doi:10.1080/00224490409552222

Stotzer, R. L., Silverschanz, P. & Wilson, A. (2013). Gender Identity and Social Services: Barriers to Care. *Journal of Social Service Research, 39,* 63-77 doi: 10.1080/01488376.2011.637858

Sue D. W. (2010). *Microaggressions in everyday life: Race, gender, and sexual orientation*. Hoboken, New Jersey: John Wiley & Sons.

Sue, D. (1979). Erotic fantasies of college students during coitus. *Journal of Sex Research, 15,* 299-305. doi: 10.1080/00224497909551053.

Sue, D. W., & Sue, D. (2012). *Counseling the culturally diverse* (6th ed.). New York: John Wiley & Sons, Inc.

Sue, D. W., Capodilupo, C. M., Torino, G. C., Bucceri, J. M., Holder, A., Nadal, K. L., and Esquilin, M. (2007). Racial microaggressions in everyday life: Implications for clinical practice. *American psychologist, 62,* 271. doi: 10.1037/0003-066X.62.4.271.

Tajfel, H. (1978). *Differentiation between social groups*. San Diego, CA: Academic Press.

Tauches, K. (2006). Challenging the "normal". In S. Seidman, N. Fischer & C. Meeks (Eds.), *Handbook of the new sexuality studies*. New York: Routledge.

Tebbe, E. A., & Moradi, B. (2016). Suicide risk in trans populations: An application of minority stress theory. Journal of Counseling Psychology, 63, 520. doi: 10.1037/cou0000152.

Terraciano, A., McCrae, R. R., & Costa Jr, P. T. (2003). Factorial and construct validity of the Italian Positive and Negative Affect Schedule (PANAS).

European Journal of Psychological Assessment, 19(2), 131. doi: 10.1027//1015-5759.19.2.131.

Testa, R. J., Habarth, J., Peta, J., Balsam, K., & Bockting, W. (2015). Development of the gender minority stress and resilience measure. *Psychology of Sexual Orientation and Gender Diversity, 2*, 65–77. doi:10.1037/sgd0000081.

Titman, N. (2014). *How many people in the United Kingdom are nonbinary*. Retrieved from: https://practicalandrogyny.com/2014/12/16/how-many-people-in-the-uk-are-nonbinary/

Tompkins, A. B. (2014). "There's no chasing involved": Cis/trans Relationships, "tranny chasers," and the future of a sex-positive trans politics. *Journal of Homosexuality, 61*, 766-780. doi: 10.1080/00918369.2014.870448 .

Torino, G. C., Rivera, D. P., Capodilupo, C. M., Nadal, K. L. and Sue D. W. (2019). Everything you wanted to know about microaggressions but didn't get a chance to ask. In G.C. Torino, D.P. Rivera, C.M. Capodilupo, K.L. Nadal, and D.W. Sue (Eds.). *Microaggression theory: Influence and implications*. Hoboken, NJ: John Wiley and Sons.

Transgender Europe. (2016). *2,016 reported deaths of trans and gender diverse persons murdered between January 2008 and December 2015*. Retrieved https://transrespect.org/wp-content/uploads/2016/03/TvT_TMM_TDoV2016_Tables_EN.pdf

Tsang, J. A., & Rowatt, W. C. (2007). The relationship between religious orientation, right-wing authoritarianism, and implicit sexual prejudice. *The*

International Journal for the Psychology of Religion, 17, 99-120. doi: 10.1080/10508610701244122.

Tufford, L., & Newman, P. (2012). Bracketing in qualitative research. *Qualitative Social Work: Research and Practice, 11*(1), 80–96. doi: 10.1177/1473325010368316.

Turner, L., Whittle, S., Combs, R. (2009). Transphobic hate crime in the European Union. Retrieved from: http://www.ucu.org.uk/media/pdf/r/6/transphobic_hate_crime_in_eu.pdf

van Anders, S. M. (2015). Beyond sexual orientation: Integrating gender/sex and diverse sexualities via sexual configurations theory. *Archives of Sexual Behavior, 44*, 1177-1213. doi: 10.1007/s10508-015-0490-8

Van Caenegem, E., Wierckx, K., Elaut, E., Buysse, A., Dewaele, A., Van Nieuwerburgh, F., De Cuypere, G., T'Sjoen, G., 2015. Prevalence of gender nonconformity in Flanders, Belgium. *Archives of Sexual Behavior. 44*, 1281-1287. doi: 10.1007/s10508-014-0452-6.

Vescio, T. K., & Biernat, M. (1999). When stereotype-based expectancies impair performance: The effect of prejudice, race, and target quality on judgments and perceiver performance. European Journal of Social Psychology, 29(7), 961-970. doi: 10.1002/(SICI)1099-0992(199911)29:7<961::AID-EJSP977>3.0.CO;2-4.

Walch, S. E., Ngamake, S. T., Francisco, J., Stitt, R. L., & Shingler, K. A. (2012). The attitudes toward transgendered individuals scale: Psychometric properties. *Archives of Sexual Behavior, 41*, 1283-1291. doi: 10.1007/s10508-012-9995-6.

Warriner, K., Nagoshi, C. T., & Nagoshi, J. L. (2013). Correlates of homophobia, transphobia, and internalized homophobia in gay or lesbian and heterosexual samples. *Journal of Homosexuality, 60,* 1297-1314. doi: 10.1080/00918369.2013.806177.

Webb, A., Heyne, G., Holmes, H. E., Peta, J. L. (2016). *Which box to check: Assessment norms for gender and the implications for transgender and nonbinary populations. Standard methods in psychology need to be adapted to fully address transgender and nonbinary aspects of gender*. APA Division 44 newsletter, April 2016. Retrieved from: https://www.apadivisions.org/division-44/publications/newsletters/division/2016/04/nonbinary-populations

Webb, A., Matsuno, E., Budge, S., Krishnan, M., & Balsam, K. (2017). Non-binary gender identities fact sheet. *The Society for the Psychological Study of Lesbian, Gay, Bisexual, and Transgender Issues.* Retrieved from: http://www.apadivisions.org/division44/resources/advocacy/nonbinary-facts.pdf.

Weinberg, M. S., & Williams, C. J. (2010) Men sexually interested in transwomen (MSTW): Gendered embodiment and the construction of sexual desire. *Journal of Sex Research, 47,* 374-383. doi: 10.1080/00224490903050568.

Whitley Jr, B. E. (1999). Right-wing authoritarianism, social dominance orientation, and prejudice. *Journal of Personality and Social Psychology*, 77, 126. doi: 10.1037/0022-3514.77.1.126.

Whittle, S., Turner, L., Coombs, R., & Rhodes, S. (2008). *Transgender Eurostudy: Legal survey and focus on the transgender experience of health care*. Brussels: ILGA Europe.

Wilchins, R., Lombardi, E., Priesing, D., & Malouf, D. (1997). *First national survey of transgender violence*. New York, NY: GenderPAC.

Wilson, G. D. (1978). *The secrets of sexual fantasy*. London: Dent.

World Health Organization. *Classification of diseases* (ICD). Retrieved from: http://www.who.int/classifications/ icd/en/.

Worthen, M. G. F. (2016) Hetero-cis–normativity and the gendering of transphobia. *International Journal of Transgenderism, 17*, 31-57, doi:10.1080/15532739.2016.1149538.

Xavier, J. (2000). *The Washington Transgender Needs Assessment Survey* (Final report for phase two: Tabulation of the survey questionnaires, presentation of findings and analysis of the survey results, and recommendations). Washington, DC: Administration for HIV and AIDS.

Zurbriggen, E. L., & Yost, M. R. (2004). Power, desire, and pleasure in sexual fantasies. *Journal of Sex Research, 41*, 288-300. doi: 10.1080/00224490409552236.