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QUE(E)R(Y)ING GENDER-BASED VIOLENCE:

INQUIRY INTO THE GENDER-BASED ASSAULTS OF TRANS-IDENTIFYING PEOPLE

Section A: What do we know about dating violence among gender-minority youth?

Word Count: 7,999

Section B: Undermined and Overdetermined Identities: A Grounded Theory of Barriers to Help-Seeking Among Trans Survivors of Sexual Violence

Word Count: 8,000

Overall Word Count: 15,999 (446)

A thesis submitted in partial fulfilment of the requirements of

Canterbury Christ Church University for the degree of

Doctor of Clinical Psychology

JULY 2021

SALOMONS INSTITUTE

CANTERBURY CHRIST CHURCH UNIVERSITY

Acknowledgements

To each of my participants who gave so generously of their time and of themselves – thank you for trusting me with your stories and for taking me to some difficult places. I hope that our work together can go some way to creating the change we hope to see.

To my wonderful supervisors, Louise Goodbody and Michael Toze. Thank you for your solid counsel, for helping me navigate my way out of some dark corners and for holding the hope when I couldn't.

To mum. As always, thank you for supporting (and suffering) me through this process. And to dad…Well, you know…You were watching.

To all the friends and family I've neglected: Thank you for your understanding, your cheer-leading and for being there at the tunnel's end.

Finally, importantly, this one's for you, Bunge!

Summary of MRP Portfolio

Section A presents a systematic review of the empirical literature on dating violence (DV) among young trans and gender non-conforming (TGNC) people. The review synthesises what is known about the prevalence of DV among TGNC youth and their risk relative to cisgender peers; how relative DV risk compares to non-dating victimisation experiences, and the psychosocial/structural correlates of DV identified in this group. The literature is critically appraised, outlining some robust findings as well as significant methodological limitations. Synthesised findings are discussed and implications for research and practice are considered.

Section B presents a grounded theory of barriers to help-seeking among trans survivors of sexual violence (SV). With reference to 10 themes, the model illustrates how psychosocial conditions ('Navigating narratives of blame'; 'Carrying lots of shame'; 'Questioning my validity as a victim'; 'Normalising sexual violence'; 'Problematising felt gender') combine with service-level interactions ('Fearing the power of services'; 'Being a curious object'; 'Feeling unseen') to inhibit support-seeking and maintain victimisation risk ('Remaining vulnerable'; 'Needing more from services'). The substantive theory suggests that help-seeking is compromised by trans identity being cyclically undermined and/or overemphasised in its relationship to SV. The model is discussed with reference to existing theories of help-seeking and minority experience, with clinical/policy implications considered.

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Section A

What do we know about dating violence among gender-minority youth?

Word Count: 7,999 (62)

Abstract

Rationale: Youth and gender-variance have been individually identified as risk factors for dating violence (DV), yet little is known about risk at the intersection of these demographics. This review draws together what is known about violence in the relationships of trans and gender non-conforming (TGNC) youth with a view delineating the scope of concern for this understudied population.

Method: Systematic literature searching identified 15 empirical studies which met criteria for inclusion. Studies were synthesised and critiqued in line with the Mixed-Methods Appraisal Tool (Hong et al., 2018).

Results: Median rates of DV among TGNC youth were 10.5% (physical), 13.8% (sexual) and 19.9% (psychological), with overall DV prevalence figures of 35.4% (TGNC-females), 25.7% (TGNC-males), and 23.9% (non-binary persons). TGNC youth had significantly greater odds of psychological and particularly sexual victimisation relative to their cisgender (including sexual-minority) peers. DV was positively correlated with anxious/depressive symptomology, suicidality/self-harm, bullying and sexual-risk behaviours across the samples.

Conclusions: Despite significant methodological limitations precluding firm conclusions, collated findings indicate worryingly high levels of DV victimisation among TGNC youth, with relative rates of sexual violence a particular concern and trans-females at greater risk. Research utilising validated measures is required to confirm findings and inform prevention/intervention initiatives.

Introduction

Inquiry into partner violence (PV) has attracted significant interest in recent decades, with research following Makepeace's seminal paper (1981) seeking to understand both its prevalence and impact at individual/systemic levels, and its structural-psychosocial predictors (Rubio-Garay et al., 2017). Defined as behaviour by a current or former spouse/intimate partner that causes physical, sexual or psychological harm to the other partner (World Health Organisation [WHO], 2021a), PV is documented as the leading cause of homicidal death for women worldwide (Devries et al., 2013), and is linked to myriad psychosocial sequalae, including anxiety, depression, PTSD, self-harm, substance misuse and eating disorders (Brignone et al., 2018; Bundock et al., 2013; Chandan et al., 2020; Romito & Grassi, 2007; Sugg, 2015).

Though PV occurs across the lifespan, particular prevalence has been noted among young people (Miller & McCaw, 2019), with women aged 20-24 most at-risk (Office for National Statistics [ONS], 2019) and almost half of U.S. female survivors (47.1%) and a third of male survivors (38.6%) reporting a first abuse between ages 18 and 24 (Breiding et al., 2014). In the U.K., 63.9% of abused persons report living separately from the perpetrator (ONS, 2019), signalling PV's predominance within the context of dating/informal relationships, as typically engaged in by youth populations. Moreover, with nearly one-in-four female respondents (22.4%) and one-in-seven males (15.0%) reporting PV between the ages of 11 and 17 (Breiding et al., 2014) – and with adolescence being critical in determining how young people learn to navigate interpersonal relationships/the pursuit of intimacy – it is indicated that early PV involvement may provide a blueprint for patterns of aggression and victimisation in adult partnerships (Goodnight et al., 2017; Leadbeater et al., 2018).

Among adolescents, PV has been seen to predict mood disorders, substance misuse, sexual risk behaviours and poor academic outcomes (Kaukinen, 2014).

Gender and PV

In addition to age, it is widely accepted that gender represents a significant PV risk factor (Fileborn, 2014). National statistics estimate that 6.3% women in England and Wales (compared with 2.7% men) are victimised, with 97.8% identifying a male perpetrator (ONS, 2019). Global estimates take this further, indicating that a third of all women will report physical and/or sexual PV within their lifetime (WHO, 2021b). Continued disparities between male and female victimisation has led to PV being understood as an extension of patriarchy and thus a subset of gender-based violence predicated on normative assumptions of gender within heterosexual partnerships (Brown et al, 2007; Langenderfer-Magruder et al, 2016; Roch et al, 2010). Though a developing literature on female-perpetrated (Douglass et al., 2020; Espinoza & Warner, 2016; Mackay et al., 2018) and same-sex PV (Edwards et al., 2015; Kimmes et al., 2019; Longobardi & Badenes-Ribera, 2017; Rollè et al., 2018) has sought to remediate this, the dominant cultural paradigm for discussing PV remains binarily gendered, with inquiry principally focusing on cisgender populations (i.e. men/women whose gender expression/identity is analogous with their assigned birth-sex). Only now, aligned to the recent upturn in trans (formerly 'transgender') visibility and activism, is a nascent body of research beginning to evidence the predominance of PV experiences amongst gender-minority persons; that is, individuals whose gender-identity (male/female/non-binary/other) and/or expression (masculine/feminine/other) does not accord with cultural norms/expectations, including trans and gender non-conforming (TGNC) people (wherein 'trans' refers to persons whose assigned biological sex does not match their felt identity, and 'gender non-conforming' describes those whose gender expression does not conform to prevailing expectations for their assigned sex). In doing so, this literature introduces a broader conceptualisation of gender-based assault.

A recent systematic review of 85 studies focusing on TGNC-directed PV found a median lifetime prevalence of 37.5% for physical abuse and 25% for sexually violent

victimisation (Peitzmeier et al., 2020), with no significant differences noted between those assigned male or female at birth (AMAB/AFAB). Research carried out by the National Coalition of Anti-Violence Programs (NCAVP; 2016) suggests that gender-minorities are approximately three times more likely than cisgender individuals to experience stalking and that trans-females are at three times greater risk of sexual PV than cisgender women. That trans females also represented 46% of all partner-perpetrated homicides in this study demonstrates a critical need to better understand PV in gender-minority populations generally, and specifically among TGNC youth, who have been in receipt of marginal research attention, but who make up a majority of all TGNC-identifying persons (Nolan et al., 2019). Certainly, the combined findings from TGNC adult- and cisgender adolescent-focused research suggest that gender-minority youth may present as doubly vulnerable, indicating an uncomfortable oversight within the current PV literature.

Understanding TGNC Risk

Though the disproportionate PV burden among gender-minorities has been understood variously, academics have most frequently turned to minority-stress frameworks (Decker et al., 2018; Scheer et al., 2020). Building on Meyer's seminal model (2003) which explains the relationship between minority-based stigmatisation and chronic stress, 'gender minority-stress theory' (Hendricks & Testa, 2012) acknowledges the distal and proximal stressors associated with non-normative gender-identity/expression, which combine to increase vulnerability to adverse outcomes. Distal minority experiences, such as stigma, discrimination and exclusionary practices maintained by cultural/legal cisnormativity, are thought to predispose gender-minorities to social and economic poverty. This can manifest as smaller/poorer social networks, familial estrangement, homelessness and high unemployment, all of which serve to increase risk of abuse and dependence on abusers (Grant et al., 2011; James et al., 2016; Wilson et al., 2016). Likewise, institutional discrimination may serve to impede help-seeking

following PV, with abuses against gender-minorities less readily acknowledged, and gendered assumptions making it harder for TGNC victims to anticipate unbiased/validating responses and/or access gender-dichotomous support services (Brown & Herman, 2015; Goodmark, 2013; Henry et al., 2018, Langenderfer-Magruder, 2016).

Distal factors can function as precipitants for proximal stressors, with internalised trans-negativity, diminished self-esteem, anxiety and depression commonly resulting from environmental hostility (Lefevor et al., 2019; Marshall et al., 2016). Gender-minorities are therefore more likely to experience multiple mental health (MH) difficulties, feelings of shame, expectations of rejection and poor self-worth, which are readily exploited by abusers. Where multiple minority identities intersect (gender/sexuality/age/race/ability), risk has been found to increase and outcomes are seen to be poorer (James et al., 2016).

TGNC youth have been noted to report higher levels of minority-stress than their sexual-minority (non-heterosexual) cisgender counterparts (Tan, et al., 2019), amongst whom elevated minority-stress levels have been consistently evidenced (McConnell et al., 2015; Sterzing et al., 2016). It follows, then, that PV as an additional stressor may have deleterious effects for this already at-risk population.

The Present Review

Although it is understood that both youth and gender minority-stress present significant PV risk factors, there has, to date, been little attempt to understand individuals at the intersection of these two vulnerabilities. Indeed, research into TGNC-directed PV has overwhelmingly regarded it an adult phenomenon, precluding appropriate recognition in younger TGNC populations until very recently. Though youth samples were used in a handful of the papers featured in Peitzmeier et al.'s recent meta-analysis (2020), this neither comments on youth experiences uniquely, nor incorporates the recent surge in studies examining PV in TGNC adolescents. As such, it remains unclear whether information on the prevalence and

correlates of PV derived from either young cisgender or adult TGNC samples can be fittingly generalised to gender-minority youth.

The present review therefore seeks to undertake a critical assessment of what is known about PV among young gender-minorities. In doing so, the review will delineate the scope of concern for this understudied population and inform the development of TGNC-inclusive youth prevention/intervention programmes. This responds to suggestions within the adult literature of an urgent need for youth service-providers to promote understanding of healthy relationships in gender-minority adolescents (Whitton et al., 2019a). The review will summarise and critique existing empirical literature and discuss implications for practice and research.

Defining Our Terms

Dating Violence

It is recognised that the terms 'partner' and 'relationship' do not best reflect the informal types of intimacy often engaged in by youth populations. The notion of 'dating violence' (DV) builds upon such concepts as partner violence and spousal-abuse to reflect equivalent interactions between (typically younger) unmarried, casual and/or non-cohabiting partners (Lewis & Fremouw, 2001). As a construct, DV encapsulates abuses of a sexual, physical and psychological/emotional nature within the context of dating/courtship; including sexual coercion/assault, rape, harassment, physical injury/restraint, threatening, stalking, social sabotage/humiliation and any behaviours that contribute to a partner's concerns for their liberty and/or safety (Rubio-Garay et al., 2017). More recently, definitions have incorporated cyber abuses (control/threats/harassment/surveillance by electronic means) and 'sextortion' (Borrajo et al., 2015).

DV will be used hereafter to denote any instance of such violence occurring between dating-, romantic- or sexually intimate partners.

Youth

The WHO's definition of 'young people' (10-24 years) is operationalised here to encompass those age groups (adolescence; emerging adulthood) known to be most at risk of DV in a general population, but neglected in the TGNC literature.

Method

A crude search using Google Scholar served to orient the author to the extant literature and inform appropriate terms for the systematic database search. Searches were conducted across five databases in December 2020, with PsychInfo, PsychArticles, ASSIA, and Web of Science yielding results based on the search terms outlined in Table 1. Since no existing reviews of a similar nature were identified, specific date parameters were deemed unnecessary. As such, searches returned literature from "all dates" up to and including 29th December 2020.

Handsearching identified three additional papers that were considered for inclusion.

Table 1.
Terms used in systematic database searches

Boolean operator	Search string
	(school OR college OR university OR adolescen* OR "young people" OR youth)
AND	(transgender OR "gender non-conforming" OR non-binary OR "gender minority")
AND	("partner violence" OR "sexual violence" OR "dating violence" OR "relationship violence" OR rape OR "sexual assault" OR "relationship abuse")

Inclusion/Exclusion Criteria

Papers identified through the systematic search were scrutinised using the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) Statement's stepwise process (Moher et al., 2009; Figure 1.). Papers were initially screened by title to establish their relevance to the review topic. Relevant studies were then screened by abstract and results in

accordance with the inclusion/exclusion criteria outlined in Table 2. The process was repeated to ensure initial screening accuracy.

Table 2.

Criteria for inclusion in/exclusion from review.

Inclusion	Exclusion
Published in a peer-reviewed journal	Does not disaggregate data pertaining to TGNC participants from sexual-minority participants
English language	
Presents original empirical research that explicitly examines DV among TGNC youth (aged 10-24).	Does not examine violence between partners separately from abuses occurring outside of dating/intimate contexts.

Of 18 papers that met criteria for a full-text screen, one was discovered to be grey literature and two were excluded due to large proportions of mature students in the samples. Although the WHO's conceptualisation of young people is operationalised in this review, three studies that used age 25 as their cut-off for a youth sample were retained in order that the small literature on DV among TGNC youth could be fully explored. Fifteen papers were thus selected for review, with relevant information summarised in Table 3 and synthesised below. The methodological quality of each study was assessed using the Mixed-Methods Appraisal Tool (MMAT; Hong et al., 2018), which offers evaluative frameworks appropriate for each of the designs featured. The appraisal process is detailed in Appendix A and discussed alongside results.

Figure 1.

PRISMA diagram illustrating systematic literature search and article identification

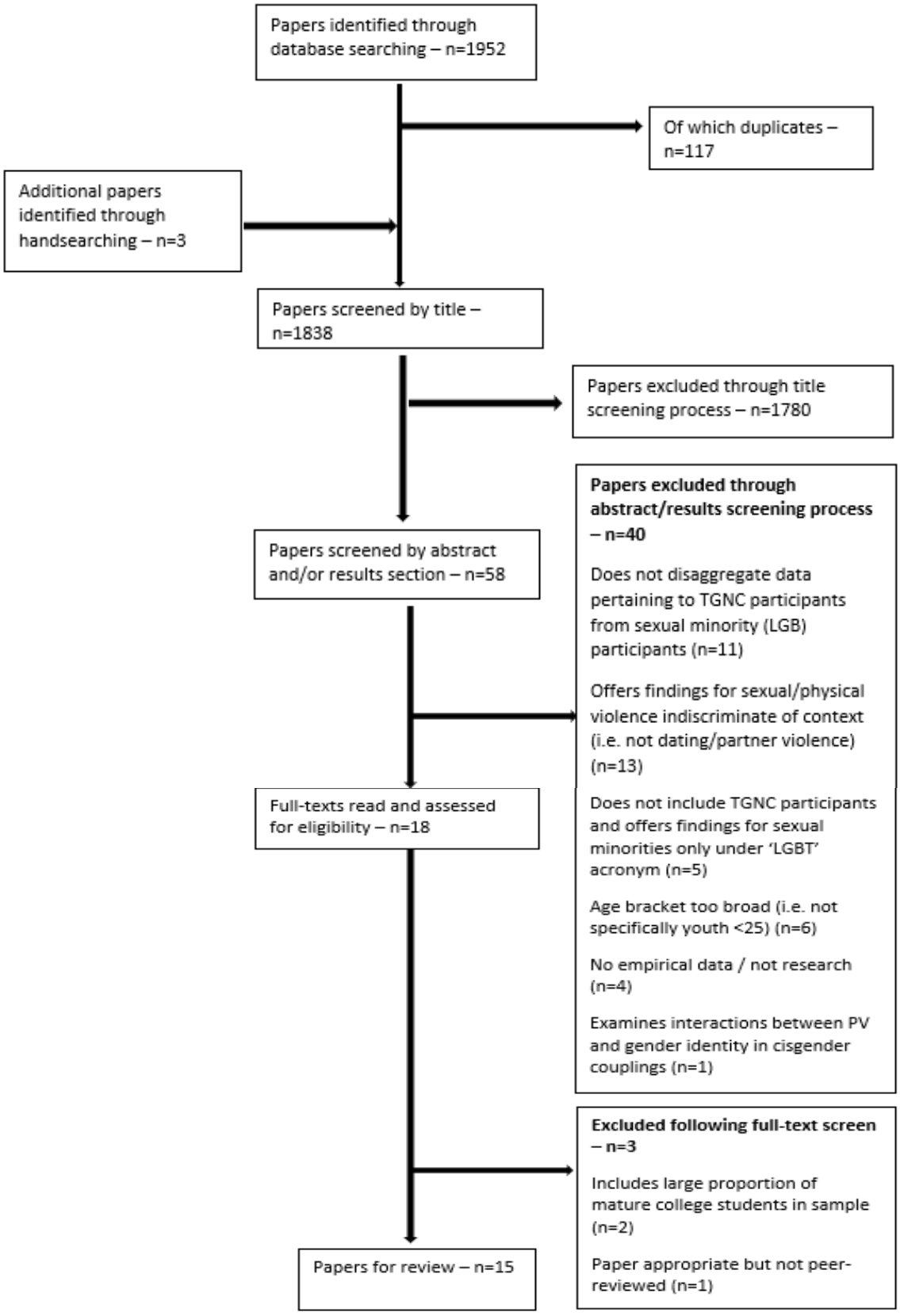


Table 3.
Summary of reviewed studies

Study	Author(s) (year of publication)	Title	Setting	Design	Sample characteristics	Measures	Main findings
1	Dank et al. (2014)	Dating violence experiences of lesbian, gay, bisexual, and transgender youth	Two middle and three high schools across three U.S. states	Quantitative ; Cross-sectional	3,745 young people (12-19; Mean = NS) who had been in a relationship in the previous 12 months. Mixed gender (52.3% cisgender female; 47.2% cisgender male; 0.5% TGNC). 73.7% White. 94% heterosexual.	Physical DV: Derived from Foshee Safe Dates scale (1996); Psychological and sexual DV: Adapted from Foshee (1996) and non-validated borrowed measures; Cyber DV: Adapted from existing non-validated measures. Parental involvement, risk-taking, and social interactions assessed using borrowed, non-validated measures. Psychosocial adjustment measured using the SA45.	Trans youth reported highest rates of victimisation across physical, psychological, sexual and cyber abuse, and highest rates of perpetration across all but psychological dating abuse. Trans identity also a predictor of LGB victimisation.
2	Espelage et al. (2018)	Peer victimization and dating violence among LGBTQ youth: The impact of school violence and crime on mental health outcomes	High schools; Wisconsin, U.S	Quantitative ; Cross-sectional	11,794 high-school students (14-18yrs, Mean = 16). Mixed gender (51% cisgender female, 57.2% cisgender male, 1.8% TGNC). 75% White. 93% heterosexual.	Past 12 months' DV, peer victimisation, anxiety, suicidality and perceptions of school violence assessed using the Dane County Youth Survey.	Trans youth reported significantly more between-person dating violence experiences, as well as significantly higher rates of anxiety and suicidality than non-trans youth (including LGBQ). DV seen to be a significant predictor of both anxiety and suicidality in whole sample.

3	Goldenberg et al. (2018)	Intimate partner violence among transgender youth: Associations with intrapersonal and structural factors	Data drawn from the Affirming Voices for Action Project (2015) with surveys administered in 14 U.S. cities associated with the Adolescent Medicine Trials Network for HIV/AIDS Intervention.	Quantitative ; Cross-sectional	187 TGNC youth (16-24, Mean = 20.9) of which 59.5% were transfeminine, 17.6% were transmasculine and 22.9% were non-conforming. 45.80% non-Hispanic Black, 16.03% non-Hispanic White and 38.17% Other.	Lifetime DV (sexual, physical) assessed using a novel, single-item measure. Experiences of stigma adapted from existing non-validated measures. Depression assessed using the CESDS, substance abuse using CRAFFT, self-esteem using the RSE, suicidal ideation and HIV assessed using single-item novel measures.	45% of TGNC youth reported lifetime DV experiences. DV was correlated with multiple instances of transphobic abuse, participation in sex-work and history of incarceration. TGNC youth who experienced more than 10 transphobic incidents were over six times more likely than those with no history of transphobic abuse to experience DV. DV was five times more likely for those involved in sex-work.
4	Griner et al. (2020)	The intersection of gender identity and violence: Victimization experienced by transgender college students	National dataset from American College Health Association's National College Health Assessment II (2013); U.S.	Quantitative ; Cross-sectional	82,538 college students (No age range stated, Mean = 22.2). Mixed gender: 66.7% cisgender female, 33.1% cisgender male 0.2% TGNC. 66.6% White. 91.3% heterosexual.	Bespoke measure used to assess for past 12 months' DV of emotional, sexual, physical and stalking subtypes. Bespoke measure used to assess for sexual violence of unelicited touching, attempted penetration and completed penetration subtypes. Bespoke measure used to assess for physical violence of assault and verbal aggression subtypes.	TGNC respondents were significantly more likely than cisgender males and females to experience all nine types of victimisation, barring psychological DV, which was not significantly higher than for cisgender females once demographic factors were adjusted for.
5	Hoxmeier (2016)	Sexual assault and relationship abuse victimization of transgender undergraduate students in a national sample	National dataset from American College Health Association's National College Health Assessment II (2014); U.S.	Quantitative ; Cross-sectional	19,639 students, (18-25; Mage = NS). Mixed gender (65.4% cisgender female, 34.2% cisgender male, 0.4% TGNC). 68.7% White. .	Two-part novel questionnaire, assessing for past 12months' sexual victimisation and DV.	Prevalence of psychological DV was similar for TGNC youth and cisgender female youth (9% and 10% respectively). Sexual DV was much higher in TGNC participants than among cisgender males and females, with non-consensual touch being the most prevalent subtype. Logistic regression found that the odds of emotional and sexual DV were six times higher for TGNC youth as compared to cisgender males (cisgender female odds were 2.5 times that of cisgender male referent group). No significant relationship found between gender and physical DV.

6	Hoxmeier & Madlem (2018)	Discrimination and interpersonal violence: Reported experiences of trans undergraduate students	National dataset from American College Health Association's National College Health Assessment II (2015); U.S.	Quantitative ; Cross-sectional	15,072 students (<25; Mean = 19.83), Mixed gender (67.1% cisgender female, 31.4% cisgender male, 1.5% TGNC). 70.36% White.	Novel measures of past 12-months' emotional, physical, sexual DV and past 12 months' general assault.	Adjusted odds ratio suggested that TGNC youth were significantly more likely to experience emotional DV than cisgender females. TGNC students did not have significantly higher odds of reporting stalking or physical DV victimisation than cisgender females.
7	Martin-Storey et al. (2020)	Profiles and predictors of dating violence among sexual and gender minority adolescents	Data from the 2016 Minnesota Student Survey (MSS) administered to fifth, eighth, ninth, and 11th grade students across 348 schools.	Quantitative ; Cross-sectional	87,532 students (14-17; Mean = 15.29). Mixed gender (2.68% TGNC). 84.72% White. 89.6% heterosexual	Novel measure to assess for lifetime DV victimisation and perpetration (verbal, physical, sexual), peer victimisation and bias-based bullying and childhood maltreatment.	Latent class analysis found trans youth more likely to be in the 'high DV victimisation and perpetration' and 'high DV victimisation' classes than cisgender youth. When social stressors were adjusted for, trans youth were more likely to be in the 'low perpetration/high victimisation' class. Gender non-conforming youth were more likely to be in the 'high DV victimisation and perpetration class', 'high DV victimisation class', and 'moderate victimisation and perpetration class' than gender-conforming youth, however, only the latter two categorisations were maintained after controlling for social stressors. Bias-based bullying relating to non-conformist gender expression predicted being in the DV victimisation classes for TGNC participants.
8	Norris & Orchowski (2020)	Peer victimization of sexual minority and transgender youth: A cross-sectional study of high school students	27 high schools across the north-eastern U.S.A, with data drawn from a larger intervention study.	Quantitative ; Cross-sectional	2766 high-school students (14-17; Mean = 15.4). Mixed gender: 51% cisgender female, 46% cisgender male, 1% TGNC, 3% declined to say/didn't answer. 85% heterosexual Ethnicity not reported.	Past year DV measured using subscales from the CADRI. Bullying, bias-based verbal harassment, sexual harassment, sexual victimisation assessed using adapted non-validated measures.	Cisgender males and females were less likely than TGNC youth to experience any of the DV subtypes. Regarding specific types of conflict, TGNC youth were more likely than cisgender males to experience sexual and psychological DV, and more likely than cisgender females to experience sexual DV. There were no significant differences in odds of physical DV between TGNC and cisgender samples.

9	Reuter et al. (2016)	Intimate partner violence victimization in LGBT young adults: Demographic differences and associations with health behaviors	Data drawn from 4th and 5th year follow-up waves of an existing Chicago-based longitudinal study of LGBT youth involving eight waves of data collection over five years.	Quantitative ; Prospective cohort study	172 LGBT young people (16–20 at baseline; Mean = 22.48 at follow-up). Mixed sex (58.1% AFAB, 41.9% AMAB) and gender (36.5% cisgender male, 54.1% cisgender female, 5.3% trans-female, 4.1% trans-male). 13.4% White, 58.1% Black, 11.6% Latino, 16.8% Other.	Past six months' physical, sexual, verbal and general DV assessed using the H-RASP. Past six months' sexual risk-taking assessed using H-RASP; Mental health assessed using the BSI-18; novel measure used to assess past six months' binge drinking and marijuana use.	Trans-females were most likely of the four gender-minority identities to experience all subtypes of DV. Trans-males did not report any DV experience. Verbal DV was associated with concurrent unprotected sex, but the association did not hold at one year follow-up. DV was not associated with any other concurrent problematic outcomes but was associated with anxiety and depression at one year follow-up (specifically, verbal PV associated with anxiety; physical PV associated with depression). No relationship found between DV and substance misuse. Significant correlations were maintained at one year follow-up after controlling for health at Time 1.
10	Ross-Reed et al. (2019)	Family, school, and peer support are associated with rates of violence victimization and self-harm among gender minority and cisgender youth	Data drawn from the 2017 New Mexico Youth Risk and Resiliency Survey (NM-YRRS) data set; U.S.A	Quantitative ; Cross-sectional	18,451 high school students (14-18; Mage = NS) across 31 of New Mexico's 33 counties. Mixed gender (6% TGNC, of which 52% trans-female). Ethnicity of TGNC participants reported as 49% Hispanic, 28% White, 13% American Indian.	Utilises NM-YRRS survey questions about past 12-months' sexual violence, dating violence, non-suicidal self-injury, suicidality and resiliency factors (family, peer, school, and community). NM-YRRS validated by the Centers for Disease Control and Prevention (Brener et al., 2004)	DV was more prevalent in TGNC youth (31%) compared to cisgender students (9%) and TGNC youth saw higher rates across all other measures of harmful event (self-injury, suicidal attempts, sexual violence). All harmful events (including DV) were significantly more likely among TGNC youth in the regression analysis. Experiences of school-based support were correlated with lower odds of DV. Disparities between cisgender and TGNC harmful events increased with more support for past-year DV and family support due a strong negative relationship between family support and DV for cisgender students, but not for TGNC youth. TGNC students were found to have low support levels across the various domains.
11	Sterzing et al. (2017)	Social ecological correlates of polyvictimization among a national sample of transgender, genderqueer, and cisgender sexual minority adolescents	Middle/high school students, recruited through Facebook, 12 community organisations, and a promotional video; U.S.A.	Quantitative ; Cross-sectional	1,177 sexual and gender-minority students (14-19; Mage = 16.4). Mixed gender, cisgender female (40.7%), cisgender male (33.1%), genderqueer AFAB (16.1%), genderqueer AMAB (4.4%,), transgender female (4.0%), and transgender male (1.6%). Sexual orientation reported as gay (30.7%), lesbian (24.0%), bisexual (18.4%), pansexual	Gender role non-conformity single item measure. AJVQ used to assess for 36 types of past year victimisation and combined with the SBS to create a polyvictimisation scale. Depression assessed using the CESD; PTSD assessed using the Short Screening Scale (Bohnert & Breslau, 2011). Novel measures used to assess family-level microaggressions/	DV was the least common form of victimisation reported in this sample overall, and also for each of the TGNC subgroups. Rates of DV were higher, but not significantly higher for all TGNC groups than for cisgender LGB respondents. DV was the only victimisation subtype for which TGNC respondents did not significantly differ from cisgender sexual-minority males.

					(11.2%), questioning (7.1%), other (4.7%), and queer (4.1%). Racial composition of sample reported as White (62.2%), Latino/a (9.9%), Black (8.2%), multiracial (13.0%), and other (5.8%).	affirmations, poverty and religiosity and peer rejection.	
12	Sterzing et al. (2019)	Polyvictimization prevalence rates for sexual and gender minority adolescents: Breaking down the silos of victimization research	Middle/high school students, recruited through Facebook, 12 community organisations, and a promotional video; U.S.A	Quantitative ; Cross-sectional	(As above. See Sterzing et al., 2017)	Lifetime polyvictimisation assessed using novel measure derived from the SBS and AJVQ.	Genderqueer AFAB youth reported significantly greater levels of DV than the referent group (cisgender sexual-minority males), where other TGNC identities did not. Trans-males and genderqueer AFAB youth were significantly more likely than the referent group to have been sexually assaulted by a minor, with greater levels of significance than cisgender sexual-minority females. Trans-males and genderqueer AFAB youth were significantly more likely than the referent group to have experienced attempted sexual assault. Genderqueer AFAB youth were significantly more likely than the referent group, but less likely than cisgender sexual-minority women to have experienced statutory sexual assault. Genderqueer AMAB participants had the highest overall rates of lifetime polyvictimization (65.4%), followed by trans-females (63.2%), trans-males (57.4%), genderqueer AFAB persons (55.0%), cisgender females (39.3%) and cisgender male (31.1%)
13	Strauss et al. (2017)	Mental health issues and complex experiences of abuse among trans and gender diverse young people: Findings from trans pathways	Social media, gender clinics, youth mental health services, support groups, and word of mouth; Australia.	Quantitative ; Cross-sectional	859 TGNC youth (14-25; Mean = 19.37) residing in Australia. Mixed sex (74.4% AFAB) and gender (29.7% trans-male/male, 15% trans-female/female, 48.5% non-binary).	Novel measure used to assess exposure to abuse, including familial physical/sexual/other abuse, extrafamilial sexual/physical abuse, partner abuse of any kind. Current psychopathology assessed using PHQ-A for mood and GAD-7	30.9% of TGNC youth reported DV, with a significant positive effect of age. No significant differences in DV were noted between those who identified as trans-female, trans-male and non-binary, or between those AFAB and AMAB. 32% of those who experienced DV attributed the abuse to their gender-identity.

					3.7% aboriginal/Torres Strait Islander	for anxiety; single item for self-reported psychiatric diagnosis; Novel measure for past 12 months' self-harm.	DV was strongly correlated with self-harming behaviours and significantly associated with all outcomes (suicidality, anxiety, depression, PTSD, psychosis, PTSD, eating disorder, substance misuse) bar the development of personality disorder.
14	Walls et al. (2019)	Gender identity, sexual orientation, mental health, and bullying as predictors of partner violence in a representative sample of youth	Data drawn from the Healthy Kids Colorado Survey, administered in public high schools	Quantitative ; Cross-sectional	9352 high school students (14-18; Mean = 15.8) who had dated within the past 12 months. Mixed sex, (52% AFAB) and gender (96.1% cisgender, 0.7 trans-female, 1.1% trans-male, 0.7 trans-other). 55.3% White, 26.3% Latino/Hispanic, 12.9% Multiracial, 2.3% Black, 1.5% American Indian/Alaska Native, 1.1% Asian, 0.4% Native Hawaiian/Pacific Islander. Sexual orientation reported as 87.3% heterosexual, 7.5% bisexual, 1.8% gay/lesbian, 4.9% unsure.	Novel measures used to assess DV, depressive symptomology, suicidality and bullying and bullying relating to past 12 months.	Experiences of DV were considerably more prevalent in TGNC youth regardless of sexuality, with trans-questioning participants most likely to experience DV of all TGNC identities, followed by trans-LGB, and then trans-heterosexual. In the unadjusted odds ratio model, TGNC youth were between 3 and 16 times more likely than cisgender heterosexual youth to experience DV, depending on their sexual orientation. Trans-questioning youth also had far greater odds of experiencing DV than both cisgender-heterosexual and cisgender-LGB youth. Bullying and depression predicted DV. Trans-questioning youth no longer had significantly higher odds of DV than cisgender heterosexual youth once mental health and bullying were introduced to the model. All other associations held, though attenuated. Trans youth remained between 2 and 8 times more likely to experience DV than their cisgender heterosexual counterparts, with highest odds among those who were both trans and questioning their sexuality.
15	Whitton et al. (2019b)	A longitudinal study of IPV victimization among sexual minority youth	Community sample; Chicago (six waves of data over a 5-year period)	Quantitative ; Prospective cohort study	246 LGBT youth (16-20 at baseline; Mean at baseline = NS). Mixed sex (50.8% AFAB) and gender (91.9% cisgender, 4.9% trans-female, 3.3% trans-male). 57.3% Black, 17.5% Other, 13.8% White, 11.4% Latino/Hispanic.	Past 6 months' physical and sexual DV assessed using the H-RASP. Current psychological distress across three domains (somatisation, depression and anxiety) measured using the BSI-18; social support measured using the MSPSS; past six months' sexual risk behaviour assessed using H-RASP.	TGNC participants were more than twice as likely as cisgender participants to have reported physical DV, and more than three times more likely to have experienced sexual DV. No significant differences were noted by birth sex. Social support was negatively associated with physical DV only. Alcohol use was positively correlated with sexual DV only. Marijuana use was positively correlated with physical DV. Number of

	Sexual orientation reported as Gay (34%). Lesbian (27.9%), Bisexual (28.7%), Questioning/ unsure/other (9.4%)	Substance misuse assessed with novel measure that looked at frequency/quantity over past 6 months; past six months' victimisation assessed using adapted non-validated measure.	sexual partners was associated with increased odds of both sexual and physical DV. In the lagged analysis, sexual DV predicted distress in subsequent waves. Both physical and sexual DV predicted marijuana and other drug use. Neither predicted alcohol use or sexual partners.

Notes: NS = Not specified; CESD = Centre for Epidemiological Studies Depression Scale (Radloff, 1977); SISES = Single-Item Self-Esteem Scale (Robins et al. 2001); CADRI = Conflicts in Adolescent Dating Relationships Inventory (Wolfe et al., 2001); AJVQ = Abbreviated Juvenile Victimisation Questionnaire (Finkelhor et al., 2011); SBS = Swearer Bullying Survey (Swearer & Doll, 2001); MSPSS = Multidimensional Scale of Perceived Social Support (Zimet et al., 1990); SA45 = Symptom Assessment-45 Questionnaire (Strategic Advantage, Inc., 1998); CRAFFT = CRAFFT Screening Test (Knight et al., 1999); CADRI – Conflicts in Adolescent Dating Relationships Inventory (Wolfe et al., 2001); BSI-18 = The Brief Symptom Inventory (Derogatis, 2001); H-RASP = HIV-Risk Assessment of Sexual Partnerships (Mustanski et al., 2014), GAD-7 = Generalized Anxiety Disorder 7-Item Scale (Spitzer et al., 2006); PHQ-A = Patient Health Questionnaire for Adolescents (Kroenke et al., 2001). Genderqueer=An identifier for persons who regard their gender identity as falling outside of the gender binary, and who reject the term 'trans' on the basis that it implies switching from one binary category to another. Often employed as an alternative to the term 'gender non-binary'.

Synthesis

Design

All fifteen papers presented quantitative data, with thirteen employing a cross-sectional (survey) design, and two using an accelerated longitudinal design across two (9) and six (15) time-points. Simple regression analyses were used in most cases to estimate relationships between gender-identity, DV and a variety of independent variables, while others took a multi-level modelling approach to assess between-groups variation (2,15) or conducted a latent class analysis to organise participant response patterns into classes of vulnerability (7). One study used a chi-square test of independence to examine gender-based differences in DV rates (1), which, while appropriate given its vastly different group sizes, was limited in its capacity to offer substantial insight into any associations between DV and TGNC identity.

Two thirds of all studies utilised secondary data from existing regional (7,8,9,10,14), national (4,5,6) or cross-state (3) initiatives, of which five employed probability sampling methods (4,5,6,10,14). While large, existing and randomly-achieved data-sets have the potential to improve sample representativeness, limited detail is offered across these studies (excepting 14) regarding how randomisation and recruitment was performed, making it difficult to ascertain the quality of sample selection. Where secondary data sources had employed convenience/purposive strategies (3,9) or a population-based census (7), sampling processes were better described.

The remaining six papers (1,2,11,12,13,15) relied on primary data collection methods with non-probability sampling strategies, acknowledging limitations in terms of bias and representativeness.

Sample

Although gender-minority youth, or both gender- and sexual-minority youth were the populations of interest across all studies, inclusion/exclusion criteria was variable across the

papers. Naturally, eligibility parameters and sample characteristics were more adequately defined in those studies that gathered primary data, and were found lacking in those that relied on secondary material.

In aiming to draw comparisons between TGNC and cisgender participants, nine studies (1,2,4,5,6,7,8,10,14) sampled general youth populations, with participant numbers ranging from 2,766 to 87,532 ($\bar{x}$=27,876) and TGNC participants averaging 2.3% of the sample whole. Others sampled sexual- and gender-minority youth (9,11,12,15), with sample sizes between 172 and 1,177 ($\bar{x}$=693) and an average of 17.5% TGNC-identifying participants. It is noteworthy that studies 11 and 12 utilised the same sample. Two studies further sampled gender-minority youth exclusively (3,13) attracting 187 and 859 participants respectively.

With the exception of two papers, which captured/analysed the responses of trans-males/females (10) and otherwise-identifying trans persons separately (14), all studies using a general youth sample regarded 'TGNC' as a homogenous identity construct (1,2,4,5,6,7,8). In doing so, these studies make it difficult to ascertain whether TGNC participants were overwhelmingly male/female/other-identifying, and whether particular TGNC subpopulations may have been responsible for driving various findings. Since TGNC health research is largely recruited through HIV-funding, attracting disproportionate AMAB participation (Coulter et al., 2014), it is widely acknowledged that AFAB- and GNC-representative samples are of paramount importance to research claiming to capture the general experience of TGNC people. Though in this collection of studies, recruitment through school/college (1,2,4,5,6,7,8,10,11,12,14) or community-based (9,13,15) populations may have served to redress the gendered imbalances identified in the extant TGNC literature, this is not explicit and precludes firm conclusions regarding the applicability of findings to certain TGNC identities.

All papers that sampled sexual- and gender-minority youth, or gender-minorities exclusively disaggregated trans-male and trans-female identities at least, with one study (which did draw data from an HIV-funded trial) acknowledging a majority AMAB sample (75%; 3). Other TGNC identifiers, such as 'non-binary' (13), 'genderqueer' (11,12), 'gender non-conforming' (3) and 'trans(other)' (14) were employed inconsistently across studies.

Several demographic indicators were collected across the papers. In addition to age, which ranged from 12 to 25 years ($\bar{x}$=age=18.2; reported in 11 studies), all but two studies (8,13) gave a breakdown of the samples' ethnicity, with 53% of the total number of participants identifying/identified as White. All studies were conducted in high-income countries and U.S. residents made up 96.6% of the collective sample, thus limiting generalisability beyond these contexts.

Measures/Outcomes

Due to considerable heterogeneity in their precise aims, what was measured varied across the papers. Thirteen studies (1,3,4,5,6,7,8,9,10,11,12,13,14) sought to capture the prevalence of DV among TGNC persons, and many examined whether rates of DV were significantly different in gender-minority and cisgender populations (1,2,4,5,6,7,8,9,10,11,12,14,15). Over half examined correlations between DV and psychosocial outcomes, including mood disorders (2,3,9,11,13,14,15), substance misuse (3,9,13,15), PTSD (11,13), eating disorders (13), self-injury/suicidality (2,3,13,14), adverse peer/other relations (3,7,11,14), perceived familial/social support (10,11,15) and sexual risk-taking (3,9); although due to most studies using either general or LGBT-spectrum youth samples, only two were able to link these outcomes directly to TGNC youth victims (3,13).

Measures ranged from validated tools with excellent reliability/validity coefficients to novel questionnaires. Validated measures were mostly used for obtaining psychosocial outcomes and are listed in Table 3.

Though several established gender-identity measures would have been available to authors at the time of study design (Bauer et al., 2017), no two studies utilised the same tool and none used a validated instrument. This, alongside reliance on secondary data, led to inconsistencies in how gender was captured across the papers, resulting in a multitude of equivocal identifiers that impeded the exercise of pooling findings by gender-identity. Furthermore, over a third of studies using general youth samples required participants to self-identify as "male", "female" or "transgender" without regard for the potential for TGNC respondents to identify as male/female (1,4,5,8,9,11). Others took a more nuanced approach, with demographic items more clearly defining gender categories and/or additionally capturing assigned birth-sex to avoid the potential for differential misclassification (2,6,7,10,12,14,15).

DV measurement also varied considerably across the papers, with around half utilising validated instruments in their original (2,8.9,10,15) or adapted form (1,11,12), and the remainder employing novel surveys. Consequently, DV, though adequately defined at individual study-level, was inconsistently understood as a construct, making it difficult to draw cross-paper comparisons. Of the nine studies that reported DV as a singular construct, for example, three asked that respondents include abuses of a sexual, physical and psychological nature (2,8,9), while three enquired about physical violence only (10,11,12) and one referred to physical and sexual, but not psychological abuse (3). A further two studies left interpretation of DV to the respondent, by asking after experiences of being "hurt" or "abused" in a relationship (13,14). Where DV was analysed as a multi-component construct, the definitional standard included sexual, physical and psychological abuses, with the exception of Study 15, which omitted the psychological, and Study 1, which also considered cyber abuses.

Further variation in DV measurement was noted in the recall time-frames specified across the papers, with differing temporal parameters potentially having implications for both how participants remembered/made sense of their experiences, and whether respondents'

present gender-identity/presentation aligned with their victimisation encounters. Exposure to DV was most often assessed using a 12-month time-frame (1,2,4,5,6,8,10,11,13,14), with two papers using a six-month recall period (9,15), and three assessing lifetime exposure (3,7,12). In the context of adolescence/young adulthood, during which people might be first beginning to understand their gender-identity, assessing lifetime DV exposure will likely capture experiences that pre-date individuals' identification as TGNC.

Given that both key constructs (gender-identity and DV) appear poorly defined across the literature on this topic, it is necessary to acknowledge that construct validity is difficult to ascertain, and that collective findings are likely limited by the psychometric properties of the measures employed. Furthermore, some studies failed to report (2,5,6,10,12,13) or reported low internal consistency in the instruments used (2,4), while others (principally on account of secondary data use) did not comment on data completeness (2,6,7,8,10,12,13) or reported higher rates of missingness (2,11) than is typically deemed acceptable (Thomas et al.,2004; Zaza et al., 2000). As such, the necessary caution will be exercised in the interpretation of findings.

Findings

The following section presents a synthesis of key findings from the reviewed literature and attends to what is known about: (a) the prevalence of DV among TGNC youth, (b) disparities in victimisation between gender-minority and cisgender samples, (c) how DV compares to other TGNC victimisation experiences, and (d) the psychosocial/structural correlates of DV in these studies.

DV Prevalence Among TGNC Youth

Synthesised prevalence rates were interpreted with caution, with the broad range reported across the studies reflecting heterogeneity in both study populations and measurement

tools. As such, median as well as mean prevalence percentages are presented. Table 4 details the individual rates of DV victimisation by type and gender where available.

DV as a Singular Construct.

Percentages of TGNC youth who identified as having experienced any kind of DV victimisation ranged from 0% to 69% (Median:30.6%, $\bar{x}$=31.8%), representing 24 gender-minority populations across eight studies (3,8,9,10,11,12,13,14). It is noteworthy that Study 9, in reporting no experience of DV among trans-males, creates a negative skew in the combined results. While its findings may be anomalous owing to its small trans-male subsample, this may equally be said of many of the findings across the studies. These results have therefore been retained in the prevalence calculations, with adjusted ranges, exclusive of these results, also presented hereafter where relevant. The adjusted range for TGNC youth having experienced any type of DV victimisation is therefore 11.8% to 69% (Median:30.7%, $\bar{x}$=33.1%).

DV by Type.

Where DV was examined by type, seven studies (1,4,5,6,7,8,9) saw reports of physical DV ranging from 0% to 88.9% (Median:10.5%, $\bar{x}$=23.5%) [Adj. range: 3.8% to 88.9% (Median:10.6%, $\bar{x}$=26.8%)], while rates of sexual violence ranged from 3.5% to 62% (Median:13.8%, $\bar{x}$=26.7%) across six papers (1,4,5,6,7,8). Psychological/emotional victimisation was reported in almost half the studies (1,4,5,6,7,8,9), with rates spanning 0% to 58.8% (Median:19.9%, $\bar{x}$=27.3%) [Adj. range: 8.9% to 58.8% (Median:21.3%, $\bar{x}$=31.2%)]. Cyber DV was noted in 56.3% of TGNC youth (1).

In studies examining DV perpetration risk in TGNC samples (1,7), rates of physical, psychological and sexual violence ranged from 4%–58.8%, 7.4%–29.4%, and 3.8%–17.6% respectively. The unusually high rates of both perpetration and victimisation in Study 1 should be considered in the context of its using a chi-square analysis with a large sample, which may

have led to statistically, but not substantively significant results. This study fails to identify/control for potential confounders.

DV by Gender.

Six papers examined DV as a singular construct by gender (3,9,11,12,13,14), with rates among TGNC females ranging from 11.8% to 66.7% (Median:35.4%, $\bar{x}$=34.1%) and rates for TGNC males spanning 0% to 31.7% (Median:25.7%, $\bar{x}$=21.4%) [Adj. range: 15.1% to 31.7% (Median:27.5%, $\bar{x}$=25.7%)]. Gender disparities here appear align with the wider DV literature, with victimisation seemingly more prevalent among female- than male-identifying persons, even once anomalous findings are adjusted for. Five studies also included figures for non-binary/genderqueer respondents (3,11,12,13,14). reporting rates between 12.6% and 60% (Median:23.9%, $\bar{x}$=29.6%).

Table 4.

Prevalence of dating violence victimisation by gender and type

Paper	Gender	Recall period	Any DV %	Physical DV %	Sexual DV %	Psychological DV %	Cyber DV %
1	All TGNC	12/m		88.9	61.1	58.8	56.3
3	TF	Lifetime	43.6				
	TM		30.4				
	NC		60				
4	All TGNC	12/m		10.3	10.8	18.6	
5	All TGNC	12/m		3.8	6.3	8.9	
6	All TGNC	12/m		3.9	3.5	16.2	
7	All TGNC	Lifetime		10.6	16.7	21.3	
8	All TGNC	12/m	69	23	62	39	
9	TF	6/m	66.7	44.4		55.6	
	TM		0	0		0	
10	All TGNC	12/m	30.7				
11	TF	12/m	11.8				
	TM		15.1				
	GQ-AFAB		12.6				
	GQ-AMAB		14.7				
12	TF	Lifetime	11.8				
	TM		23.8				
	GQ-AFAB		23.9				
	GQ-AMAB		16.3				
13	TF	12/m	31				
	TM		31.7				
	NB		31.4				
14	TF	12/m	39.7				
	TM		27.5				
	T(O)		48.5				
	T(Het)		23.9				
	T(LGB)		38.9				
	T(Q)		59.1				

Note: TF=Trans-female; TM=Trans-male; NC=Gender non-conforming; GQ-AFAB=Genderqueer assigned female at birth; GQ-AMAB=Genderqueer assigned male at birth; NB= Non-binary; T(O)=Trans (other); T(Het)=Trans (heterosexual); T(LGB)=Trans (lesbian/gay/bisexual); T(Q)=Trans (questioning sexual orientation)

Rates of DV Relative to Cisgender Youth

The collective data did not lend itself to a random effects meta-analysis for comparing the prevalence of DV in TGNC and cisgender samples. This was largely due to significant heterogeneity in comparative groups (how gender-identities were disaggregated) and variation in how DV was defined (as a singular/multi-component construct), allowing data from a maximum of three studies to be meaningfully pooled. A narrative synthesis is therefore offered,

with Tables 5a–5d presenting an overview of the odds ratios reported across studies that calculated relative risk.

Thirteen studies (1,2,4,5,6,7,8,9,10,11,12,14,15) examined differences in prevalence rates between cisgender and TGNC youth, with the cisgender samples in four papers being sexual-minority youth exclusively (9,11,12,15). Studies were broadly unanimous in their findings, with all but one study (11) reporting that TGNC youth were significantly more likely than cisgender respondents to be victims of at least one DV subtype.

Table 5a

*Prevalence of **any** DV relative to cisgender peers – OR(95% CI)*

Paper	Ref group	TGNC	T-Het	T-LGB	T-Q
8	Cis male	8.3 (2.63, 33.33)*			
	Cis female	4.1 (1.31, 16.66)*			
10	Cis youth	1.73 (1.45, 2.06)*			
14	Cis youth		3.71 (2.26, 6.10)*	7.03 (4.59, 10.79)*	15.63 (8.42, 29.02)*

*p<.05. T-Het= TGNC heterosexual; T-LGB= TGNC gay/lesbian/bi-sexual; T-Q= TGNC questioning sexual identity.

Table 5b

*Prevalence of **sexual** DV relative to cisgender peers – OR (95% CI)*

Paper	Referent group	TGNC
4	Cis male	6.48 (4.01, 10.49)*
5	Cis male	6.13 (2.41, 15.60)*
6	Cis female	1.15 (0.56, 2.36)
8	Cis male	16.66 (5.88, 50.00)*
	Cis female	5.88 (1.92, 20.00)*
15	Cis SM youth	3.42 (1.85, 6.33)*

*p<.05. SM= Sexual-minority.

Table 5c

*Prevalence of **physical** DV relative to cisgender peers – OR (95% CI)*

Paper	Referent group	TGNC
4	Cis male	2.93 (1.81, 4.73) *
5	Cis male	2.04 (0.64, 6.56)
6	Cis female	1.71 (0.86, 3.39)
8	Cis male	2.00 (0.31, 7.14)
	Cis female	1.47 (0.32, 5.00)
15	Cis SM youth	2.46 (1.24, 4.92)*

*p<.05. SM= Sexual-minority.

Table 5d

*Prevalence of **psychological** DV relative to cisgender peers – OR (95% CI)*

Paper	Referent group	TGNC
4	Cis male	2.02 (1.41, 2.91)*
5	Cis male	1.73 (0.79, 3.79)*
6	Cis female	1.49 (1.04, 2.14)*
8	Cis male	3.70 (1,08, 11.11)*

*$p<.05$

Disparities Between Generic Cisgender and TGNC Samples.

In papers that used a generic cisgender youth sample as the referent group, TGNC identity was correlated with significantly higher odds of DV across all studies that examined DV as a homogenous construct (2,7,8,10,14). One such study, using a latent class analysis, categorised gender-minority youth as significantly more likely than cisgender persons to be at high-risk of DV victimisation and at either low- (trans and gender non-conforming persons) or moderate-risk (gender non-conforming persons only) of DV perpetration once transphobic discrimination and social disadvantage were controlled for (7). Despite unanimity in results, reported confidence intervals were often broad, precluding firm estimates regarding the increased likelihood of victimisation for TGNC persons. Study 10, which had the highest proportion of TGNC participants and therefore offers the greatest degree of certainty around the effect, estimated victimisation to be almost twice as likely for TGNC youth relative to cisgender peers (OR:1.73 [CI:1.45, 2.06]). Since DV is operationalised in this study as being "physically hurt…on purpose", it is helpful to note that sexual violence was also significantly more likely among its TGNC respondents (OR:1.43 [CI:1.25, 1.64]).

Where DV was separated into subtypes, all studies observed that TGNC youth were considerably more likely to experience sexual and psychological DV (1,4,5,8) and cyber DV (1) than cisgender males. Study 5's reporting of significance for its findings on psychological DV, however, is undermined by a confidence interval that crosses the null hypothesis. While

support for differential rates of psychological and particularly sexual DV appear fairly robust, only half the studies found significant differences relating to physical victimisation (1,4). Where the contrast was cisgender females, two of three studies found that TGNC youth were more likely to be sexually (4,8) and psychologically victimised (4,6), while only one reported significant disparity relating to physical violence (4).

Disparities Between Sexual-minority Cisgender and TGNC Samples.

Comparisons with sexual-minority youth demonstrated similarly increased, though attenuated odds of DV victimisation for TGNC participants, with one robustly-conducted study finding that gender-minority persons were more than twice as likely to experience physical DV (OR:2.46 [CI:1.24, 4.92] p <.05) and three times more likely to experience sexual DV (OR:3.42 [CI:1.85, 6.33] p <.001) than sexual-minority peers (15). Likewise, significant and highly significant differences in experiences of psychological (p=.017) and physical (p=.006) DV were noted between the referent group (sexual-minority males) and both sexual-minority and trans-females (9). Though sexual DV was not examined independently in this study, the pooled analysis of all types of DV (including sexual) was even more greatly significant than for physical and psychological subtypes independently (p=.005), indicating that sexual DV disparities may be especially pronounced. Although the nature of the analysis here (chi-square) precludes certainty regarding which of the female groups is driving the results, it is notable that trans-females reported greater levels of each DV subtype than cisgender sexual-minority girls.

Conversely, two studies found little (12) to no (11) effect of TGNC identity on DV victimisation rates, with genderqueer-AFAB youth being the only sub-population (of trans-males, trans-females, genderqueer-AMAB and genderqueer-AFAB) to experience significantly more victimisation than the sexual-minority male referent group (12). It is of note, however, that these two studies define DV in terms of physical violence only, employing measures that treated sexual abuse as a separate phenomenon. Incidentally, three of four TGNC

identities – genderqueer-AMAB (12), genderqueer-AFAB (11,12) and trans-males (11) – reported significantly higher rates of sexual violence than cisgender sexual-minority males. Results here broadly accord with findings across the studies, in which stronger evidence is presented for increased risk of sexual over physical abuses.

How Does DV Victimisation Risk Compare to Other Victimisation-types?

Several studies offer information on how rates of DV compare to other forms of violence experienced by TGNC persons. Table 6 presents an overview of their findings, with odds ratios indicating that elevated victimisation rates among TGNC youth extend beyond dating relationships. Again, it is noteworthy that abuses of a sexual and psychological nature, whether in- or outside of a dating context, appear to be most consistently and most significantly increased for gender-minorities. Study 6 offers the greatest degree of certainty around the effect size, reporting a moderate but significant impact of gender-identity on several sexual and all psychological abuses relative to cisgender females.

The trend of pervasive victimisation was seen to continue in studies where relative risk was not calculated. TGNC youth reported significantly more victimisation in 23 of 32 violent subtypes than did cisgender males (12), and experienced greater levels of violence across all six violent subtypes in Study 11. As an important point of comparison, the victimisation of cisgender females was significantly greater than for cisgender males in just 1of 6 and 9 of 32 subtypes in Studies 11 and 12 respectively.

Table 6.

DV relative to other types of violence – OR (95% CI)

Paper	Sexual DV	Physical DV	Psych. DV	Attempted penetration	Completed penetration	Non-consensual touch	Violent threats	Physical assault	Stalking/ Harassment
4	6.48 (4.01, 10.49)*	2.93 (1.81, 4.73)*	2.02 (1.41, 2.91)*	9.49 (6.17, 14.59)*	9.06 (5.64, 14.53)*	4.45 (3.09, 6.39)*	1.39 (1.04, 1.87)*	1.93 (1.27, 2.95)*	3.25 (2.19, 4.82)*
5	6.13 (2.41, 15.60)*	2.04 (0.64, 6.56)	1.73 (0.79, 3.79)*	5.32 (2.09, 13.50)*	4.95 (1.51, 16.19)*	4.17 (2.17, 7.99)*			
6	1.15 (0.56, 2.36)	1.71 (0.86, 3.39)	1.49 (1.04, 2.14)*	1.63 (1.01, 2.65)*	1.68 (0.93, 3.06)	1.10 (0.73, 1.64)	1.78 (1.32, 2.41)*	1.59 (0.86, 2.97)	1.35 (0.86, 2.11)
8 (m)	16.66 (5.88, 50.00)*	2.00 (0.31, 7.14)	3.70 (1,08, 11.11)*		9.09 (2.04, 33.33)*	14.29 (5.00, 33.33)*			1.89 (1.56, 12.5)*
8 (f)	5.88 (1.92, 20.00)*	1.47 (0.32, 5.00)			5.88 (1.35, 20.0)*	5.56 (2.04, 14.29)*			1.82 (0.69, 5.55)

*p<.05; (m)= Male contrast; (f)= Female contrast.

Psychosocial and Structural Correlates of DV Among TGNC Youth

Seven studies examined associations between DV and MH (2,3,9,11,13,14,15).

DV and Anxiety.

Current (2,13) and lifetime (13) anxiety was positively correlated with DV in both cross-sectional studies that measured this association. Study design, however, imposes constraints on what can be known about the temporal ordering of the variables examined. Study 9 offers further predictive information, with significant relationships between anxiety and all DV subtypes reported at 12-month follow-up (though not concurrently), suggesting the development of anxiety in response to victimisation. One study, using a measure of overall psychological distress with an anxiety component, found no significant associations between DV and MH distress (15).

Due to predominantly gender-heterogenous samples, only Study 13 was able to directly evidence correlation between anxiety and DV in TGNC youth specifically. Although Study 2 found significantly greater levels of anxiety in TGNC victims of DV than in cisgender victims, this association was lost when peer victimisation and perceived school violence were controlled for, indicating that anxiety may be linked to wider victimisation experiences rather than DV specifically.

DV and Depression.

DV was positively correlated with current (3,9,13,14) and lifetime (13) depression in four studies, with longitudinal inquiry reporting no association at cross-sectional level, but finding all DV barring psychological abuse to predict depression at follow-up (9). Of the two studies that did not find significant relationships between DV and depression, one did not report on depression singularly, but rather as a component of overall distress (15), and the other found no correlation between depression and aggregated victimisation subtypes, of which DV was one (11). It is therefore difficult to attribute much weight to these non-significant findings.

DV and Other MH.

Singular significant and positive correlations were found between DV and PTSD, psychosis and eating disorders (13), alongside non-significant relationships between DV and self-esteem (3). Further scientific inquiry is required to substantiate these findings.

DV and Health Behaviours.

Six studies explored interactions between DV and health behaviours (2,3,9,13,14,15). Serious self-harm (13) and suicidality (2,13,14) were strongly correlated with DV victimisation in three of four studies. It is relevant that Study 3, which alongside Study 13 was one of two studies to use a wholly TGNC sample, did not find a relationship between the variables. While this may indicate that some other population is driving the relationship between DV and self-injury, it is also noteworthy that Study 3's sample size is small for a logistic regression (n=131), which may have impacted whether a truly significant relationship could be detected. Certainly Study 2, which has a TGNC sample size close to population levels (1.5%), found a highly significant correlation between DV and suicidality and reported significantly higher rates of suicidality among TGNC youth.

There was mixed evidence for the presence of a relationship between DV and substance misuse, with studies using TGNC-only samples finding a moderate but significant positive association (13), or a relationship approaching significance (3), and studies with broader samples finding no correlation (9) or variability in which cannabis was positively associated with physical DV, but no further associations found between other DV subtypes and substances (15). Echoing the extant literature (Brennan, 2012), this suggests that difficulties with substance misuse may affect gender-minority youth uniquely, and indicates a need for further TGNC-specific research.

Both studies examining sexual risk-taking found significant positive correlations with DV victimisation (3,9), with the latter observing that psychological- and 'any' (including

sexual) DV predicted concurrent sexual risk behaviours, but not at follow-up. A possible explanation is that such risk may be a feature of relationship abuse, rather than an outcome of it. Physical DV was not associated with sexual risk at either time-point.

DV and Social/Structural Factors

Six studies commented on DV's relationship to social/structural factors (3,7,10,11,14,15).

Experiences of bullying (14,11) and specifically transphobic/bias-based bullying (3,7,14,15) were positively correlated with DV in five studies, with one finding that bias-based victimisation predicted sexual but not physical relationship violence (15), and another reporting that multiple instances of transphobic abuse predicted greater levels of DV (3).

Significant negative interactions were found between DV and perceived social support (10,11,15), though one found this to be true only of physical (not sexual) DV (15). While further inquiry is warranted here, this finding may be indicative of young people anticipating greater difficulty and/or shame in seeking support for abuses of a sexual nature. That these studies used a general youth sample is also of interest, with Study 10 finding that while DV was negatively correlated with all support types in the sample whole, support did not appear to moderate levels of DV experienced by TGNC youth as it did for cisgender participants (10). This may be partially explained by already negative/strained relationships between TGNC youth and their families/peers, as is evidenced in the wider literature (Clark et al., 2014). Indeed, Study 11 supports this explanation, finding positive correlations between trans-negative family environments and young people's odds of multiple forms of victimisation, including DV (11).

Discussion

This review collates what is known about DV in TGNC youth populations. Though variation in quality and heterogeneity in measurement across the studies dictates that results be

treated with caution, a number of broadly consistent findings allow for some inferences to be made about trends within the literature on this topic. Several standout findings merit discussion, namely: the predominance of sexual DV for TGNC youth relative to other DV subtypes, cisgender youth, and TGNC adults in the wider literature; the increased but attenuated odds of experiencing DV relative to sexual-minority cisgender youth; and the understanding of DV as part of a broader victimisation experience.

Epidemiology

The epidemiological findings from this review accord broadly with the adult TGNC literature. Almost a third of TGNC youth identified as victims of at least one DV subtype, which is marginally lower than the 37% in Peitzmeier's predominantly adult-focused review (2020). While this may initially appear to indicate that TGNC youth present with less risk than their adult counterparts, it is noteworthy that 86% of the studies used to obtain this figure in the adult review assessed lifetime prevalence, while 80% of the youth-related literature examined past-year DV. That gender-minority youth should recall equivalent rates of DV in their immediate pasts alone suggests that adolescence/young adulthood may represent a period of particular vulnerability for TGNC persons.

A departure from Peitzmeier's findings is noted once DV subtypes are disaggregated, with past-year physical DV seen to be lower (10.5% vs 16.7%) and sexual DV comparatively higher in the youth period (13.8% vs 10.8%). Although the higher incidence of sexual DV may, on the one hand, reflect young people's occupying a life-stage in which they are learning to negotiate issues of sex and consent generally, the additional complexity of sexual-identity development in TGNC adolescents might also be an explanatory factor. Recent research indicates that adolescent DV is most prevalent amongst those with multi-gender sexual attractions/partners (Petit et al., 2021). Given the complex interplay between sexual orientation and gender-identity for young people coming out as TGNC (Hereth, 2020), there is an

increased likelihood that gender-minority youth will explore both same- and opposite-sex intimacy as they navigate sexual/gender-identity formation, thus heightening sexual DV risk. Youth may also feel less able to withstand rigid, hegemonic gender-role expectations within intimate contexts, which may lead to unwilling compliance with sex-acts.

A further factor may relate to trends in sexual initiation among TGNC people. Age-discrepant sexual partnerships among gender-minority youth are well-documented both anecdotally and in research, with the ubiquity of dating apps now facilitating contact between potential dissimilarly-aged partners (Carballo-Dieguez et al., 2012; Macapagal et al., 2020). Though many of such relationships are entered into consensually, unequal power dynamics may increase the likelihood of sexual coercion, risk-taking and assault. Moreover, where partners are not themselves TGNC, risk may exist relating to the sexual fetishization of young trans bodies on the one hand (Ussher et al., 2020), and punitive/'corrective' rape born of desire to enforce gender conformity on the other (Cense et al., 2017).

TGNC and Cisgender Disparities

Evidence of disparities between cisgender and TGNC DV in early dating relationships appears robust, with almost unanimous support for this conclusion across the studies. The review found that 35.4% of trans-females, 27.5% of trans-males and 23.9% of non-binary youth reported DV victimisation of some kind, far exceeding figures relating to cisgender adolescents in the wider literature (Breidling et al., 2014; Rostad et al., 2019, Wincentak et al., 2017). Beyond descriptive statistics, TGNC youth were found to be up to 3.9, 3.7 and 16.7 times more likely than cisgender males, and up to 1.7, 1.5 and 5.9 times more likely than cisgender females to experience physical, psychological and sexual DV respectively (notwithstanding broad effect estimates and suggestions that disparities many attenuate when other stressors are accounted for).

That sexual DV was the most discrepant subtype for gender-minorities relative to cisgender youth is alarming, particularly given suggestions that TGNC youth are typically less sexually active than their cisgender peers (Bungener et al., 2017). Since sexual violence, more so than other DV subtypes, sees heavily disproportionate numbers of female victims and male perpetrators generally (Black et al., 2011), it is possible that proximity to femininity across TGNC identities presents a risk factor for this population, with pre-surgical trans-males bearing feminine markers in their physiology and trans-females in their gender-presentation. Such an interpretation would accord with theoretical perspectives that align TGNC-directed violence with misogyny more so than with anti-trans sentiment (Serano, 2016). Understandings of sexual violence foremost as a means of degrading and asserting control over less powerful persons, often in response to feelings of disenfranchisement (WHO, 2003) may also be important. Since TGNC bodies may present a sexual conflict for cisgender partners – and particularly youth partners still navigating their sexual-identity – sexual violence may occur as a projection of self-hatred and in attempt to reassert control over a now problematised sexuality/masculinity. Indeed, evidence suggests that male sexual partners of female-identifying gender-minorities may adversely respond to conflictual feelings about their sexual orientation, which can lead to denial and ultimately violence towards the TGNC partner (Roch et al., 2010). It is therefore necessary to recognise that risk for gender-minorities exists at the intersection of misogyny and homo/transphobia.

The increased vulnerability of trans-females relative to both cisgender females and trans-males warrants further explication, given the heavy representation of AFAB persons in population-level DV figures. Though the aforementioned ‘challenge’ to masculinity presented by trans-females may go some way to assisting our understanding of such discrepancies, we might equally consider variations in different populations’ socialisation to gendered violence, with AFAB persons acquiring a greater risk-sensitivity in their formative years by necessity.

Conversely, for female-identifying TGNC youth on the cusp of social transition, the necessary protective skills required for their self-identified gender may develop much later in life (Roch et al., 2010), leaving them less well-equipped to anticipate and forestall situations/interactions that might lead to endangerment.

Though rates of psychological DV in this review were closer to those seen among cisgender females, the still significantly increased odds are attention-worthy. In adult populations, researchers have understood this differential in terms of the additional modes through which gender-minorities might be uniquely victimised. TGNC-specific forms of psychological DV may include threats to 'out' the victim, asserting control over their transition, withholding transition-related hormones and employing non-affirming statements/microaggressions to undermine victims' confidence/self-esteem (Roch et al., 2010). Although psychological DV is often perceived as less damaging than other subtypes, research has frequently observed a greater impact on wellbeing than physically-oriented violence in minority populations (Hellemans et al., 2015; Pepper & Sand, 2015).

TGNC and Sexual-minority Disparities

The dichotomy observed between undifferentiated cisgender and gender-minority samples was not wholly replicated in comparisons with cisgender sexual-minority youth. Although TGNC persons were consistently found to experience greater levels of DV than LGB participants, findings were statistically significant in only half of papers comparing the two populations. One possible explanation for these non-significant findings is that these studies conceptualised DV in terms of physical violence only. While physical violence is thought to be the most commonly-reported DV subtype among LGB persons (NCAVP, 2015), it was, contrastingly, the least frequently reported subtype among TGNC youth in this review and the least discrepant subtype relative to cisgender persons in the wider empirical literature (Peitzmeier, 2020), indicating that gender- and sexual-minorities may be differently victimised

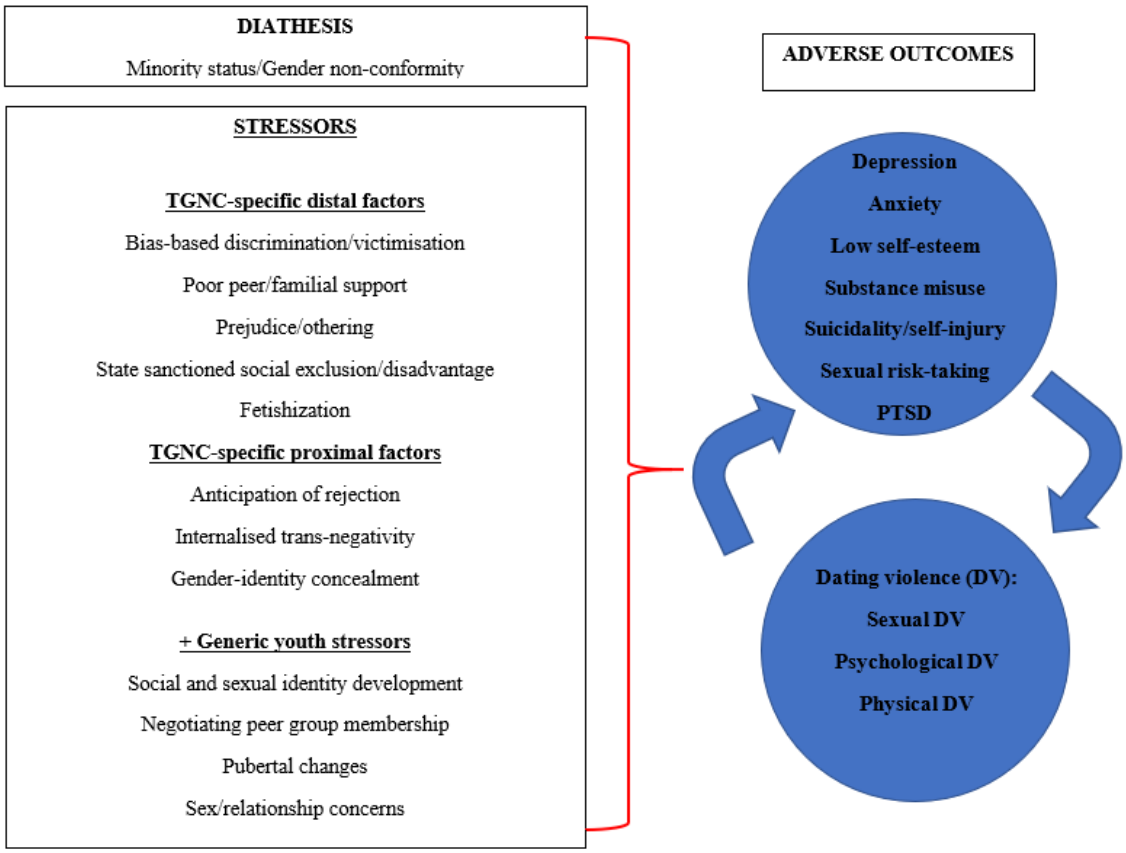
in relationships. Inconclusive evidence for differential DV rates between sexual- and gender-minorities may also support that DV constitutes part of a broader minority experience, with LGB youth already two to four times more likely to be victimised than heterosexual youth (Espelage et al., 2018; Luo et al., 2014). Indeed, minority-stress models acknowledge aspects of shared experience between LGB and TGNC-identifying persons, including stressors relating to discrimination, rejection, identity concealment and internalised trans/homonegativity (Testa et al., 2012), which appear to mediate the relationship between minority identity and DV (Martin-Storey & Fromme, 2021). It is noteworthy, then, that where victimisation experiences beyond DV were examined relative to LGB youth (11,12), gender-minority participants reported significantly more discrimination across a greater range of violent subtypes. This suggests that TGNC youth may face more unique than shared minority stressors (or at least may be more greatly impacted by minority-stress) and gives weight to those studies reporting their increased DV risk relative to LGB samples (9,15). Certainly, an intersectional approach to minority-stress might consider TGNC youth as potentially dually vulnerable, with as many as 73% of gender-minorities also identifying as LGBQ (Callander et al., 2019; Grant et al., 2011). Studies have consistently evidenced how multiple minority identities/identifiers can combine to increase risk of marginalisation and thus vulnerability (Bowleg, 2013; Whitfield et al., 2018).

Psychological/Social/Structural Correlates of DV Among TGNC Youth

Consistent with the wider youth literature, the review demonstrates links between DV and myriad adverse psychosocial outcomes (Kaukinen, 2014). Generally, study design did not allow for direct observation of the impact of DV on gender-minorities, with most papers examining relationships between DV and psychosocial variables across the entire mixed-gender sample. However, those that focused exclusively on TGNC-identifying participants also found strong evidence associating DV with depression, anxiety, suicidality, substance-misuse,

and sexual risk-taking. That the direction of these relationships is inconclusive and only alluded to in one study is of great importance when viewed through a minority-stress lens. Though it is well-documented that DV victimisation can lead to poorer health/social outcomes (Ahmadabadi et al., 2019; Loxton et al., 2017), it is also true that adverse social factors which contribute to MH distress might increase DV risk (Gartland et al., 2016; VanDulmen et al., 2012). This latter interpretation may mark the distinction in cisgender and gender-minority experiences of DV, and account for the uniquely high rates of victimisation in the latter. Certainly, distal minority stressors including bias-based bullying, transphobic discrimination and social disadvantage were noted in the collective samples, and when controlled for, appeared to moderate the association between victimisation and gender-identity. We might arrive, then, a bidirectional understanding of the relationship between adversity and DV for gender-minorities, with psychosocial and environmental stressors precipitating susceptibility to DV, and DV constituting one of the stressors that leads to adverse health/social outcomes. This might be usefully conceptualised using a diathesis-stress model (Albee, 1982; Zubin & Spring., 1977), which formulates the joint roles of vulnerability and environmental stressors in the development of MH distress/other health phenomena. Figure 2 demonstrates how predispositional diathesis (minority identity) and structural inequalities (minority-stressors) may lead to complex and reiterative processes in the development of individual-level problems for gender-minority youth.

Figure 2. Diathesis-stress model adapted to incorporate TGNC specific minority stressors.



Implications

Research

Although the evidence synthesised in this review clearly positions DV victimisation as a significant problem among TGNC youth, methodological limitations within the literature render specific findings inconclusive, securing a need for ongoing research. While collated results offer preliminary suggestions that some TGNC identities are more at-risk and some DV subtypes more prevalent than others, inconsistencies in how both gender and DV were conceptualised across the papers preclude meaningful data-pooling and cross-study comparison. It is therefore imperative that validated gender-identity measures (McGuire et al., 2019) and standardised measures of DV are utilised in future research. Given the current cultural opening for young people to identify in gender-diverse ways and the emergence of

novel means of DV enactment, it is also necessary that such measures are subjected to regular evaluation to ensure their continued relevance to new gender-identities/modes of victimisation. Further, it is noted that existing measures examine DV through a cis-centric, heteronormative lens (Peitzmeier, 2020), and may therefore lack content validity. Given findings that TGNC youth may experience DV uniquely and as part of a wider system of violence, the development of more nuanced DV measures is warranted.

Notwithstanding the broad homogenisation of TGNC identities, the review found that trans-females experienced greater levels of DV than trans-males and non-binary persons. It will be important that this is further explored in future research efforts, either by recruiting female-identifying samples exclusively, or disaggregating TGNC identities in mixed-gender research so as not to delimit future understandings of gendered differences in risk. Indeed, it might be argued that there remains a need to continue with mixed-gender research on this topic, given the inconclusiveness of the extant literature.

That TGNC youth (and particularly trans-females) saw increased odds of DV victimisation relative to cisgender females as well as cisgender males unsettles current understandings of gender-based violence (GBV) by positioning gender-minorities at the far end of the gender-based risk spectrum. This makes a case for representative TGNC samples in all GBV-focused research, which at present – and despite GBV being broadly defined as violence "directed at an individual based on their gender… rooted in gender inequality[…]and harmful norms" (UN Refugee Agency, 2021) – demonstrates a parochial focus on the experiences of cisgender women (Wirtz et al., 2020). Certainly, if GBV as a construct has gender inequity at its core, we might expect TGNC populations to be disproportionately affected.

Echoing the adult literature (Peitzmeier, 2020), the seeming predominance of sexual DV among gender-minority youth appears robust, and is thus concerning. Specific focus on

the sexual victimisation of TGNC persons is warranted, with inquiry into whether high rates are linked to the disproportionate victimisation of trans-females a potential direction for future research. Moreover, the review adds that sexual DV exists within a broader experience of sexual violence for this population. Since sexual violence in both youth- and adult-focused research has typically centred around dating contexts, there may be merit to exploring broader sexually-abusive experiences in both populations, as has been the case for physical violence types (Gallardo-Nieto et al., 2021). Early assertions might be built upon using robust qualitative inquiry and theory-development to add depth to our understanding of this phenomenon and to elaborate on what positivist research can tell us.

Though the review evidences associations between DV and suicidality, substance-misuse, mood disorders and poor social support, there remains a need for further high-quality research examining psychosocial/structural outcomes in TGNC youth specifically. Moreover, given the known high levels of adversity and minority-stress among gender-minorities, longitudinal inquiry should be favoured to establish the direction of effect.

Finally, only two of the reviewed papers gathered information on perpetrators of DV enacted against TGNC youth, with findings from one study deemed unsound. Since best practice guidelines suggest that DV interventions are most effectively placed at perpetrator rather than survivor level (Ellsberg et al., 2015), this constitutes a striking omission in the literature and a pressing future direction for research.

Practice

The review suggests that vulnerability to DV (and other) victimisation begins early in the life-course for TGNC individuals. Clinicians should therefore be aware of the disproportionate likelihood that gender-minority individuals across the life-span will present with sexually-/emotionally-violent experiences that may not be disclosed due to stigmas attached to both DV victimisation and TGNC-identity (Scheer, 2020; Shin et al, 2014). A

trauma-informed approach, which assumes traumatic exposure in the absence of disclosure, should thus guide clinical contacts with TGNC service-users. Likewise, practitioners should be mindful of cis-centric DV narratives perpetuated by binary service-configuration and healthcare legislation, and should work towards policy-embedded structural interventions focused on TGNC-inclusion and facilitating care-seeking. In the meantime, clinicians should forge/maintain links with community-based DV support functions operating explicit TGNC inclusion policies. Psychologists' formulation skills might be usefully employed in assisting community colleagues' understanding of the complex interactions between distal and individual-level stressors that may increase gender-minority risk.

Schools and colleges are aptly placed to provide primary prevention and intervention strategies, and may play a crucial role given suggestions that family support does not moderate DV for gender-minority youth. While TGNC-specific protocols may be optimal, existing DV prevention strategies should also reflect gender-diversity, incorporating TGNC-inclusive language and education relating to what DV might look like in gender-diverse contexts. The present review offers information on how schools might identify DV victimisation (or victimisation risk), including changes in mood, self-harming, bullying and new problems with substance-use. Educational establishments may also forge a role in promoting awareness of DV prevalence among young gender-minorities, such that teachers, parents and peers are alert to signs.

Conclusion

This review synthesises what is presently known about DV among young gender-minorities. Despite methodological limitations, findings illustrate troublingly elevated levels of victimisation relative to cisgender/sexual-minority youth, alongside positive correlations with anxious/depressive symptomology, self-harm, substance misuse, and (bias-based) bullying. Though it is unclear whether these correlates represent outcomes or predictors,

clinicians/educators should be alert to DV risk upon identifying psychosocial stressors in this population.

Findings further exposed that sexual violence represents a particular concern for gender-minority youth (and possibly trans-females in particular) both in and outside of dating contexts, highlighting the likely role of trans-misogyny in the violent experiences of TGNC persons.

Until gender-identity is reliably and consistently captured in participant demographics, and DV measures validated with TGNC populations, evidence relating to the experiences of TGNC youth will remain inconclusive. It is reasonable to question, however, whether it is possible to statistically capture the complexity of gender-variance, and whether idiographic, qualitative inquiry is better suited to furthering understandings of TGNC risk.

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Section B

Undermined and Overdetermined Identities: A Grounded Theory of Barriers to Help-Seeking Among Trans Survivors of Sexual Violence

Word Count: 8,000 (384)

For submission to: Journal of Gender-based Violence

Abstract

Individuals identifying as trans face disproportionate risk of sexual violence, and yet are underrepresented among those who seek survivor support through statutory and specialist services. Though preliminary research suggests that perceptions of agency in help-seeking among trans survivors are bound to experiences of stigma, there has, to date, been little systematic inquiry into the specific help-seeking barriers for this population.

Reporting data from eight semi-structured interviews with trans-identifying participants and using a trauma-informed ethical framework, the present grounded theory analysis aimed to elucidate aspects of care-seeking perceived as challenging for trans survivors, and explore what a culturally-competent model of survivor support might look like.

Ten themes emerged through analysis, illustrating how blame, shame, objectification and various invalidations in public and institutional spheres serve to inhibit sexual violence disclosure and help-seeking for this group. The substantive theory suggests that support-seeking is compromised by a complex interplay between the hypo- and hyper-visibility of trans identity in its relation to survivorship and subsequent care needs, with trans and survivor identities experienced as mutually invalidating.

The study presents a case for how service-providers might work towards legitimating the experiences of trans survivors and facilitate care-seeking through commitment to inclusive models of survivor care.

Key words: trans, LGBT, help-seeking, sexual violence, stigma

Background/Rationale

Sexual violence (SV) is an undeniable public health concern. Though individual responses are complex and variable, SV has been consistently linked to myriad adverse psychological outcomes, including anxiety, depression, PTSD, substance abuse and eating disorders, as well as more commonly cited sequalae such as guilt and shame (Brown et al., 2019; Campbell et al., 2009; Dworkin et al., 2017; World Health Organisation, 2013).

The dominant cultural paradigm for discussing SV remains a gendered one, with assaults consistently and parochially figured as the violation of female bodies by men (Fileborn, 2014). Within this context, legal reform and activism has helped reduce systemic and psychological barriers to survivor help-seeking (Donovan & Barnes, 2020; Sable et al., 2006). Where survivors and/or circumstances do not conform to hetero-/cisnormative conventions, however, 'rape myths' (Burt, 1980) continue to pervade public and institutional spheres, perpetuating the experiential erasure of other victimised groups. Such myths typically comprise gendered stereotypes about what constitutes SV, and attributions of blame, including notions that assaults were provoked/desired, or that internalised homo-/transphobia has driven the accusation (Davies & Hudson, 2011; Peitzmeier et al., 2017; Rumney, 2008; Wakelin & Long, 2003). This may have serious implications for mental health, given that the nature of response to SV disclosure is a key indicator of psychological outcomes (Bonnan-White et al, 2015; Marriott et al, 2015).

Though a nascent literature on same-sex SV has sought to challenge prevailing discourses (Davies, 2002; Langenderfer-Magruder et al., 2016; Peitzmeier et al., 2017), the experiences of trans-identifying individuals; that is, people whose gender-identity does not correspond with their birth-sex; have frequently been discursively subsumed beneath the LGBT umbrella (Rogers, 2016). As such, scant inquiry has been made as to the experiences and needs

of trans survivors, and their relationships to help-seeking in such contexts, despite preliminary evidence of elevated victimisation rates within this demographic.

A Word on Trans Vulnerability to SV

SV encompasses several forms of assault, including attempted/completed rape, unelicited touch, and forced sex-acts. With SV understood foremost as a means of exerting power/control (Armstrong et al., 2018), intersectional inequalities render some marginalised/minoritised groups more at-risk than others. Among trans individuals, relationships between structural discrimination, and social exclusion, poverty and negative self-concept are posited as vulnerability factors (Murchison et al., 2017).

Trans SV in Context

Though recent attempts to gather gender-diverse population data were made through the 2021 UK Census, the number of trans-identifying people in the UK is presently unknown, precluding estimates of sexual victimisation risk. Research into trans-directed violence has more commonly been situated within a U.S. context, with national data suggesting a 29% past-year- and 47% lifetime prevalence of sexual assault (James, 2016). In further large-scale research, over two-thirds of trans participants reported multiple lifetime SV incidences, with almost half citing their gender-expression as a contributing factor (Munson & Cook-Daniels,2015). Relative to trans non-victims, trans survivors are four times more likely to attempt suicide and three times more likely to report substance misuse (Testa et al., 2012).

While UK-based research remains in its infancy, the emerging domestic picture appears to reflect the extraordinary levels identified in the U.S. Studies suggest that between 13% and 47% of trans individuals will experience at least one sexual attack within their lifetime (Bradley, 2020; Haynes & Schweppe, 2017; Roch, 2010; Valentine, 2015), compared with 3.9% of the adult population at large (Flatley, 2018). Alarmingly, over half of trans respondents

in McNeil et al's study (2012) reported knowing of the assault of a trans-identifying friend/acquaintance, rendering the violation of trans bodies endemic.

Records of help-seeking, however, belie these preliminary figures (Haynes & Schweppe, 2017, Hester et al, 2012; Mitchell & Howeth, 2009; Roch et al., 2010), with just one-in-five trans persons seeking SV-related support through statutory or third-sector services, and 98% of respondents citing their gender-identity as a major help-seeking barrier (Rymer & Cartei, 2015). For this same reason, 42% of trans survivors in Roch et al.'s pioneering study disclosed their assault to no-one or to only one friend (2010). In a qualitative comparison of the help-seeking patterns of various minority groups, trans participants emerged as the only population to avoid medical care, support groups, shelters and therapeutic contacts in favour of anonymous informal support functions, such as internet chat rooms and email support (Hester et al., 2012).

Though inconsistencies between victimisation and help-seeking figures should prove concerning to health/social-care professionals, there remains a dearth of inquiry into specific support-seeking barriers for UK trans survivors. What is suggested by the extant literature – though small, largely grey and frequently lacking in methodological rigor – is that trans individuals may face unique inhibitors to accessing care at psychological, social and structural levels. These have been hypothesised to include negative/dysphoric feelings when acknowledging disidentified body-parts (Harvey et al, 2014), perceived attributions of blame/incredibility (Rymer & Cartei, 2015; Turner et al., 2009), outing/confidentiality concerns (Haynes & Schweppe, 2017; Hester, 2012), and expectations/experiences of service-level transphobia (Bradley, 2020; McNeil et al, 2012). Though further inquiry is warranted, this literature suggests that perceptions of help-seeking agency for trans individuals are bound to experiences of stigma, with survivors anticipating further violence within social/professional systems of support. Certainly, in attempting to understand trans help-seeking, we might look

towards a gender minority-stress hypothesis (Hendricks & Testa, 2012), which maps how enacted and internalised transphobic discrimination leads to expectations of rejection or recrimination that (in this context) culminate in help-seeking avoidance.

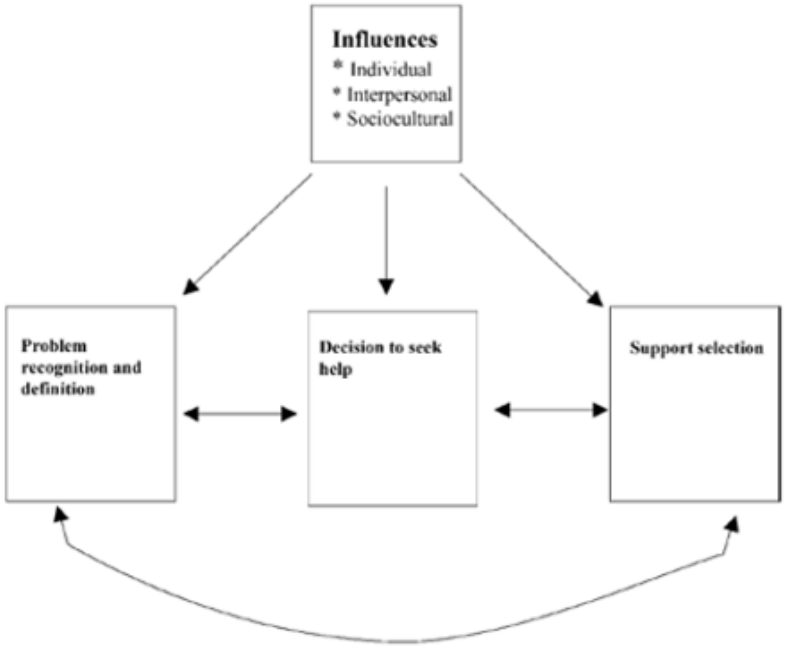
Trans-posing Models of Help-seeking

While many theories of help-seeking examine individual-level barriers (Fishbein & Ajzen, 2010; Rickwood et al., 2005), scholars have emphasised the importance of recognising the structural-systemic factors that undermine care-seeking within minority populations (Whitehead et al., 2016).

Liang et al.'s model of survivor help-seeking (2005) goes some way to considering this broader context (for cisgender females, at least), acknowledging decision-making as a multidimensional, nonlinear process shaped by personal/interpersonal/sociocultural factors that impact the recognition of support needs and the identification/availability of care provisions (Figure 1.). It is thus argued that survivors' appraisals of abuse and decisions around support-seeking are influenced by a dialectical interaction between the socially- and culturally-sanctioned narratives available at a given point in time.

Figure 1.

Liang et al.'s model of survivor help-seeking in the context of gender-based violence.



If we accept, then, that understandings of SV have remained bound to hegemonic cis-normativity, then the sociocultural shift towards tackling gender-based violence through policy/practice reform (Home Office, 2011; 2016) and social movements (see: Slutwalk; #MeToo) may be said to have sanctioned new help-seeking narratives for cisgender but not trans survivors. This is not to deny the continued plight of, or indeed, variation in the social/cultural contexts of cisgender women. Rather, it seeks to acknowledge that trans people's decisions around SV-related help-seeking may remain tethered to the same (as well as unique) socio-structural 'rape myths' – both imposed and internalised – that cisgender women have enjoyed some success in dispelling over the past half-century.

It is necessary, then, that new research seeks to transpose existing models of help-seeking through examining the complex interplay between (micro/meso/macro-level) stigma and service-use that exists for trans survivors.

Aims

The present research seeks to understand the processes impacting help-seeking for trans survivors. In doing so, it aims to further the nascent UK literature on trans SV experiences and contribute a much-needed schema for informing a culturally-competent model of survivor support. It is necessary to acknowledge that cultural-competence is a broad and indeed highly-contested term (Danso, 2018). For the reader's clarity, it is intended here to denote services and professional interpersonal practices that are informed by, and sensitive, relevant and responsive to the experiences of people of diverse gender expressions and identities, and which recognise their intersections with other dimensions of identity and social categorisation.

Specifically, the research will ask:

1. What are the personal/social/institutional factors that enable/disable trans individuals from help-seeking following SV?
2. What would a trans-specific culturally-competent model of survivor support look like?

Method

Design

Since SV in trans populations is presently under-researched, a non-experimental, qualitative approach was indicated. Constructivist Grounded Theory (CGT; Charmaz, 2014) is deemed particularly well-suited to exploring "uncharted, contingent… phenomena" (Charmaz, 2008, p.155), and, as such, was adopted as the guiding methodology. CGT seeks to explore the social processes present within participant narratives and works inductively through a process of simultaneous data collection and analysis to elevate data to the level of theory that is both 'grounded' in participants' descriptions and 'constructed' through mutual sense-making. Its emphasis on co-constructed meaning and explicit acknowledgment and interrogation of power, bias and influence within the research process makes CGT an especially valuable methodology

for work with marginalised and historically erased participant groups (Charmaz, 2011). Indeed, CGT has frequently been favoured in research into the help-seeking behaviours of trans-identifying persons (Carroll-Beight & Larsson, 2018; Poteat et al., 2013).

Consistent with CGT principles, extant theoretical literature was examined *a posteriori*, to allow for theory-generating, rather than theory-derived analysis.

Recruitment

Prior to participant recruitment, the researcher met with former service-users of a trans survivor support group, who consulted on study feasibility, potential oversights, and on the proposed interview schedule.

Purposive sampling was used to identify initial participants, with eligibility criteria outlined in Table 1.

Table 1

Eligibility criteria for inclusion in study

Inclusion	Defined as…
Adult	> 18 years
U.K.-based	
trans-identifying individuals	Inclusive of all gender-minority/gender-expansive identities, including, but not limited to: trans/transgender, genderqueer, gender non-binary/non-conforming, three-spirit, agender or gender-fluid.
who identify as having experienced some form of sexual violence (not within six months of participation in research to allow for sufficient processing of the event)	Any form of victimisation that was both sexual in nature and experienced as violent, as self-defined by the participant.

Due to the sensitivity of the research topic and matters of research fatigue/scepticism in trans populations, the researcher established relationships with moderators of three online forums and one third-sector organisation in order to gain trust and consent before accessing safe spaces for trans individuals. Once established, the study was advertised using a recruitment poster and accompanying research website detailing study information alongside information about the researcher (Appendix B). Theoretical sampling followed, with early data analysis

informing revisions to the interview schedule and from whom subsequent data was sought. In this way, data collection was guided by the emerging theory, with early theoretical propositions tested empirically.

Sample

Aligned to the practice of theoretical sampling, an iterative approach to data collection, analysis and theory development was taken, with an initial analysis conducted following the first three interviews and early trends informing the characteristics sought in the next wave of participants. Three further interviews formed the second wave of data, after which two more elaborated the theory to the point of theoretical sufficiency. Sufficiency is said to be achieved when "fresh data no longer sparks new theoretical insights" (Charmaz, 2006, p.113), and is frequently operationalised at 8–16 participants (Dey, 1999).

Sample demographics are listed in Table 2.

Table 2.
Self-reported participant demographics

Pseudonym	Age	Gender-identity	Pronouns	Sexual orientation	Employment status	Racial identity
Cara	23	Trans female	She/her	"Confused"	Employed	White British
Charlotte	34	Trans female	She/her	Pansexual	Employed	White
Roisin	45	Trans female	She/her	Lesbian	Employed	White-ish
Albert	27	Trans male	He/his	Gay/bisexual	Student	White British
James	23	Trans male /non-binary	He/their	Queer	Employed	White British
Oscar	49	Trans male	Mx	"Me"	Long-term disabled	White British
Rosa	51	Trans female	She/her	Fluid/bi-curious	Self-employed	White British
Alison	57	Trans female	She/their	Pansexual	Long-term disabled	White British

Procedure

Due to COVID-19 social distancing requirements, interviews were conducted via Skype™. Each began with an opportunity to address outstanding queries. Prompted by open-ended interview questions (Appendix C), participants were then invited to discuss their experience of SV and help-seeking.

Seven interviews were audio-recorded, yielding 113–214 minutes of data (Total:1,049). Adjustments were made for one participant, who was deaf and opted to utilise the 'chat' function to read/respond to questions. Care was taken to encourage detailed responses, and to follow/probe divergent narratives.

Interviews were later transcribed verbatim.

Ethics

Research involving participants exposed to traumatic life-events requires additional ethical consideration (Seedat et al, 2004). Certainly, reflecting on traumatic/peri-traumatic experiences may be sufficient to cause significant distress, while latent responses to insidious trauma (microaggressions) can be activated by seemingly minor stressors (Richmond et al., 2012). A trauma-informed approach to design was thus adopted, with research procedures aiming to continually support survivors' empowerment, choice and control (Campbell et al., 2019; see subsections for how this was operationalised) and adhering closely to specific trauma-informed guidelines for research with both trans participants and SV survivors (Adams et al., 2017; Faulkner, 2004; Morgan & Taylor, 2016).

Ethical approval was granted by the University's Ethics Panel (Appendix D).

Informed Consent

The need to communicate transparency and agency was recognised as paramount. Potential participants were issued with an information sheet detailing the nature and purpose of research, onward support agencies and all information necessary to making an informed choice regarding participation (Appendix E). Those wishing to participate received a consent form for their perusal and signing prior to interview, which highlighted their right to withdraw from participation without consequence (Appendix F). Consent was revisited throughout the course of participants' involvement.

Confidentiality

Issues pertaining to confidentiality and/or 'outing' are known to be of particular concern for trans individuals (Haynes & Schweppe, 2017) and survivors alike (Campbell et al., 2019). Though the benefits of 'face-to-face' contact in providing a supportive/safe environment were emphasised, participants were given the option to attend interviews off-camera (all declined). Limits to confidentiality were stated verbally and in the participant information.

Data was stored securely in accordance with GDPR and data protection requirements. Identifying information (to which only the researcher had access) was stored in encrypted electronic form on a password-protected USB and kept separate from interview data. Interviews were anonymised during transcription and audio-recordings deleted thereafter. Participants were encouraged to choose their own pseudonyms both to avoid potential overlap with names they may have experimented with during transition and in acknowledgement of the significant safety and confidentiality risks that research dissemination poses for SV survivors.

Debriefing

Opportunities for debriefing followed each interview, with the aim of both providing further information about the nature of the study and identifying/addressing any distress/re-traumatisation participants may have experienced through their involvement. Six participants accepted the offer to discuss their experience of talking, with no adverse effects reported.

Participants were also asked whether they would like to review their transcripts and receive a copy of the final report (Appendix G).

Data Analysis

Data was analysed through a process of coding and constant comparison (Willig, 2008), with NVivo-12 utilised to assist the analytic procedure.

Analysis began with a deep reading to establish familiarity with each transcript. A line-by-line coding strategy was employed, with each data-unit coded for the action it described as

a means of elucidating social processes present within the data (Charmaz, 2014). Focused codes were developed from the most frequently occurring initial codes, and were used to sort/synthesise data describing conceptually similar processes (Appendix H). Analysis moved in this way to a higher level of abstraction whilst remaining grounded in the particularity of participants' words (Charmaz & Thornberg, 2020). Focused codes that were substantiated through further data collection/analysis were elevated to subthemes. Those that did not find additional empirical support were further analysed and collapsed into alternative codes where indicated.

Through the relationships between subthemes, a narrative of superordinate themes took shape, informing the development of a theoretical model representing support-seeking barriers. Themes were identified based on their prevalence, but also their capacity to shed new light on phenomena/illuminate other aspects of participants' accounts. Diagrams were used to illustrate the relationships between thematic concepts and their interdependency (Strauss & Corbin, 1998; Appendix I).

Finally, themes were cross-checked against the transcripts to ensure trends had not been overrepresented (Willig, 2001).

Quality Assurance

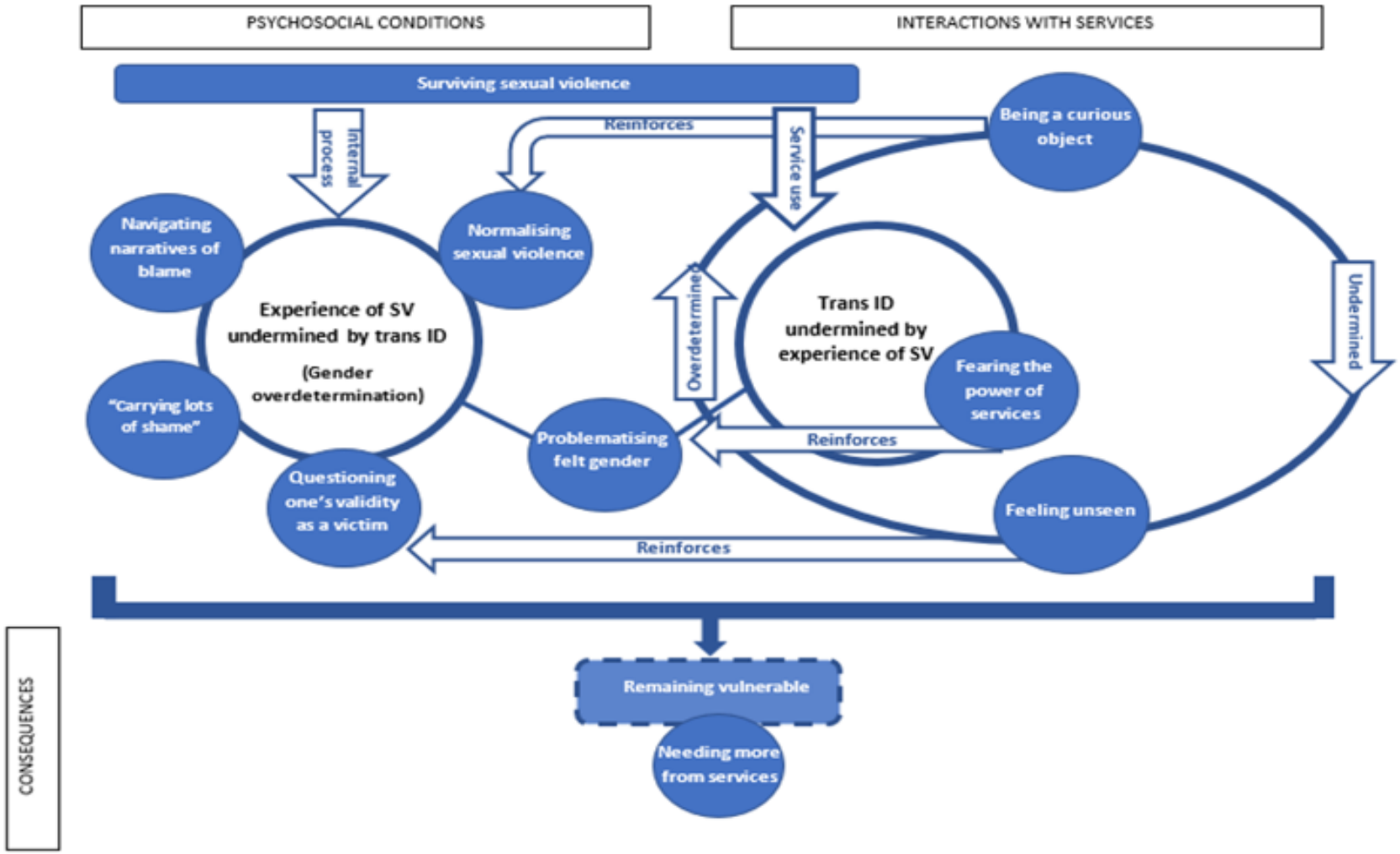
CGT emphasises reflexivity, urging researchers to reflect upon their role in the research process and acknowledge their identity/power within it (Charmaz, 2014). Attendance to how research can accentuate power structures is especially pertinent in work with marginalised populations. Recognising the potential to perpetuate the misrepresentation of trans personhood, the researcher employed ethical validation principles by seeking participant feedback on the credibility/experiential resonance of theoretical propositions. Coding and model development were also cross-checked by peer researchers/supervisors at various stages to lend rigour to analysis.

Memoing, as a "written record of reflexivity" (Birks & Mills, 2015, p.53) functioned to facilitate openness to discovery and analytical transparency (Appendix J). Any extant concepts/judgements identified were scrutinised in such ways as to earn any place afforded to them within the analysis (Glaser, 1978). Reflexive diaries chronicled the researcher's engagement with the process (Appendix K).

A bracketing interview, conducted prior to data collection, brought awareness to the researcher's subjectivity and assumptions, and was used to inform a positioning statement (Appendix L).

Figure 2.

"Undermined and overdetermined identities": A model of barriers to help-seeking for trans survivors of sexual violence



Results

The model presented overleaf offers a theoretical understanding of barriers to support-seeking for trans SV survivors, and represents a CGT analysis of eight participant narratives (Figure 2.).

Model Summary

Analysis led to the emergence of a central theme: 'Undermined and overdetermined identities', which captures that at heart of help-seeking for this group lies fear and/or experience of trans identity being undermined or overemphasised in its relationship to SV.

The model encompasses 10 themes set around the organising principle of contextual 'conditions', 'interactions' and 'consequences' to demonstrate process within the hypothesised theory (Strauss & Corbin, 1998). The conditions of decisions around support-seeking represent internal/internalised states, and include the themes 'navigating narratives of blame', '"carrying lots of shame"', 'questioning one's validity', 'normalising SV' and 'problematising felt gender'. These themes revolve around a core notion that one's identity as trans undermines one's identity as a survivor, and as such serves to delegitimate the experience of SV for the individual.

The theme 'fearing the power of services' speaks to an equal and opposite process, with real and imagined service interactions demonstrating a sense in which trans identity is clinically undermined by the experience of trauma. This echoes a wider experience (represented by the larger circle) of trans identity being either always-already present ('being a curious object'; overdetermined) or transphobically absent ('feeling unseen'; undermined) in service-provider contacts more generally. Such interactions in many cases reinforce the psychosocial conditions that lead to minimising trans experiences of SV.

'Remaining vulnerable' represents the consequence of cyclical hyper/hypo-visibility within institutional and public domains, with both perceived to maintain/reinforce vulnerability to SV. The permeable boundary around this theme acknowledges participants' expressed hope

that services could be helpful in breaking the cycle of vulnerability, with the theme 'needing more from services' issuing an implicit appeal.

Table 3. presents an overview of themes/subthemes.

Table 3.

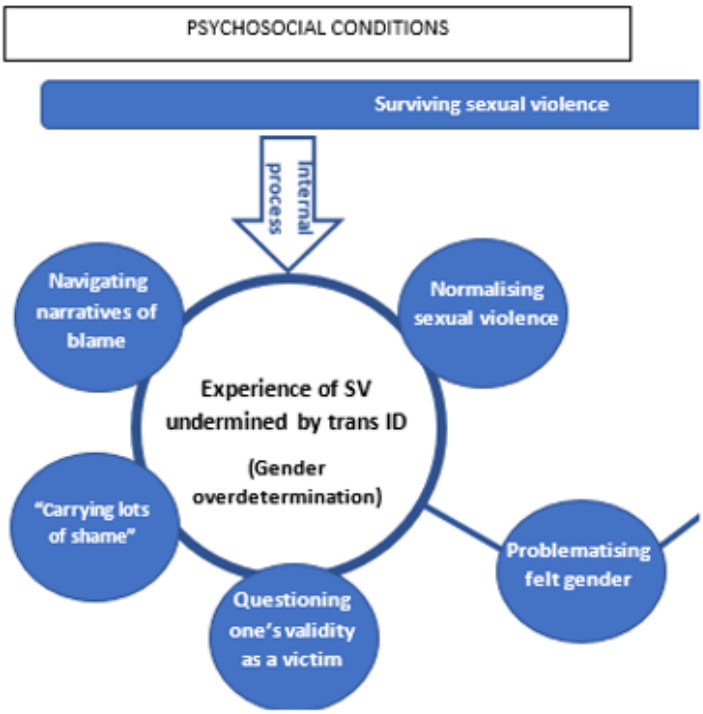
Themes and subthemes constituent to the model of help-seeking barriers for trans survivors of SV

Process	Theme	Subthemes
Psychosocial conditions	Navigating narratives of blame	Blaming the self Sexualising trans people Victim-blaming
	"Carrying lots of shame"	Compounding the experience of shame Losing control of a carefully curated transition Outing self / being outed Being too self-conscious to seek support
	Normalising SV	Anticipating the bad Failing to recognise abuse
	Questioning one's validity as victim	Being believable Being lesser Battling the public imagination
	Problematising felt gender	Problematising felt gender Complicating feelings about transition
Interactions with services	Fearing the power of statutory services	Worrying that disclosure will impact transition Fearing the power of services
	Being a curious object	Being trans before being the patient Fielding questions about the body
	Feeling unseen	Invalidating my identity Negotiating the binary
Consequences	Remaining vulnerable	Distrusting services Coping in my own way
	Needing more from services	Promoting inclusivity Expecting trans-literate staff Being involved

Psychosocial Conditions

Figure 3.

Left hand side of the model: Trans identity overdetermined in relation to SV (experience of SV undermined by trans identity).



Psychosocial barriers to support-seeking were underpinned by the central notion that being trans served to overshadow participants' victimhood. This was experienced largely as an internalisation of transphobic stigma, which functioned to cultivate a conspiracy of silence among survivors.

Navigating Narratives of Blame

Participants recalled navigating multiple blame narratives in the aftermath of SV. Self-blame was prominent, and characterised as a felt culpability that was at once related and not related to being trans. Querying whether the survivor had "somehow wanted it"/"led [the perpetrator] on" (Albert/Oscar) was considered a universal victim experience. However, for many participants, self-blame was inextricably linked to having transitioned.

You think about all the things you could've done to prevent it…Like, with transitioning… transitioning is a choice...It would be difficult for me to not think, well, maybe if only I'd stayed a boy... (Cara)

Self-blame attributions frequently conveyed an internalised transphobia, and the immediate appraisal that assault was somehow deserved. Survivors spoke of introjecting narratives regarding having misrepresented or fetishized themselves, or violated acceptable gender-roles.

…this idea "I brought this on myself "[…]is definitely very easily internalised…I deserved it because I'm not a real woman or a real man. Because I tricked you. (Albert)

Self-blame narratives were consistently supplemented by real or imagined accusations of culpability from within participants' immediate networks and the wider populace. An awareness of transphobic discourses and how survivors' lifestyle choices might be scrutinised in the context of SV was persistently present.

We've all been to Facebook comments…It's like, well, this is why it's happening. You deserve it because of your lifestyle. (Albert)

[My ex] felt it was my fault…friends telling me it was my fault…"You're dressed as a girl in a short skirt and high-heels, what do you expect?" (Rosa)

Relatedly, participants conveyed a deft awareness of how social misunderstandings of trans personhood, perpetuated by structural-systemic discriminatory practices, might confer responsibility for assault onto trans survivors. Specifically, an understanding of trans bodies as always-already sexualised in the public imagination left participants with few expectations of an empathic response to disclosure.

We're not seen in a very good light. As though we're always wanting sex or being sexual…And some trans women do end up in sex work because it's the only work they can get. (Alison)

Trans identity is wildly fetishized. Sexualised...When people read transgender, they also read paedophile, prostitute…Every single negative connotation that can come from sexual misgiving. And so no-one cares. (Charlotte)

"Carrying Lots of Shame"

In considering barriers to support-seeking, participants recounted a deep and debilitating sense of shame. Indeed, the concept of shame was used by one participant to encapsulate "what it's like to be trans" (Albert). There was a complexity to the experience of shame, which connected the shame of being assaulted with shameful feelings about identity on the one hand, and about the disidentified violated body on the other.

There's a weird link between SV and being trans…You're in denial[…]until somebody[…]says, "It's fine, you're not bad...Don't be ashamed". SV is kind of the same. (Alison)

It's the same [trauma-related] shame. Although for trans people there is-, gosh, it becomes very complicated. When it happened to me, I had different genitals…So that's different. That's a different shame. (Roisin)

Despite acknowledging their support-needs, identity-related shame was enough, for most, to prevent/delay help-seeking, and was noted to override the negative consequences of trauma, with the "fear of being found out so much stronger than anything else" (Rosa). Embarrassment in disclosing trans identity/behaviours was coupled with a generalised negative self-concept, and shame (in trans-women) at having "surrender[ed] male privilege" (Rosa).

I didn't have the self-worth to believe that I could [help-seek]…The fact that I even exist[…]was something I was ashamed of…I didn't feel like I deserved [support]. (Cara)

[It was] how I felt about myself…I was still so embarrassed…And the fact that I'd have to expose myself to these people....(Charlotte)

Presenting to professionals as trans was just one area of concern. Through help-seeking, survivors anticipated their lives being exposed far beyond the services they approached. Many emphasised a need for "secrecy"/"anonymity" (Rosa/Cara), which services were not trusted to adhere to. Fears ranged from their story "ending up in the press" as trans-negative "propaganda" (Alison) to losing control of their transition journey and being outed.

Having that area of my life exposed more widely and having it fall outside my control was terrifying…Everything about my transition was meticulously controlled…That control made me feel safe. (Charlotte)

I felt if I reached out, I'd just set a ball rolling that I couldn't then stop…and before I knew it the world would know. I wasn't ashamed so much that somebody had raped me. I was ashamed that people would know I was dressing-up and having sex with men. (Rosa)

Normalising SV

Notwithstanding the myriad psychological sequalae of abuse, participants described how SV became imaginally absorbed into a wider system of trans-directed violence, forming part of a broader, normalised trauma narrative.

It's just a part of the life that you're going to get harassed, assaulted or, like, abused in sexual ways. So, it just felt part of it…Kind of normal, which is sad. (Albert)

We just think here we go again. (Alison)

Survivors characterised SV as "expected" (James), and conveyed a resignation and "acceptance among trans people that it's going to happen" (Rosa). With SV "endemic" (Roisin) within trans communities, participants observed how the violation of trans bodies was downplayed such that abuse frequently went unidentified. This was felt to be echoed outside of the community, with trans-directed violence sanctioned by media and authorities.

Trans women don't even view the violation of their bodies as abuse…They just see it as a little incident, another happening or another bullying. Just a drop in the ocean. (Roisin)

Take Jerry Springer…getting people to sit with some guy they've been dating and say "there's something I haven't told you. I'm really a man". And then everyone boos and they get violent towards them…It's just conditioning people. Telling people that's the way you react. (Rosa)

The widespread normalisation of assault within and beyond trans circles was noted as a key barrier to reporting/disclosure.

Questioning My Validity as a Victim

Participants described questioning their victimhood, with fears about being disbelieved a core concern. While many acknowledged such fears as common to all survivors, participants also felt that being trans impacted their perceived credibility, with most anticipating/experiencing the dismissal of their assault on account of their gender-identity.

Because a straight person will always be treated differently to a trans person, you start to feel, am I valid? Will they listen? (Alison)

Blown-off. Didn't feel listened to…It was to do with my perceived gender. (Roisin)

Indeed, for some participants, the reputation of trans people as unreliable narrators of their own bodily experience was felt to precede them, leading to additional caution in decisions around help-seeking for fear of the perception of "crying wolf" (Rosa).

It's like, "You need to prove[…]that you're a reliable source of information". I mean, yes, there are people out there trying it on...Who do we see, for example, in the media from the trans community? People who've gone through transition, realised it wasn't for me and want to go back…That makes other people think the way they do, because it's the only thing we're ever hearing about – mind-changers!...This is why victims won't go to police or services. (Oscar)

Survivors' credibility as a victim was evaluated relative to cisgender women, with a unanimous sense that their diminished societal status afforded them fewer opportunities for validation. Enmeshed within this already-established hierarchy of credibility was the perception that trans victimhood would be negated by the socially-sanctioned dehumanisation of trans people.

It's very hard for us to go in as the victim, because we're demonised a lot. There's a lot of propaganda about us being predators. (Alison)

Trans people are seen as lesser and therefore whatever happens to them doesn't happen to a person...One that often comes up is, "trans women will never experience the vulnerability of being raped"…Because most people don't see them as women, they don't think SV against us is bad. (Charlotte)

Problematising Felt Gender

The theme 'problematising felt gender' is itself problematic, uniquely straddling categorisation within the undermined/overdetermined paradigm. Here survivors describe a psychological process through which one's sense of gender is challenged by the experience of SV, the effects of which must in turn be undermined as a means of safeguarding the integrity of trans identity:

Participants recalled gender-related confusion in the aftermath of SV. Although most recalled identifying differently from childhood and had long been experimenting with gender,

assaultive experiences were felt to complicate an already confusing journey, in some instances provoking “a massive conflict” (Rosa).

Like, what does this mean for my manhood?...Being a trans man? It’s still something I think about. It’s complicated. Problematised by[SV]. (Albert)

I knew I was trans since I was very little, but…I second-guessed myself. Was I wanting to be trans to get away from it all? (James)

SV also impacted feelings about transition. Some participants described how the abuse precipitated a “regress[ion]” in their transition journey (Charlotte), causing them to “pause”/reconsider (Rosa). For others, the assault created an urgency to expedite transition, making them “more determined, because life is short” (Oscar).

The abuse probably suppressed [my femaleness]. Because that was a vulnerable side of me. (Alison)

Where the psychological effects of SV posed a challenge to their sense of self, participants perceived a degree of risk in support-seeking. For many, it was deemed necessary to conceal the internal conflict, undermining the effects of violence as a means of protecting the consistency of others’ current (for those who were ‘out’) or future perceptions of their gender-identity. Indeed, as one participant put it: “We have to stay passionate about [being trans] so that people believe us.” (Rosa).

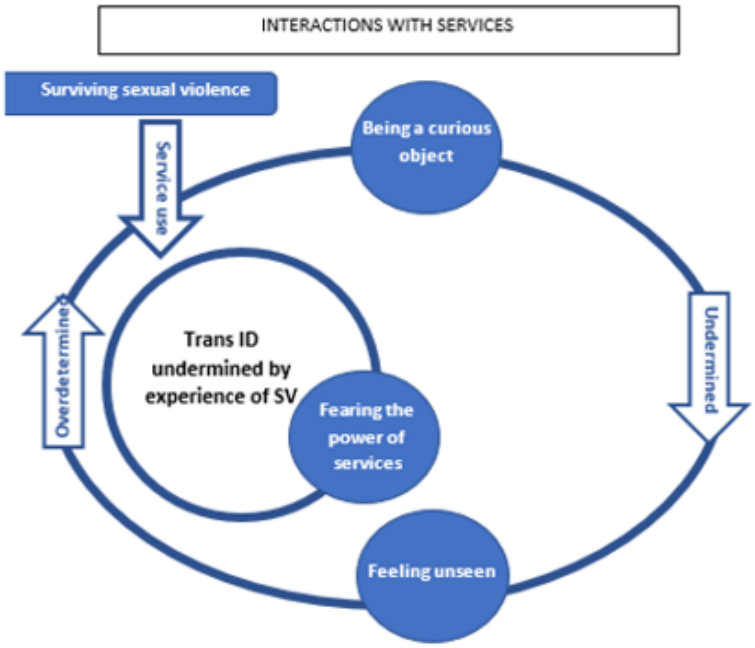
It’s something the mean voice in your head says…Like when people say, y’know, you're gay because you were molested…So yeah, that [made help-seeking] a concern. (Albert)

It’s one thing you have to be careful about saying. (Alison)

Interactions with Services

Figure 4.

Right hand side of the model: Trans identity undermined by SV (and cyclically undermined and overdetermined in service-provider contacts more generally).



Where the left-hand side of the model depicts the conditions under which trans identity is employed either personally or socially as a vehicle for minimising SV experiences, with the effect of impeding help-seeking, the right-hand side represents an opposite process, with SV-related trauma used within services as a means of clinically/professionally undermining trans identity. Though the delegitimising of trans personhood within support settings was felt to extend beyond SV presentations, gender-identity was felt to be equally (and paradoxically) hyper-visible during professional contacts, in much the same way as experienced in the public domain. As such, participants described a broader experience of vacillating between being unseen/invalidated and overseen/overpronounced within support contexts.

Fearing the Power of Services

Participants frequently characterised professionals as powerful, and felt that that power was to be feared. There was an anticipation of discriminatory practices among service-providers that echoed survivors' everyday experiences with prejudice, and which, when combined with the perceived power imbalance, marked service-use unsafe.

People who are discriminatory against you are only dangerous[…]when they have power…So, if it's, say, your G.P.[…]or police and you need them to be intimate with you…then no! Just no! From experience. (Roisin)

They started medicating me, and I didn't like it…I said I had every reason to hate my body…But her thoughts on the matter were very religious-led. (Oscar)

One of the core ways in which survivors anticipated professionals exercising prejudicial power was in relation to treatment around their transition. There was a collective acknowledgement of the parallels drawn by clinicians between sex/gender incongruence and mental health disorders, with many fearing that trauma disclosure would give credence to a psychiatric understanding of trans identity, and be employed as an argument to block transition. Subsequently, participants described "an incentive among trans people to avoid using NHS mental health services" lest it "limit their access to other things" (Cara).

[Counsellor] threatened to phone my GIC and tell them I'd been horribly abused and to stop my transition…in which case I'd have a double burden – the burden of being a survivor, plus having my transition halted because of it. (Roisin)

It's easy to say you should seek help, but[…]they would've refused to give me the surgery. (Rosa)

Those that had gone some way towards help-seeking following the assault recalled an unwelcome insistence that their gender-identity was trauma-related, with experience/awareness of this appraisal leading some participants to avoid services.

Double-guessing. Asking me am I sure. Am I using being male to hide what happened…I've been asked it in psych by pretty much everyone. (James)

I'd have to be seriously, seriously unwell…I don't want to have to justify the fact that I'm trans. (Charlotte)

The threat to identity posed by professional interrogation was noted to echo and feed the internal conflict experienced in the pre-contemplative phase of help-seeking (see *'Problematising felt gender'*), with the effect of participants doubling-down on efforts to suppress feelings arising from the traumatic encounter.

Research doesn't suggest that trauma causes being trans. But, like, because I've experienced trauma before transition, the link seems obvious[…]I can't tell [psychologists] the truth. If I do, I run the risk of them saying that. (Cara)

Feeling Unseen

Experiences of service-level erasure were felt to extend beyond the reduction of identity to a trauma-response. Many survivors perceived clinicians to apply "zero effort" (Cara) to respecting their gender-identity, and conveyed how frequent microaggressions (deadnaming; deliberate/ungainly misgendering) functioned to painfully invalidate their personhood.

Every time they say Milly, it's traumatising. (Oscar)

[Clinicians] referred to me as her father in front of other patients...It was so awful...Therapists, psychiatric nurses, every single one along the way negated me. (Roisin)

The expectation that survivors should disclose trauma to services that were themselves perceived to be (re)traumatising was thus jarring.

If my basic level isn't being respected then anything above and beyond that-, why should I trust that that's going to be taken seriously? (Oscar)

I'd rather suffer, because[…]these people are very acutely transphobic and it can be really damaging. (Roisin)

Negotiating binary pathways and "cis-centric" systems (Roisin) was experienced as a further example of institutional trans-erasure. Participants' knowledge of how support provisions were configured fostered a sense of "imposter syndrome" (Charlotte) when attempting to imagine a space for themselves in services, echoing earlier difficulties in positioning themselves as a victim (see *Questioning my validity*).

Barriers to trans people accessing services happen because they feel like they don't belong. (Charlotte)

They don't explicitly say, but you get the impression that you're always in the wrong service. (Cara)

I've been told I should go to support groups[…]but I don't fit into either male or female groups. (James)

Contrary to how they saw themselves represented in politics and the public sphere, many participants described an implicit respect for traditional women's spaces and a discomfort in disrupting the status-quo, despite a clear, regrettable understanding that this left them without support.

I don't want to go to men's groups because if I get a flashback with a bunch of men around me…But I'm not[…]kicking in the door saying, "I'm coming here instead". That's a women's space. (Alison)

I needed help but I didn't want to upset anyone…But to think that I beat myself up so much over upsetting other people when I was so distressed is really sad. (Roisin)

Being a Curious Object

Alongside experiences of erasure, participants conveyed a paradoxical sense in which the transitioned/transitioning self was over-emphasised in care-seeking contexts. Survivors

referenced an unwelcome clinical fascination with trans bodies, with clinicians felt to assume "intrusive", "insensitive" and dehumanising (Albert) levels of intimacy.

[Clinicians] ask all these really personal and invasive questions...Like, our life isn't your entertainment! Why do you want to know? You wouldn't ask it to anybody else. (Charlotte)

The experience of one's body being "everybody's business" and even "groped by nurses" (James/Roisin) appeared to resonate with the community's resignation to unsolicited touch (see *Normalising SV*), replicating abusive social contexts, as well as being potentially dysphoria-inducing.

It's kinda normalised for them to ask trans people about their genitalia. They don't see it as wrong, and[…]they don't see how something that "isn't wrong" could trigger something that is so wrong…I hate it, but it's expected to an extent. (James)

The concept of 'trans broken arm' (wherein being trans is deemed clinically relevant regardless of the individual's reason for presenting) featured heavily in survivors' clinical encounters, echoing social experiences of being trans first and foremost to the exclusion of their humanity. Participants unanimously recalled a professional preoccupation with their gender-identity at the expense of their support needs, leading in some instances to their being dismissed by services. Though this was experienced across contexts, particular frustrations related to how this impeded addressing their sexual trauma.

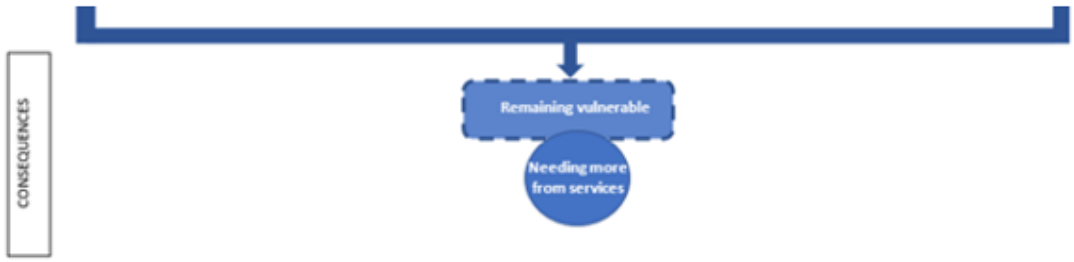
I paid for a therapist experienced with PTSD for SV and…it was like, "Oh, I can't help you with trans issues"! (Cara)

He completely ignored the[...]abuse and instead hammered on about surgeries and hormones…Where they should be supporting the emotions and carrying you[…]they spend their time sort of coming to terms with you. (Roisin)

Consequences

Figure 5.

Consequences of cyclical hyper-/hypo-visibility.



Remaining Vulnerable

Participants suggested that the above combination of psychosocial and service-user experiences functioned to reify an existing sense of vulnerability. Stigma and evidence of systemic bias stimulated a deep distrust of services, with subsequent help-seeking avoidance maintaining their position of risk.

> *The reason it's easy for people to perpetrate SV against trans people is that there's such stigma around being trans…You can almost do anything you like to them and know they're never going to speak-up. (Rosa)*

Avoiding disclosure for fear of trans-negative reactions was felt to further maintain vulnerability in terms of survivors' risk to self while grappling with the emotional fallout of SV alone. With no outlet for their distress and efforts to "shove it down" failing (Roisin), many participants described turning towards maladaptive coping.

> *You cope with lots of alcohol! I have issues with substances (Albert)*
>
> *I should have been able to seek help. I was on the verge of taking my own life. (Rosa)*
>
> *Punishing yourself…Drunk every night...Any way I could escape, I would. (Oscar)*

Needing More from Services

Seeking a space for validation of both their trauma and personhood appeared to be survivors' foremost concern. Many had a clear concept of how this might look, with a validating environment figured as one in which they would "have the trauma accepted" (Rosa), "not have to explain [them]selves", and where "no-one gives a shit that [they're] trans" (Albert). Though it was agreed that the promotion of trans-acceptance in services would be a first step to regaining their confidence, variation existed between survivors as to how this could be communicated. For some "something simple, like a trans flag" (Rosa) would serve as an "explicit indicator that it was a safe place to go" (Albert). Others felt sceptical of such strategies, deeming them empty and performative.

> *Some condescending picture on a website? "Look, we've met a trans person. That means we care". Whatever! That's for the cameras. (Alison)*

Rather, most participants felt so deeply misunderstood within services – with providers often "stumped by [trans] experiences" (Roisin) or else "putting them in a box based on what they think trans is" (Oscar) – that inclusivity and competence was only deemed demonstrable through trans-literacy and training.

> *They need to understand trans for themselves, rather than expect me to educate them during appointments. (James)*

Participants emphasised the need for survivors to be involved in training and service-design, with many professing "a strong desire" (Rosa) to contribute to the positive visibility and demystification of trans people among service-providers.

> *Fire questions at me. Don't worry about how politically-incorrect…Like a workshop…Because if they're not comfortable sitting[…]and asking [a trans person] any question they want, how can they sit with survivors in an appointment? (Oscar)*

Participants also implied that feeling accepted within services would demand undermining/expanding binary pathways. Few survivors wanted/saw sense in trans-specific support groups, rather wishing to integrate with cisgender survivors, and present to services without having to negotiate their entry. Indeed, services were urged to ensure that viable trans-inclusive support options were pre-defined.

We need to not have everything gendered (James)

Wanting to integrate…Because we're all men, but we're all different. Like, I'm a man, but I'm a trans man. And then someone else is like, I'm a man but I'm a black man…Catholic…Working-class. (Albert)

There would be a full list [of inclusive services] already...Proper investigation to show what's felt...Like, we've tested this group and they're supportive of trans survivors. (Alison)

Discussion

The present study proposes a model of barriers to help-seeking for trans SV survivors. Encompassing themes of blame, shame, objectification and various invalidations, the emergent theory posits that support-seeking is compromised by a complex and cyclical interplay between the *hyper*visibility of trans-ness in its relation to assault and care needs, and the *hypo*visibility of trans-ness as a legitimate and accounted for identity, with individual-, social- and institutional-level stigma combining to either undermine or overdetermine trans (and by extension, survivor) identity at each stage of help-seeking contemplation. Participants imagined that services could work to legitimate their experiences and thus facilitate care-seeking by developing a trans-specific cultural-competence, which integrates inclusive policy and gender-expansive service-configuration with bias-awareness training, service-user consultation and trans-literate staffing.

Findings are now discussed with reference to existing theory.

Evil Deceivers/Make-believers

The perverse cycle of under/overdetermination highlighted in this study echoes Bettcher's deceiver/pretender paradox (2007), which describes how trans identity becomes culturally characterised as either deceptive in its invisibility (and therefore contemptuous), or else a visible pretence (and thus fictitious), rendering personhood and all experiences relating to that personhood "doubly delegitimate[ed]" (Fig 3.).

Figure 6.

Excerpt from Evil Deceivers and Make-Believers (Bettcher, 2007, pp.51).

> Through such a construction, we will invariably be represented as deceivers or pretenders. This has the effect of doubly delegitimating our own voices by constructing us as both fictitious and morally suspect. Hence, after identity enforcement, nothing we might say could possibly matter. A framework has been deployed whereby transphobic violence may be excused or justified on the grounds that deception had been involved. The only latitude appears to involve the degree to which our pretense is viewed as harmless make-believe

The present study adds empirical evidence to Bettcher's theoretical assertions, and lends support to the pervasiveness of this construction, with SV imaginally or experientially undermined/excused by survivors' characterisation as 'deceiver' and sympathised with only on the condition that identity is reduced to a dissociative response. In help-seeking contexts, then, trans survivors seem prohibited from existing in the fullness of themselves, with victimhood and trans-ness positioned as mutually invalidating.

Concern that trauma disclosure might lead to the dismissal of identity claims – or worse, compromise medical transition – was proposed as a key help-seeking barrier, and appears to be a unique finding in the empirical literature on trans SV. Such fears arose jointly from both a personal sense that SV had troubled survivors' gender-identity (despite prior, and often early awareness of sex/gender incongruence) and from known clinical opinion that trans identity

results from sexual trauma (Davy, 2015; Devor, 1994). While at first glance survivors' confusion seems to support clinical assumptions of a causal relationship between SV and trans identification, it is likely that participant narratives build on indications within the wider SV literature that rape can precipitate temporary sexual-identity confusion where victims' sexual orientation and the sex of their attacker are misaligned (Myers, 1989). In the case of cisgender survivors, however, notions of causality between SV and sexual-identity have long been discredited (ibid.). If trans and cisgender narratives of identity confusion following SV do indeed represent equivalent psychological processes, then this has important implications for how trans identity is understood, and may go some way to challenging the continued assumptions of causation among service-providers that (here, at least) deter trans survivors from help-seeking.

Participants' querying of the validity of their victimhood in the minds of others appears to illustrate the alternate side of Bettcher's paradox. Though exclusion from victim status may reflect the feminist paradigm of SV, echoing male rape literature (Depraetere et al., 2018), participants' concerns about their credibility in this study has less to do with gender and who qualifies as sufficiently vulnerable to secure empathic help-seeking responses than it does the societal status of trans people and constructions of trans-deviancy. Survivors described lacking faith in the ability of potential support resources to reimagine them outside of stereotypes that sexualise, or worse, demonise trans people, or indeed in contexts that did not question their soundness of mind/intention.

Minority-Stress

It is scarcely possible to interpret participants' anticipation of blame and rejection, experience of stigmatising practice/narratives, and exclusion from services without attendance to minority-stress theory, which posits that the systemic discrimination of minority persons

leads to internalisation of negative societal attitudes, identity concealment, and expectations of adverse outcomes (Meyer, 2003). The present study therefore lends support to a growing literature that attributes variations in trans health and healthcare use to experiences of stigma and prejudicial practice (Hendricks & Testa, 2012, Lefevor et al., 2019).

A clear example of minority-stress was noted in participants' anticipation of unsafe experiences with power, which for many had been substantiated by prior exposure to bias-based iatrogenic violence (receiving inappropriate treatment/medication; dismissal of identity claims; misgendering/dead-naming) and service-level exclusion. Rejection sensitivity owing to experiences of institutional discrimination has been cited as a specific minority stressor affecting help-seeking (Scheer et al., 2020). In the context of sexual abuse, service-level disempowerment and insidious trauma may serve to replicate experiences of powerlessness and lack of bodily autonomy faced in SV victimisation.

Shame took on a minority-stress-specific quality for trans survivors, with the more commonly-reported trauma-related shame identified in the broader SV literature (Shin et al, 2014) coupled with shame about gender/natal sex disclosure. Since gender is integral to identity, gender-related shame may be considered a pervasive attack on personhood, characteristic of internalised stigma. That the shame conveyed by trans survivors is more dispositional than situational may shed new light on disparities between trans and cisgender help-seeking following SV, calling for further research into interactions between identity- and trauma-specific shame for this population. Moreover, since shame has been linked to the devaluing of personal safety (Mendhelson et al., 2007; Straub et al., 2018), it is possible that self-stigmatising appraisals (informed by social/institutional rejection) divest trans survivors (and communities) of the protective dignity that might otherwise facilitate care-seeking.

Liang's Help-seeking Model

As anticipated, Liang's model of help-seeking contemplation (2005) is well-suited to understanding the processes conveyed by participants, with analysis elucidating how individual, interpersonal and sociocultural cisgenderism impacts both problem recognition and the availability of appropriate support agencies for trans survivors. Fricker's bipartite notion of 'epistemic injustice' (2007) provides a useful theoretical frame here, with survivors seemingly finding themselves vulnerable to both 'hermeneutical injustice', wherein their assaultive experiences are unintelligible to themselves/others due to the absence of frameworks for interpreting SV beyond the cultural imperative of assigned-sex/gender alignment; and 'testimonial injustice', whereby their speaking-position as trans renders their accounts of violence, identity and the relationship between the two less credible. Certainly, participants' tendency to question/have questioned their victimhood, culpability and experience of gender following SV is suggestive of testimonial scrutiny, while experiences of clinical reductionism ('trans broken arm'/genital curiosity) and exclusion from binary services represent a systemic failure to interpret the nuances of gender. Survivors' lack of confidence in the possibility of satisfactory help-seeking experiences thus appears substantiated by the sociocultural context in which SV occurs.

'Trans broken arm syndrome' is seen regularly in empirical studies of trans healthcare usage (Dowers & Eshin, 2020) and was one way in which participants found themselves misunderstood within services. Where research frequently describes this phenomenon as a psychological barrier to service-use given the necessity that service-users overcome the implicit transphobia it communicates (ibid.), this study elucidates how 'trans broken arm' also functions more concretely as a form of diagnostic overshadowing that prevents trans people from accessing the help they require.

Cultural-Competence

Survivors saw cultural-competence as a necessary compliment to professionalism and requisite to care-seeking. Turner et al. (2006) define trans-specific cultural-competence as comprising 'awareness' of cultural needs/history/terminology, 'sensitivity' to minority issues, 'competence' demonstrated through knowledge and empathy, and 'mastery' of the aforementioned, such that learning can be disseminated. Survivors' stated (unmet) needs were aligned to this model, with an emphasis on trans-literacy, respect and inclusive policy While this will be discussed further in the next section, it is noteworthy that the needs voiced here are precisely those voiced by LGB survivors in past decades (Pierre & Senn, 2010). The present study thus highlights a lack of progress in service-providers' movement towards culturally-competent care, and calls for renewed commitment to these values.

Clinical and Policy Implications

The model suggests that help-seeking avoidance among trans survivors is informed by the ways in which stigma and misconceptions about trans personhood are both internalised and felt to permeate support settings, precluding culturally sensitive and accessible support. Though addressing the pervasive stigma that leads to internalised trans-negativity is beyond the remit of care-providers, demonstrating inclusivity and competence at service-level may have a direct impact on reducing the self-stigmatising psychological conditions that inhibit help-seeking. It is crucial, however, that service-providers consider the order in which this is achieved, given the ethical implications of actively welcoming trans survivors into oppressive and ill-informed systems of care.

Preventing enacted stigma within services requires compulsory and ongoing staff training, which seeks to acknowledge and address transphobic bias, build awareness of trans-specific minority-stressors (including those perpetuated by services) and understand when trans

identity is/is not relevant to an individual's support needs. For healthcare professionals, such training should be integrated into educational curricula. Practitioners should be sensitive to the doubly-potent experiences of shame and the internally/externally-generated blame narratives that exist for trans survivors within the current cultural milieu, and mindful that trauma disclosure is not lost to professional curiosity about trans bodies. Participants explained that practitioners may require greater exposure to trans people in training contexts as a means of demystifying gender-diversity.

The study raises that survivors are fearful not only of encountering trans-negativity within services, but also of the impact that trauma-disclosure may have on their longer-term care needs. This exists within the context of clinicians having preserved the damaging and unfounded formulation that trans identity is a trauma-induced pathology, and sits alongside current legal challenges that threaten to hamper trans-affirmative treatment (High Court of Justice, 2020). There is an urgency, therefore, for clinicians and researchers alike to work towards re-conceptualising understandings of gender-identity development in ways that align to the lived experience of trans survivors.

Since barriers to service-use are as much practical as psychological, service-evaluation to assess the availability and accessibility of support is necessary. Though recent proposals to allow for gender self-identification under the Gender Recognition Act (2004) received significant backlash, service-providers have a duty of care to ensure inclusive and non-traumatising support provision. This may mean communicating clear, policy-embedded decisions regarding whether to allow for integration into current binary service-configurations, offer trans-specific support, or dismantle the binary altogether. Participants were clear that services should commit resources to engaging with trans communities in the design/delivery of care, and saw potential in integration as a means of addressing the stigma perpetuated through segregation.

Finally, services may consider a proactive outreach approach in promoting/advertising inclusion where true inclusion has been established, acknowledging the problem of SV victimisation within trans communities and communicating a validating response. Best practice may be drawn from existing trans-inclusive services.

Limitations

The present study is limited principally by its non-experimental design and small participant numbers, both of which limit the generalisability of findings. The model presented, however, finds resonance with extant theoretical and empirical literature, adding a systematic mode of inquiry to the field and providing a foundation for future larger-scale research to elaborate the theory.

Although demographic heterogeneity existed within the sample, the study struggled to recruit black and minority ethnic participants, meaning that findings are delimited to white, Western culture on account of the study's exclusively white British sample. Certainly, there exists a fledgeling literature on how minority-stressors intersect to produce increased SV risk and worse help-seeking outcomes for trans people of colour (James et al., 2016), which should be explored as a priority in future research on this topic. Researchers might also consider how culture, religion, and rural geography may impact help-seeking processes, since this was not possible within the scope of the present study.

Finally, although the study adhered to ethical validation principles by a) having participants comment on the credibility of theoretical propositions throughout, and b) inviting assurance that concepts had been conveyed and understood as intended, time constraints did not allow for the final model to be validated by the study's participants. As such, resonance with the substantive theory had not been ascertained at the point of submission to the examination board.

Conclusion

This paper offers to the field hitherto absent systematically-derived knowledge about what inhibits help-seeking for trans SV survivors. Though some of the barriers highlighted proved consistent with cisgender/other minority survivor help-seeking patterns, unique challenges relating to the stigma, misunderstanding and cultural erasure that surrounds trans identity appear to account for discrepant service presentations. Moreover, the model identifies how social and professional conceptualisations of trans personhood render taking a position as both trans and a survivor culturally inconceivable, with either identity having a totalising effect to the exclusion of the other.

The research calls on service-providers to consider their role in articulating a more integrated understanding of the experience of SV for trans-identifying people and emphasises the importance of validation where survivors likely present with histories of erasure and have already minimised the experience for themselves. This paper contributes a schema for the provision of culturally-competent and inclusive survivor support.

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Section C

Appendices of supporting material

Appendix A. Appraisal of quantitative non-randomised studies

MMAT – Summary table appraising quantitative non-randomised studies

Study	Are the participants representative of the target population?	Are measurements appropriate regarding both the outcome and intervention (or exposure)?	Are there complete outcome data?	Are the confounders accounted for in the design and analysis?	During the study period, is the intervention administered (or exposure occurred) as intended?
1	Partially – Convenience sample recruited through any school willing to administer the questionnaire, limiting representativeness. Very small proportion of TGNC participants. Clear description of criteria against which participant data included/excluded from analysis. Well-described non-response rate. Detailed reporting of participant demographics.	Yes – Variables clearly defined and relevant to research question. Utilises validated DV measures in adapted form. Reports reliability coefficients for most measures relevant to inquiry relating to TGNC participants.	Yes – Reports outcome data for TGNC-relevant measures at 94-99%.	No – No mention of potential confounders/efforts to control for confounders in sections relevant to inquiry into TGNC youth.	N/A
2	Partially – Convenience sample recruited through local schools, limiting representativeness. Eligibility criteria simply any students present on the day the questionnaire was administered. Reports 95% response rate but does not offer information on non-consenters. Detailed description of participant demographics.	Partially – Variables clearly defined and relevant to research question. Validated measures used with reliability coefficients reported, however, reliability scores low (<70) for some constructs, including DV.	No – No description of data completeness across the sample.	Yes – Controls for demographic, person- and school-level factors.	N/A
3	Partially – Secondary data from study using a purposively selected sample, which may introduce bias. Clearly defined eligibility criteria. Does not offer information on non-consenters, but a response rate of 99.5% can be inferred. Good breakdown of sample demographics.	Partially – DV clearly-defined, assessed using a novel, single-item measure. Independent variables well-described, with some validated measures employed. Reliability coefficients not reported.	Partially – Data missingness well-described at each stage but reports data completeness at 70.6% (i.e. low).	Yes – Sociodemographic variables included as covariates in regression analyses. Measures also taken to ensure no systematic bias in missing data.	N/A

4	No – Random sampling strategy improves representativeness, however, no detail of how randomisation was performed. Eligibility criteria unclear. No information on potential sample size or non-responders/non-consenters. Detailed description of participant demographics, however, age-range of college students implied by year of study, rather than stated.	Partially – DV clearly-defined. Validated measures employed and low reliability coefficients reported, although test-retest reliability for individual items (as used in this study) had not been measured.	Yes – Complete case analysis and listwise deletion used to attend to data missingness. Data completeness reported at 92.7%.	Yes – Demographic factors controlled for based on what was known from previous literature. Sexual orientation, race, school year and year of participation adjusted for.	N/A
5	Yes – Does not comment on sampling strategy, but as the study uses secondary data, further research ascertained that the sample was randomly achieved, though it is unclear how randomisation was performed. Clear eligibility criteria and well-described participant demographics.	Partially – Variables clearly defined and measured using a validated tool. No indication of internal consistency scores.	Yes – Data completeness reported at 99%.	No – No mention of potential confounders and no statistical methods employed to control for them.	N/A
6	Yes – Secondary data with random sample achieved, though it is unclear how randomisation was performed. Thorough demographic breakdown. Eligibility criteria clearly stated.	Partially – Variables clearly defined and measured using a validated tool. No indication of internal consistency scores.	No – Figures for incomplete data not disaggregated from number of participants not meeting eligibility criteria.	Yes – Offers unadjusted and adjusted odds ratios, factoring in sexual orientation, race and school year.	N/A
7	Partially – Secondary population-based data drawn from regional schools (census design), so likely representative. No information offered on non-consenters/non-responders. Eligibility criteria not explicit. Fair description of participant demographics, though not presented in tabular format.	Partially – Variables relevant to research question and mostly clearly defined, although some constructs appear reductive. Novel measures used throughout.	Partially – Does not report on proportion of data missingness. Uses full information likelihood where data incomplete, which is deemed appropriate for LCA.	Yes – Adjusts for covariates, including age, sex, ethnicity and socioeconomic status.	N/A
8	No – Secondary data used from larger intervention study, with no further details on strategy. No information on potential sample size or non-responders/non-consenters. Fair breakdown of participant demographics.	Partially – Variables clearly defined and measured using a mix of validated and non-validated tools. Alphas reported where relevant.	No – Data completeness unknown by author as not reported by data source. Dichotomises data to account for missingness in some cases.	Partially – Controls for age but does not offer adjusted odds ratio.	N/A
9	Partially – Secondary data drawn from larger study which used convenience and purposive sampling strategy, limiting the representativeness of data and potentially	Yes – Variables relevant and clearly defined. Utilises a range of validated measures, plus one novel single-item	Yes – Reports 83% and 82% retention at 4- and 5-year follow-up, though does not offer reasons for attrition.	Yes – Controls for Time-1 health variables at Time-2.	Yes – Potential changes in exposure status accounted for. Both gender identity and

	introducing bias. No information on non-consenters/non-responders. Good description of eligibility criteria and thorough breakdown of participant demographics.	measure. Reliability coefficients reported where possible.			exposure to DV re-captured at Time-2.
10	Partially – Utilises secondary data, with participants selected via a two-stage cluster sampling protocol to improve representativeness. No information offered on eligibility criteria or non-consenters. Detailed demographic breakdown offered.	Partially – Variables not clearly defined, but constructs relevant to the research question. Uses single validated instrument to assess all dependent/independent variables. Reliability coefficients not reported.	No – Does not reference data completeness or treatment of missing data.	Yes – Controls for predictor variables in adjusted OR model.	N/A
11	Partially – Quota sampling employed to improve sample representativeness but may introduce bias. Very clear outline of eligibility criteria. No information on non-consenters. Clear description of participant demographics.	Yes – Survey and variables pilot tested and amended accordingly prior to study launch. Constructs well defined, though DV construct lacking. Some validated measures used alongside novel instruments. Internal consistency values reported where possible.	Yes – Reports data missingness across each of the variables. Data completeness reported at between 72.2% and 99.7%, with three variables (peer rejection, PTSD, and school climate) missing more than 20% of data.	Yes – Multiple logistic regression used to control for covariates.	N/A
12	No – Quota sampling employed to improve sample representativeness but may introduce bias. Eligibility criteria unclear. No information on non-consenters. Clear breakdown of participant demographics, though not presented in tabular format.	Partially – Uses established validated measures. Reliability coefficients not reported. Variables relevant to research question but less relevant to the present review. Constructs fairly well-defined, though DV construct deficient.	No – Does not comment on missing data.	No – No mention of potential confounders or efforts to statistically control for covariates.	N/A
13	Partially – Purposive sampling, thus vulnerable to bias. Offers clear eligibility criteria. Fair breakdown sample demographics.	No – Variables relevant to research question but constructs open to interpretation. Employs a mix of novel and established and validated questionnaires. Novel instruments piloted prior to use. Reliability coefficients not reported for established measures.	No – Does not comment on data completeness.	Yes – Multiple logistic regression used to control for covariates.	N/A
14	Yes – Secondary data used from larger survey employing a random sampling strategy. Gives some detail on non-consenters and describes eligibility criteria. Fair description of participant demographics.	No – Uses novel questionnaire. Variables relevant with some constructs well-described, though DV narrowly defined.	Yes – Reports data missingness across each variable, with completeness ranging from 89.1% to 99.9%.	Yes – Controls for mental health and other victimisation experiences in later models.	N/A

15	Partially – Snowball sampling strategy involving community-based convenience sampling followed by purposive sampling, thus limiting representativeness and introducing potential bias. Clear description of eligibility criteria and thorough breakdown of participant demographics.	Yes – Clearly-defined and relevant variables. Validated measures used where possible with reliability coefficients reported.	Yes – Reports retention at each wave as 85%, 90%, 82%, 83%, and 82%, respectively, and offers reasons for attrition.	Yes – Controls for demographics and health variables at each previous data wave.	Yes – Changes in DV exposure assessed at each phase, but gender identity reported at baseline only.

Appendix B. Recruitment poster and researcher bio from website.

The brief researcher biography aimed to promote an atmosphere of candour and reduce power differentials inherent to the research process (Morgan & Taylor, 2015).

PHOTOGRAPH CREDIT: JOEL GOODMAN/LNP/REX/SHUTTERSTOCK

About the researcher

Amy Obradovic (she/her) is a mixed-race (white-passing), vegetarian Clinical Psychologist in training, with particular professional interests in advocacy, trauma and widening access to psychology professions.

Although she has always been keen to take a firm position on matters of social justice, she first became interested in trans rights while studying Queer Theory at King's College London (2005 and 2010) and becoming interested in the writing of Judith Butler, Eve Kosofsky Sedgwick and Julia Serano. Her undergraduate and master's dissertations addressed social constructions of gender on the Shakespearian stage, and in the literary works of Jean Rhys, respectively.

In more recent years Amy has become interested in the parallels between her own sense of racial "othered-ness"/"inbetweenness" and how trans communities have historically and presently occupied a neither/nor space in the cultural imagination.

Her current research on help-seeking amongst trans surviviors of sexual violence builds on preliminary suggestions that trans people are disproportionately vulnerable to sexual violence, and yet significantly less-likely to seek support through mainstream or specialist healthcare and support services. Amy's research aims to better understand why this is, and hopes to work alongside participants to improve levels of support and care for trans survivors within both NHS and third sector service provisions. The research will contribute to one of the first guidelines for informing a trans-inclusive model of survivor healthcare.

Appendix C. Initial interview schedule

Barriers to Help-seeking Interview

1. Research suggests that trans individuals are significantly more vulnerable to acts of sexual violence than the general population. What do you make of that?

2. Do you have thoughts on how sexual violence perpetrated against members of the trans community is perceived?

Prompts:

- By the trans community
- By members of the wider population
- How do your own views align/not align with these wider perceptions?

3. At your own pace and level of detail, can you tell me a little about your own experience(s) of sexual violence?

Prompts:

- Feelings arising
- Interpretation in immediate aftermath
- Longer-term meaning-making

4. What did it feel important to do/who did it feel important to speak to after this had happened to you?

Prompts:

- What support were you looking for?
- Types of help-seeking considered (formal/informal, statutory/other services (if formal))
- Did these routes seem available to you?
- Actual help-seeking behaviours
- What was most helpful/unhelpful?

5. And can you tell me a bit about how you managed to cope after it happened?
    - Elicit strengths/resources/ideas of personal agency

6. Thinking about decisions around help-seeking, how much of this was influenced by your own beliefs, or what you understand to be the trans community's/society's beliefs about sexual violence?

7. Again, thinking about decisions to seek help, how able did you feel to approach the services that felt most appropriate for you?

Prompts:

- Actual barriers (externally generated)
- Concerns/fears (internally generated)
- Expectations (internally/externally generated)

8. (If not covered, query safety concerns, outing concerns, i.e. How safe did it feel to approach services?)

9. And if/when you did approach formal services, what was your experience of this?

Listen for:

- Gender assumptions/gendered assumptions of services approached
- Feeling welcomed/believed/respected/acknowledged/understood
- Receiving the support you'd hoped for
- Well-intentioned support received that felt inappropriate for your needs

- Regrets

10. If you ran the services you approached/felt unable to approach, how would they be different to what you experienced/anticipated you would experience?

Prompts:

- What would help you to feel that these services are appropriate for trans survivors?
- What difference would this make to a) help-seeking behaviours following experiences of sexual violence, b) the problem of sexual violence perpetrated against trans people?

11. Is there anything else that feels relevant to your experience that we haven't covered during the course of the interview?

<DEBRIEF>

Appendix D. Ethical approval letter

This has been removed from the electronic copy.

Appendix E. Participant information sheet

Canterbury Christ Church University
Salomons Centre for Applied Psychology

Invitation to participate in research

Help-seeking among trans survivors of sexual violence

The purpose of this leaflet is to provide you with all of the information that you may need in considering whether to participate in a research study. The study is supported by SurvivorsUK and is being conducted by me, [redacted] (she/her) as part of the fulfilment of my doctoral degree at Canterbury Christ Church University. The study is supervised by Dr Louise Goodbody, Joint Clinical Director at the Salomons Institute for Applied Psychology, and Dr Michael Toze, Lecturer in Public Health and experienced researcher in the field of healthcare for trans service-users. It is hoped that the study's findings will improve levels of support and care for trans survivors within both mainstream and specialist services.

What is the purpose of the study?

The aim of this study is to better understand which aspects of healthcare and support services are experienced as more and less challenging for trans survivors of sexual violence and how these impact on feelings and attitudes towards self and help-seeking. We hope that by speaking to individuals who have sought help/considered seeking help from mainstream (NHS, police) and specialist services (crisis centres, support networks, etc), we will be able to better understand trans experiences and improve support services for trans survivors in the future.

The research seeks to contribute towards one of the first guidelines for informing a culturally competent and inclusive model of survivor healthcare and support.

Why have I been invited?

You have been invited to take part because:

- you live/have lived in the UK and identify as trans, genderqueer, genderfluid, agender, gender non-conforming, third-gender or non-binary
- you identify as having experienced some form of sexual violence (not within six months of the interview date)
- we are interested to confidentially and respectfully hear about your experience of seeking (or not seeking) help following this/these event(s).

Do I have to take part?

No, you are under no obligation to take part in the study and should not feel coerced (forced) into doing so. If you do decide to take part, you are free to withdraw from the study up to the point at which the data is analysed. Should you choose to withdraw,

you may do so without disadvantage to yourself and without any obligation to give a reason.

Please feel free to ask any questions if you are unsure or if you would like to discuss the study further (see contact details listed at the end of this information sheet). If you are happy to continue with the study, you will be asked to sign a consent form to say that you have understood what participation entails and agree to be involved. Please keep a copy of this invitation sheet for reference.

What will happen if I take part?

You will take part in a one-to-one informal interview and will be asked to describe your personal experience of and perceptions of help-seeking following sexual violence. This can take place in a private space at SurvivorsUK or at an alternative location of your choosing. In some cases, if preferred, it may be possible to conduct interviews over Skype. The session will not be interrupted, but I may be required to check in and out of our meeting by telephone, depending on where the interview takes place.

At the beginning of our meeting, you will be given the opportunity to read through this information again and ask any questions that you may have before the interview begins. The interview will last approximately 75 minutes and will be recorded with an audio-recording device so that I can transcribe (write up) the interview at a later stage.

With your agreement, you may be contacted at a later date by telephone or email to clarify some of the things you said in your interview. This is so that I can be sure that I have understood your words in the way you wished for them to be understood.

Will my taking part in the study be kept confidential?

Yes – only the interviewer (me) and anyone that you choose to tell will be aware that you are taking part in the study. Any information (data) that you give in your interview will remain strictly confidential. The only exception to this is if I am concerned about your safety, in which case your G.P. may be contacted with your permission. This will be discussed openly with you at the time, should such a situation arise.

The audio recording of the interview will be kept in a secure, electronic location until the study has been completed, after which the recording will be destroyed. When the interview is transcribed, your name (as well as any identifying references) will be removed from the transcript to protect your confidentiality and anonymity. The anonymised transcripts may be retained for further analysis / reference for up to 10 years after the study has been completed, but data will not be traceable to its source.

What are the possible benefits of taking part?

By taking part in the study, you will be contributing to research that aims to improve services for future trans survivors of sexual violence, as well as trans service-users

more generally. You will have the chance to speak in as much detail as you would like about your experience of help-seeking following the traumatic event and the impact this has had on your use and opinion of services. Many people find it cathartic (emotionally relieving) to have the opportunity to discuss their experience.

You may request reimbursement for your travel expenses (where applicable), and in exchange for your time, I will make a donation in your name (or anonymously) to an organisation offering support to trans survivors of sexual violence.

What are the possible disadvantages/risks of taking part?

It is not expected that you, the participant, should experience any disadvantage either during or after the interview, although it is recognised that thinking back to adverse life experiences may be difficult and upsetting. You are welcome to take a break from the interview, or terminate it at any time you wish. Should you encounter any distress in the days following the interview, please contact your G.P. or one of the organisations listed below.

Survivors UK – t: 020 3598 3898 / Whatsapp: 07491816064 / w: survivorsuk.org
Survivors UK offers an inclusive service for survivors of sexual violence. They offer free individual and group counselling and a safe and confidential space to talk for anyone identifying as male, trans, non-binary or who has identified as male in the past. They also have an Independent Sexual Violence Advisory Service, which provides support for individuals who are thinking about reporting sexual violence to the police.

Galop – t: 020 7704 2040
Galop is an LGBT+ anti-violence charity which offers advice and support to people who have experienced biphobia, homophobia, transphobia, sexual violence or domestic abuse. Galop professionals can offer a time to talk, specialist advocacy services and help with accessing financial compensation following hate crime. They also offer support to lesbian, gay, bisexual, trans and queer people who have had problems with the police or have questions about the criminal justice system.

MindLine Trans+ – t: 0300 330 5468
MindLine Trans+ offers a confidential, non-judgemental listening space for people who identify as Trans+ or nonbinary, and their friends and families. The service does not record calls nor ask for any personal details. Listeners are often trans volunteers with lived experience or allies with experience of supporting difficulties commonly encountered by trans people. The crisis line operates on Mondays and Fridays from 8pm to midnight.

Switchboard LGBT+ - t: 0300 330 0630 e: chris@switchboard.lgbt
Switchboard provides an information, support and referral service for lesbians, gay men and bisexual and trans people, and anyone experiencing difficulties related to their sexuality and/or gender identity. Switchboard can provide support around experiences of abuse, details for LGBT-friendly therapists, housing advice, and information about local support and/or social groups. The line operates between 10am and 10pm every day of the week, 365 days of the year, and is run by volunteers and professionals who identify as LGBT+. The Switchboard LGBT+ website (https://switchboard.lgbt/) also features an instant messaging support service.

What will you do with the findings from the study?

Once all data gathered in the study has been analysed and written up, the research will be offered for publication in an academic journal. The research team will also create a set of guidelines based on the study findings, which will be disseminated to relevant support services to help inform their practice. Please note that although direct quotations from the interviews will be used, your identity will remain anonymous at all times. Your data will never be shared and your personal details will not be identifiable at any point during or following the research.

What if there is a problem?

If you have any questions or concerns about how the study has been conducted, please contact the Chair of the School of Psychology Research Ethics Sub-committee on 01227 927700.

Contact us

If you have any questions or if you would like to participate in this research, please contact the study's Principal Investigator, [redacted]@canterbury.ac.uk.

Thank you.

Appendix F. Participant consent form

Canterbury Christ Church University
Salomons Centre for Applied Psychology

Consent to participate in research

Help-seeking among trans survivors of sexual violence

I have read the information sheet relating to the above research project and have been given a copy to keep. The nature and purpose of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what my participation will involve.

I understand that my involvement in this project, and any data gathered, will remain strictly confidential. Only researchers involved in the project will have access to identifying data. It has been explained to me what will happen to the data once the project has been completed.

I freely and fully consent to participate in the project, which has been explained to me in full. I understand that I have the right to withdraw from the study at any time, up until the point at which the data has been analysed, without disadvantage to myself and without giving any reason.

Participant's name (BLOCK CAPITALS) Participant's signature

....

Researcher's name (BLOCK CAPITALS) Researcher's signature

....

Date: .....

Help-seeking among trans survivors of sexual violence
Consent form Version 1.2
12/12/2019

Project title: Help-seeking among trans survivors of sexual violence

		Initial here
1	I have read and understand the information sheet dated __/__/__ (version _) for this project and I have had the opportunity to ask questions about the study.	
2	I understand that my participation is voluntary and that I am free to withdraw without giving any reason. I understand that if I withdraw this will not affect my healthcare or my legal rights in any way.	
3	I understand that if I withdraw from the study, the researcher will use the information I have provided up to that point, unless I indicate that I do not want them to.	
4	I understand that data that has already been analysed will still be used if I decide to withdraw.	
5	I understand that the information I give to the researcher will only be used for the purposes of research, and that personal details will be treated in the strictest confidence.	
6	I understand that my interview will be audio-recorded.	
7	I understand that will be asked questions about my experience of sexual violence, and that this may feel difficult. I feel able to take part in such discussions.	
8	I agree to take part in the study.	

Date: ……

Appendix G. End of study report for participants (also submitted to University Ethics Panel)

End of study notice and report

Research Title:
Barriers to Help-seeking Among Trans Survivors of Sexual Violence

Final Title:
'Undermined and Overdetermined Identities':
A Grounded Theory of Barriers to Help-seeking Among Trans Survivors of Sexual Violence

Dear participant,

Once again, thank you for your participation in the above research. The research is now complete and will in future be submitted for publication in a peer-reviewed journal. In this way, it is hoped that our work together can assist healthcare professionals and researchers in better understanding trans people's experience of seeking/not seeking support in the aftermath of sexual violence and improve support services for trans survivors in the future.

Below is a brief summary of the research.

Background
Research suggests that trans people are disproportionately at-risk of sexual violence, and yet are underrepresented among those who seek survivor-related support from statutory services (NHS, Police, etc) or specialist third-sector agencies (community support groups, crisis centres, etc). The research team working on this study wanted to understand whether there were specific barriers to help-seeking that prevented trans survivors from accessing care.

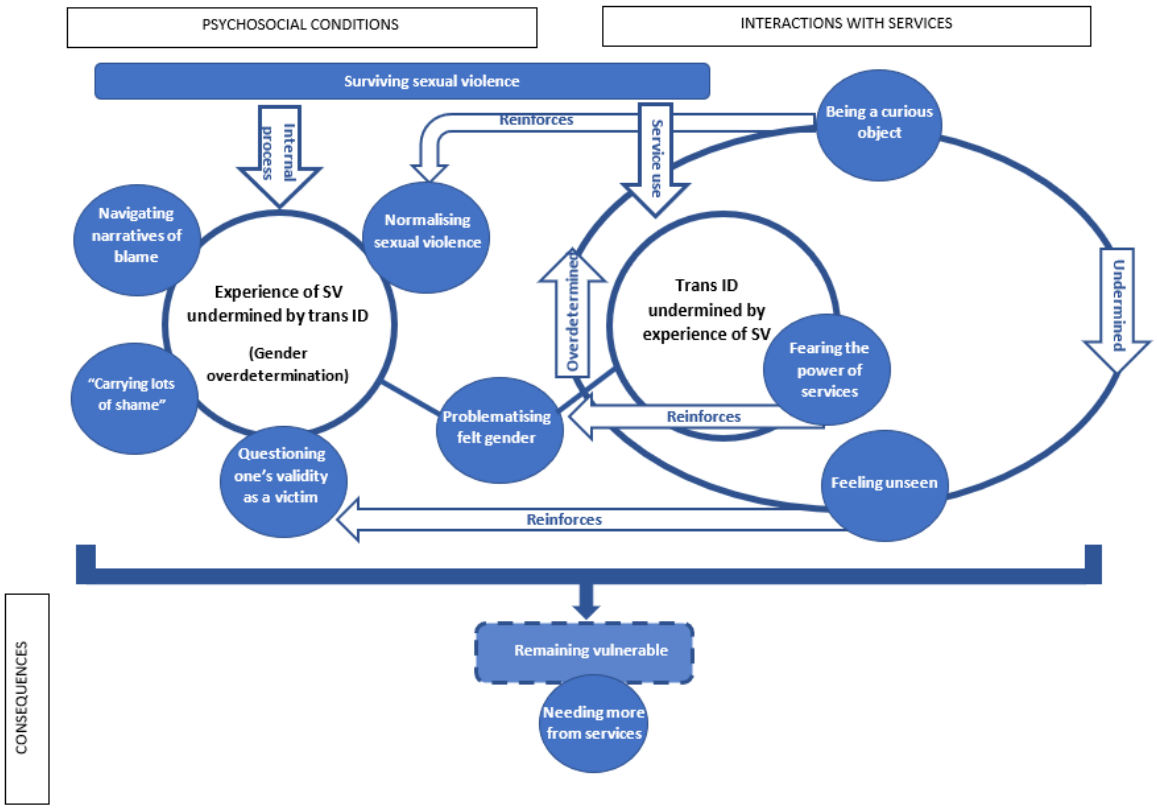
The study
Eight trans participants who identified as having experienced some kind of sexual violence took part in the research. The research was conducted between January 2020 and June 2021. Participants each attended a one-to-one informal interview and were asked to describe their personal experiences and perceptions of help-seeking following sexual violence.

The interviews were transcribed and analysed using a research method called Constructivist Grounded Theory – it is called this because it aims to develop a **theory** (in this case of help-seeking for trans survivors) which is **grounded** in the interview data (rather than existing research) and **constructed** between the research participants and the researcher. The end theory is developed from an analysis the themes that occurred most often and which participants described as most important to their experiences of help-seeking. However, it is acknowledged that the theory represents just one way of interpreting the experiences narrated at interview.

The theory
In brief, the data suggests that when thinking about seeking help, trans survivors must contend with a combination of psychological barriers (internalised trans-negativity; shame; self-blame), social barriers (how trans people are perceived by others; social stereotypes) and institutional barriers (how support-providers treat/understand trans people; whether services are easy for trans people to access). Because many of these experiences are painful and based on discrimination, trans people often do not feel comfortable seeking help.

At the heart of help-seeking contemplation was the fear and/or experience of trans identity being either undermined or overemphasised in its relationship to sexual violence due to the stigma and misunderstanding that surrounds trans identity. Participants found that they were either regarded by others foremost as trans (and therefore demonised or considered blame-worthy/shameful) or regarded foremost as survivors, in which case trans identity was perceived to be a response to sexual trauma rather than an identity in its own right. In these ways participants felt that it was not possible to attend services as both a trans person and a survivor, because the two identities seemed to cancel one another out (or were 'mutually invalidating'). This idea that trans identity is either over-emphasised or completely ignored was also echoed in participants' wider experiences of service-use.

The model is depicted and explained below:



On the left-hand side of the model sit the internal (psychological) processes that impact whether survivors seek help, which are influenced by their experiences of being trans in a transphobic society. Psychological barriers to support-seeking were experienced largely as an internalisation of transphobic stigma, and were underpinned by the central notion that being trans served to overshadow participants' victimhood. The following themes demonstrated how being trans undermined the experience of sexual violence for survivors:

- **Negotiating narratives of blame** comprises experiences/anticipation of victim-blaming on account of trans people's lifestyle choices and the way that trans bodies are sexualised in the public imagination. Participants also spoke of how this became internalised, leading to self-blame for having transitioned or for having taken decisions that were unsafe, and feeling that the violence was somehow deserved.

- **Questioning one's validity as a victim** focuses on concerns about being believed as a trans person, feeling that sexual violence for trans people is dismissed/seen as less important, and battling public perceptions of trans deviancy/predation, which make it difficult for trans people to imagine being taken seriously as victims.
- **Carrying lots of shame** speaks to participants' sense of being ashamed of who they are as well as feeling ashamed about what has happened to them. Participants spoke of how this undermined their needs as a survivor, due to feeling too self-conscious to seek support for fear of being outed or having to explain their gender-identity to services.
- **Problematising felt gender** speaks to the additional confusion sparked by sexual violence as a trans person, and how this can lead to the painful experience of either questioning or confirming the need to transition. Participants spoke of having to suppress these difficult emotions in order to protect the integrity of their gender identity.
- **Normalising sexual violence** encapsulates the expectation and acceptance of violent life experiences as a trans person as well as frequent failure to recognise abuse as abuse. Participants also saw violence against trans people sanctioned by the media and authorities. Sexually-violent experiences therefore become imaginally absorbed into the wider experience of being trans, with the widespread normalisation of assault within and beyond trans circles noted as a key barrier to reporting and disclosure.

Where the left-hand side of the model depicts the conditions under which trans identity overshadows sexual trauma (with the effect of impeding help-seeking), the right-hand side represents an opposite process. In their interactions with services, participants described a fear and/or experience of sexual trauma being employed by service-providers as a means of clinically undermining trans identity. The following theme describes how trans identity becomes professionally erased by sexual violence:

- **Fearing the power of services** conveys participants' experiences of having professionals insist that trans identity is a trauma-response, and describes the worry that trauma disclosure will therefore impede access to medical/surgical transition. Services are thus avoided because participants deem living with dysphoria more traumatic than living with the effects of sexual abuse.

This theme sits within a wider experience (represented by the larger circle) of having trans identity overemphasised or undermined in clinical contacts generally. Trans personhood was experienced as either invalidated through service-level microaggressions (deadnaming; misgendering; not having access to services due to binary service-configuration) or seen as always-already present, regardless of their reasons for attending services. The experience of vacillating between being invalidated and overseen/overpronounced within support contexts is conveyed by the following themes:

- **Being a curious object** (the overseen part) covers participants' experiences of 'trans broken arm syndrome' (wherein being trans is deemed clinically relevant regardless of the individual's reason for presenting, often at the expense of their actual support needs). It also speaks to the experience of being exoticised within services, with professionals being overly-curious about trans bodies. Participants described how these things not only made care-seeking uncomfortable, but prevented them from accessing appropriate support.

- **Feeling unseen** (the undermined part) looks on the one hand at the microaggressions experienced within services and how these contribute to identity erasure (and re-traumatisation); and on the other hand at difficulties negotiating binary services/finding one's place within support systems.

The above combination of psychological, social and institutional barriers to help-seeking were felt to keep trans survivors stuck in a position of vulnerability, with effects on self-esteem and mental health putting them at-risk of harm and vulnerable to further violent experiences.

Since seeking a space for validation of both their trauma and personhood appeared to be survivors' foremost concern, participants described how support services could work towards legitimating the experiences of trans survivors by developing a cultural-competence, which integrates inclusive policy and gender-expansive service configuration with bias-awareness training, service-user consultation and trans-literate staffing.

This report represents a brief overview of the research undertaken. It is anticipated that the full research paper will be available in its published form in 2022.

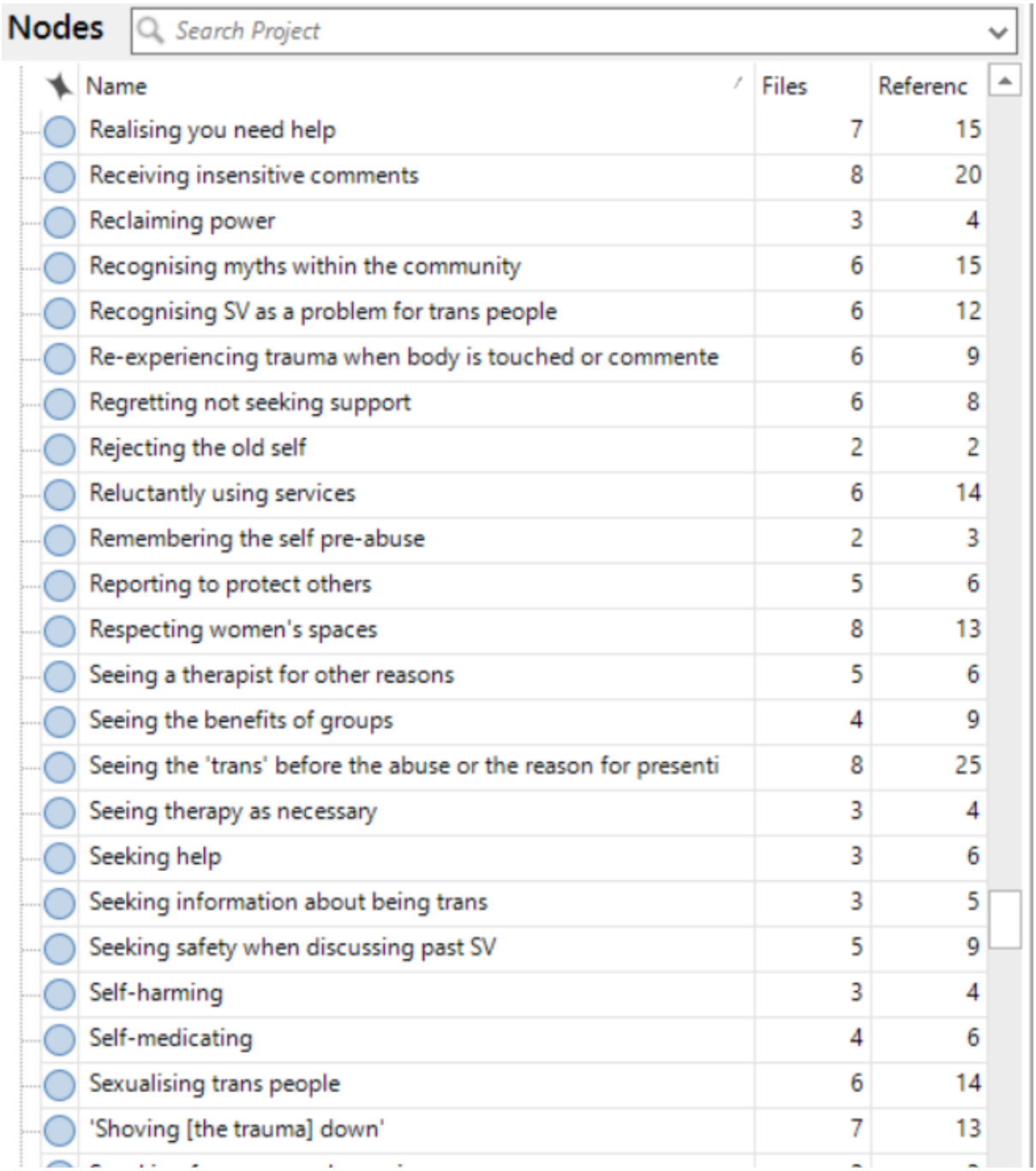
What next?
The full research paper has been submitted in partial fulfilment of the requirements for a doctoral degree. Once assessed and approved, the research team will refine the paper before submitting it for publication. Based on the study findings, the principal researcher intends to develop a short guidance document for dissemination among relevant support agencies, detailing what participants imagined a culturally-competent, trans-inclusive model of survivor support to look like.

I would like to once again thank you for your time and commitment to this research. As discussed, donations will be made to your chosen charities as a small token of appreciation.

Yours sincerely,

Amy Obradovic
Clinical Psychologist in Training
The Salomons Institute for Applied Psychology

Appendix H. Example of initial codes to focussed codes development

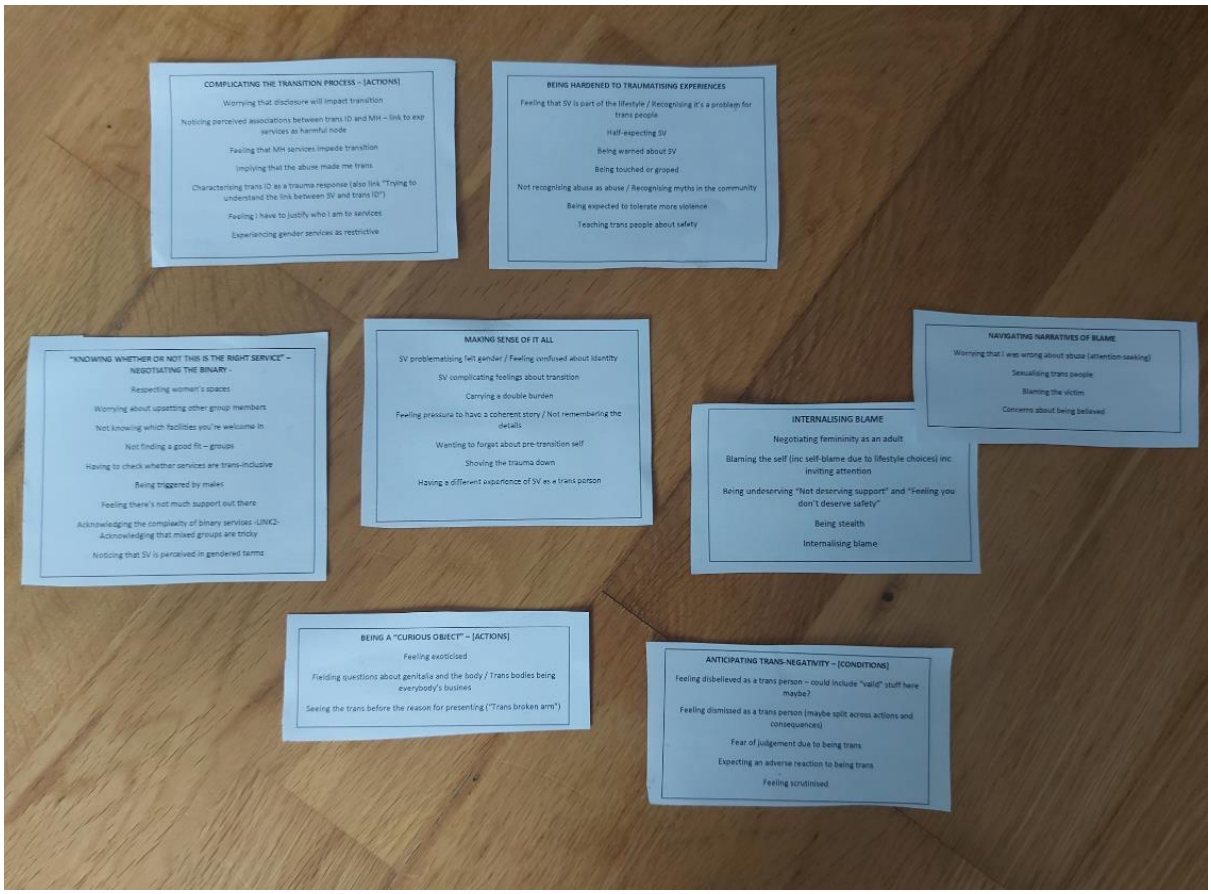


Nodes

Search Project

Name	Files	Referenc
Realising you need help	7	15
Receiving insensitive comments	8	20
Reclaiming power	3	4
Recognising myths within the community	6	15
Recognising SV as a problem for trans people	6	12
Re-experiencing trauma when body is touched or commente	6	9
Regretting not seeking support	6	8
Rejecting the old self	2	2
Reluctantly using services	6	14
Remembering the self pre-abuse	2	3
Reporting to protect others	5	6
Respecting women's spaces	8	13
Seeing a therapist for other reasons	5	6
Seeing the benefits of groups	4	9
Seeing the 'trans' before the abuse or the reason for presenti	8	25
Seeing therapy as necessary	3	4
Seeking help	3	6
Seeking information about being trans	3	5
Seeking safety when discussing past SV	5	9
Self-harming	3	4
Self-medicating	4	6
Sexualising trans people	6	14
'Shoving [the trauma] down'	7	13


What are the perceived barriers to help seeking for trans survivors of sexual violence? What enables trans survivors to feel comfortable in approaching support services in the aftermath of sexual violence?
(2) COMPLICATING THE TRANSITION PROCESS
Worrying that disclosure will impact transition
Noticing perceived associations between trans ID and MH – link to exp services as harmful node
Feeling that MH services impede transition
Implying that the abuse made me trans
Characterising trans ID as a trauma response (also link "Trying to understand the link between SV and trans ID")
Feeling I have to justify who I am to services
Experiencing gender services as restrictive
(3) DISTRUSTING SERVICES
Distrusting services
Getting away with it
Feeling that trans people aren't protected
Avoiding police
Not trusting trans-inclusive claims
Not seeking help unless absolutely necessary
Feeling I have to justify who I am to services
(3) ANTICIPATING TRANS-NEGATIVITY
Feeling disbelieved as a trans person – could include "valid" stuff here maybe?
Feeling dismissed as a trans person (maybe split across actions and consequences)
Fear of judgement due to being trans
Expecting an adverse reaction to being trans
Feeling scrutinised
(2) HAVING NEGATIVE PAST EXPERIENCE OF SERVICE USE
Experiencing services as ill-informed (also: in rfx to trans care, "services don't know what to do")
Feeling misunderstood by services
Experiencing microaggressions within services
Experiencing services as disrespectful
Experiencing services as traumatising (inc. touch and questions being retraumatising + D on not wanting to reveal the body)
Being outed by services
Experiencing services as stigmatising – trans/MH (see unsafe and harmful)
Feeling services don't know what to do with you
Feeling dismissed as a trans person / Feeling unheard within services
(1) TALKING ABOUT SV IS HARD [CONDITIONS]
Talking about SV is hard (include coding body language – see "seeking safety" tab RTW and R and Chr dissociating and RTW talking about eyes welling)
Finding disclosure difficult
Receiving insensitive comments
No one talking about SV (inc not wanting to burden people)
Talking to friends and family?? (include also "feeling unsupported")
(3) NEEDING MORE FROM SERVICES
Wanting trans-inclusive services, not segregation / Not wanting trans-only groups / Finding common ground with cis people
Having a choice (inc feeling entitled to choice)
Expecting trans literate staff / Training
Feeling that cis people can be understanding
Understanding that services will slip up
Knowing what help you need
Promoting inclusivity – include good? "don't realise that services can be helpful" and "feeling valid". (Could this be linked with 'representation' – as a way to promote inclusivity??)
Representation – "finding it easier to talk to other trans people" "preferring an LGBT therapist", "needing to be around people who understand"
Starting the services you want to see (hopeful) (Trans people want to be involved in service design)
(2) "KNOWING WHETHER OR NOT THIS IS THE RIGHT SERVICE"
Respecting women's spaces
Worrying about upsetting other group members
Not knowing which facilities you're welcome in
Not finding a good fit – groups
Having to check whether services are trans-inclusive
Being triggered by males
Feeling there's not much support out there
Acknowledging the complexity of binary services -LINK2- Acknowledging that mixed groups are tricky
Noticing that SV is perceived in gendered terms
(2) NAVIGATING SELF/OTHER BLAME
Worrying that I was wrong about abuse (attention-seeking)
Sexualising trans people
Blaming the victim
Concerns about being believed
(1) BATTLING THE PUBLIC IMAGINATION
Being lesser (or rename 'feeling less than'??)
Battling the media representation of trans people (incorporate trans people as dangerous??)
Feeling everyone has an opinion on being trans
Perceiving ignorance among cis people – hence problem ignored
Speculating on perpetrator shame
(1) BEING HARDENED TO TRAUMATISING EXPERIENCES
Feeling that SV is part of the lifestyle / Recognising it's a problem for trans people
Half-expecting SV
Being warned about SV
Being touched or groped
Not recognising abuse as abuse / Recognising myths in the community
Being expected to tolerate more violence
Teaching trans people about safety
(1) SHAME
Feeling shame
Being too self-conscious to seek support
Fear of losing control of your story or what happens next
Concerns about outing self or being outed (link to 'Being out' and "not wanting family to know")
Valuing telephone support
Feeling the need to be anonymous
Using a text service
Having concerns about confidentiality
(1) MAKING SENSE OF IT ALL
SV problematising felt gender / Feeling confused about identity
SV complicating feelings about transition
Carrying a double burden
Feeling pressure to have a coherent story / Not remembering the details
Wanting to forget about pre-transition self
Shoving the trauma down
Having a different experience of SV as a trans person


COMPLICATING THE TRANSITION PROCESS – [ACTIONS]
Worrying that disclosure will impact transition
Noticing perceived associations between trans ID and MH – link to exp services as harmful node
Feeling that MH services impede transition
Implying that the abuse made me trans
Characterising trans ID as a trauma response (also link "Trying to understand the link between SV and trans ID")
Feeling I have to justify who I am to services
Experiencing gender services as restrictive
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Being touched or groped
Not recognising abuse as abuse / Recognising myths in the community
Being expected to tolerate more violence
Teaching trans people about safety
"KNOWING WHETHER OR NOT THIS IS THE RIGHT SERVICE" – NEGOTIATING THE BINARY -
Respecting women's spaces
Worrying about upsetting other group members
Not knowing which facilities you're welcome in
Not finding a good fit – groups
Having to check whether services are trans-inclusive
Being triggered by males
Feeling there's not much support out there
Acknowledging the complexity of binary services -LINK2- Acknowledging that mixed groups are tricky
Noticing that SV is perceived in gendered terms
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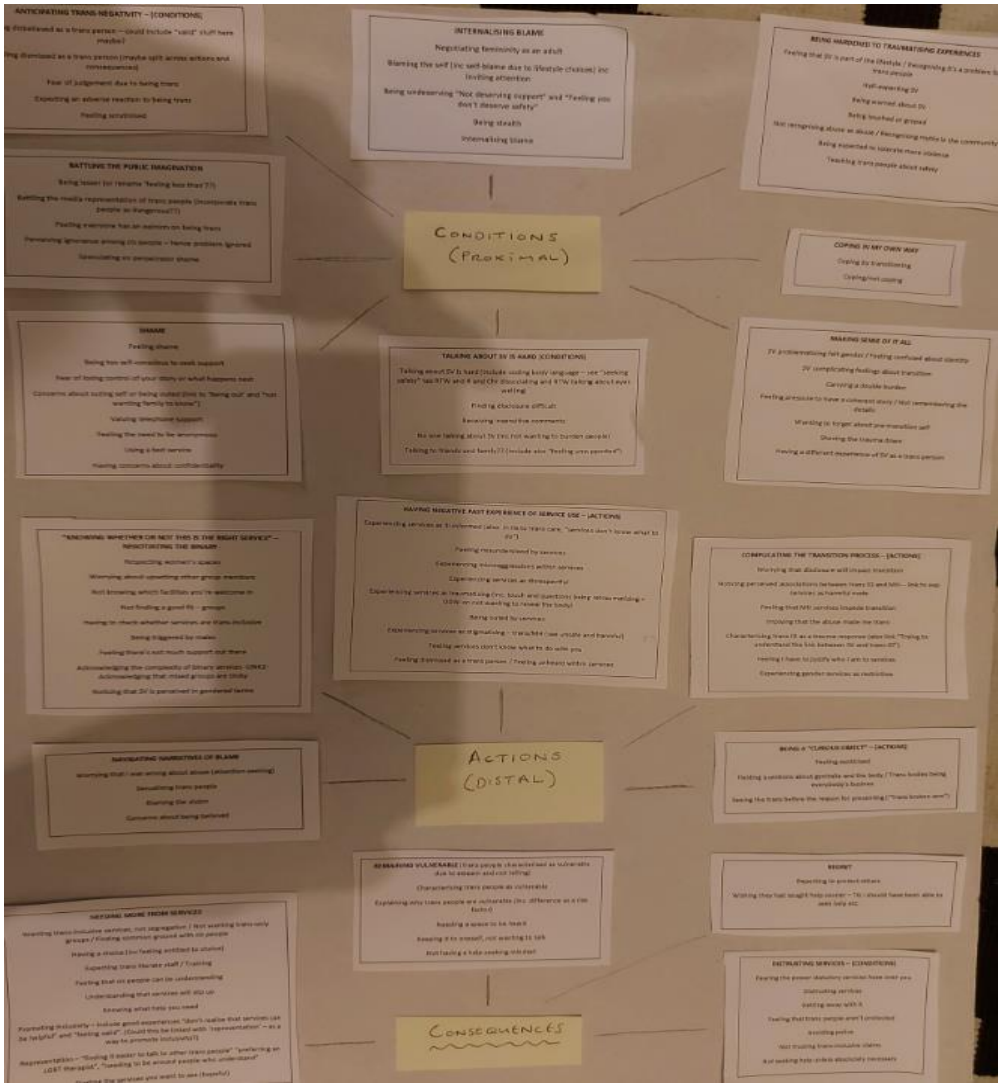
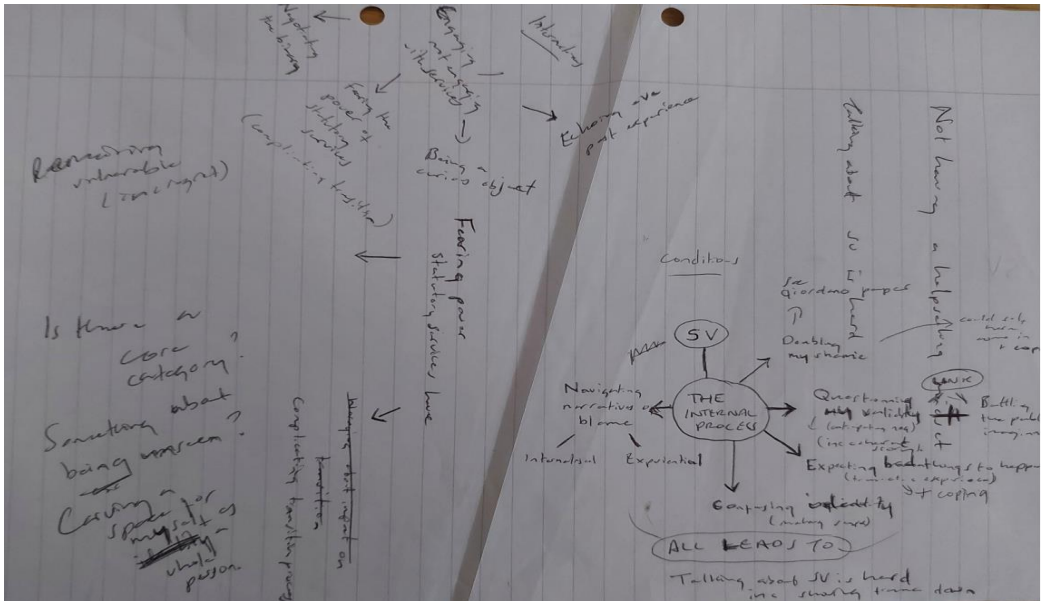
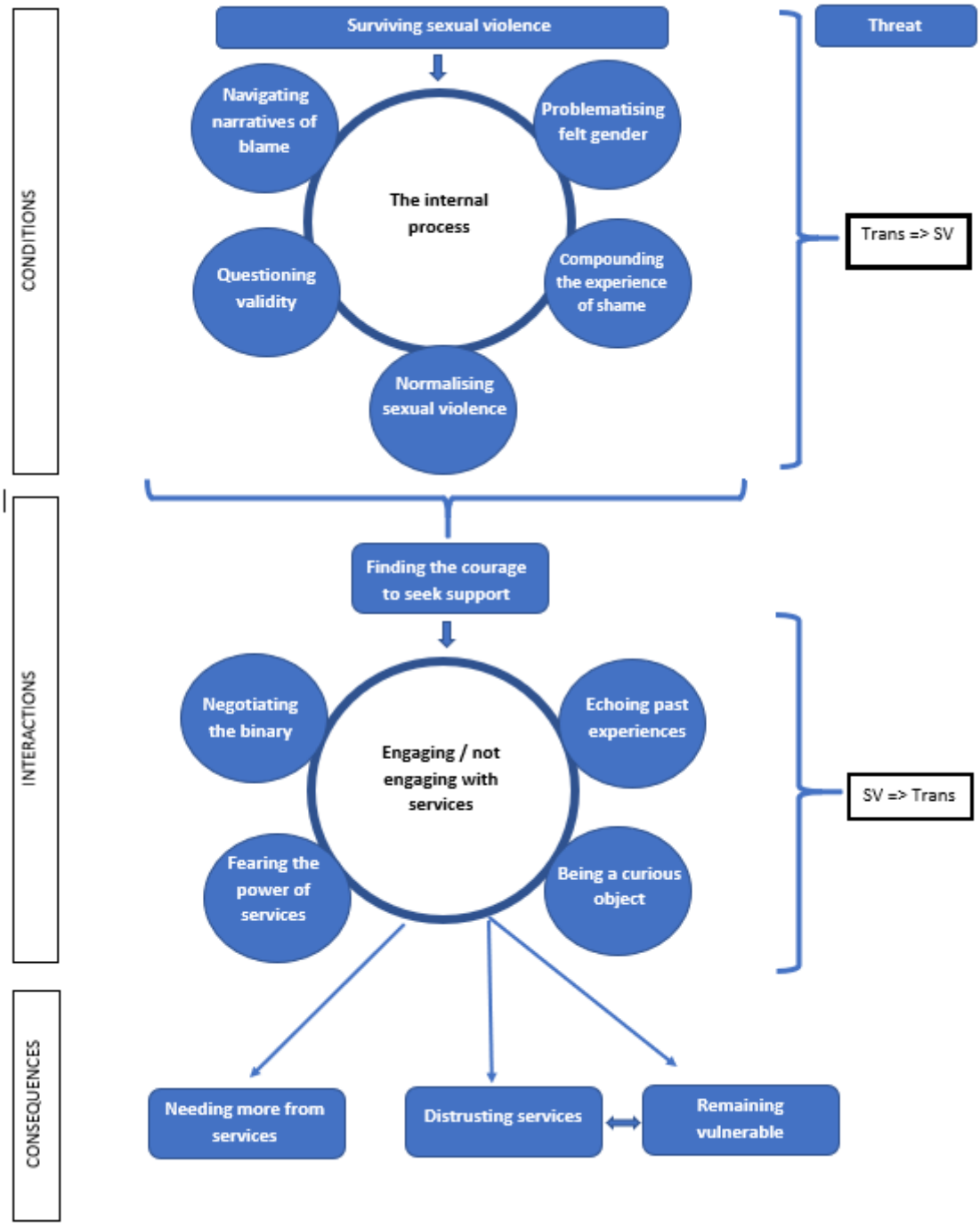
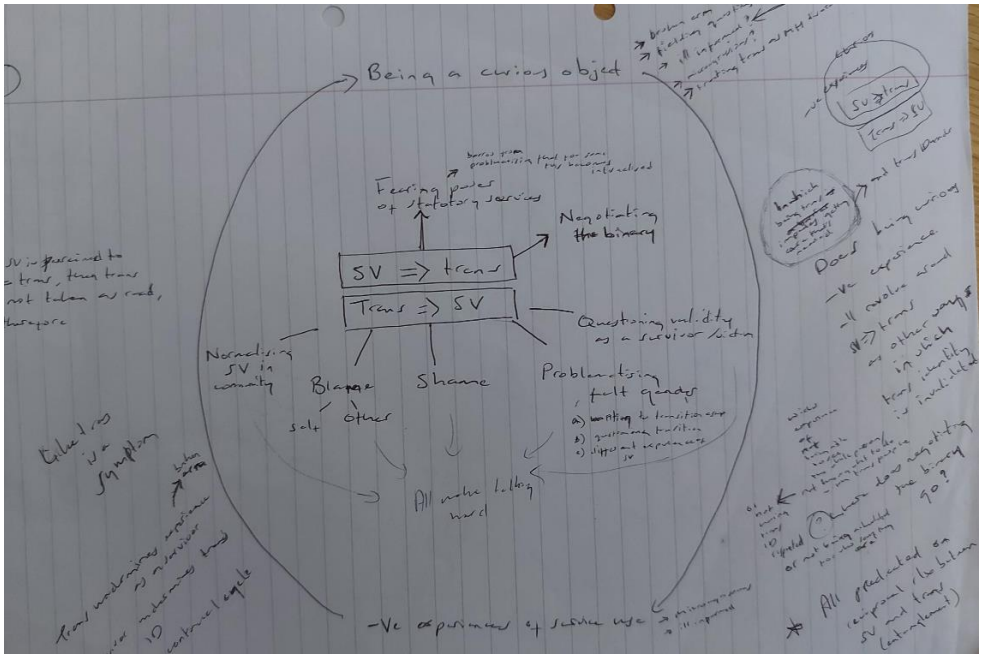
SV problematising felt gender / Feeling confused about identity
SV complicating feelings about transition
Carrying a double burden
Feeling pressure to have a coherent story / Not remembering the details
Wanting to forget about pre-transition self
Shoving the trauma down
Having a different experience of SV as a trans person
NAVIGATING NARRATIVES OF BLAME
Worrying that I was wrong about abuse (attention-seeking)
Sexualising trans people
Blaming the victim
Concerns about being believed
INTERNALISING BLAME
Negotiating femininity as an adult
Blaming the self (inc self-blame due to lifestyle choices) inc inviting attention
Being undeserving "Not deserving support" and "Feeling you don't deserve safety"
Being stealth
Internalising blame
BEING A "CURIOUS OBJECT" – [ACTIONS]
Feeling exoticised
Fielding questions about genitalia and the body / Trans bodies being everybody's busines
Seeing the trans before the reason for presenting ("Trans broken arm")
ANTICIPATING TRANS-NEGATIVITY – [CONDITIONS]
Feeling disbelieved as a trans person – could include "valid" stuff here maybe?
Feeling dismissed as a trans person (maybe split across actions and consequences)
Fear of judgement due to being trans
Expecting an adverse reaction to being trans
Feeling scrutinised

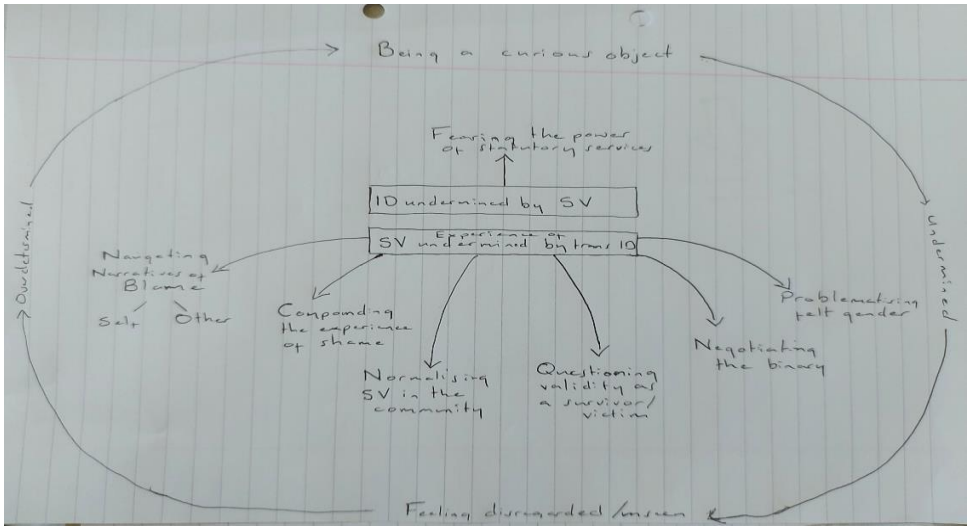
Appendix I. Examples of diagramming thematic concepts/model development

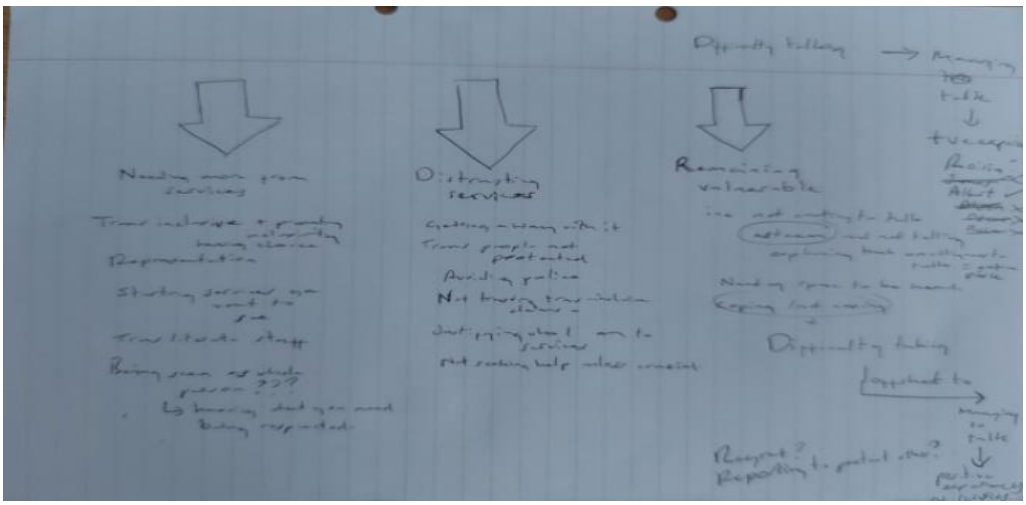





CONDITIONS
INTERACTIONS
CONSEQUENCES
Surviving sexual violence
Navigating narratives of blame
Problematising felt gender
The internal process
Questioning validity
Compounding the experience of shame
Normalising sexual violence
Threat
Trans => SV
Finding the courage to seek support
Negotiating the binary
Echoing past experiences
Engaging / not engaging with services
Fearing the power of services
Being a curious object
SV => Trans
Needing more from services
Distrusting services
Remaining vulnerable


Being a curious object
Fearing power of statutory services
Negotiating the binary
SV ⇒ trans
Trans ⇒ SV
Questioning validity as a survivor/victim
Normalising SV in community
Blame
Shame
Problematising felt gender
Self
Other
All while talking
-Ve experiences of service use


Being a curious object
Fearing the power of statutory services
ID undermined by SV
SV undermined by trans ID
Negotiating Narratives of Blame
Self
Other
Compounding the experience of shame
Normalising SV in the community
Questioning validity as a survivor/ victim
Problematising felt gender
Negotiating the binary
Overdetermined
Undermined
Feeling disregarded/unseen



Appendix J. Select early memos (table) and theoretical memos (free-text)

Early memos table has been removed from the electronic copy. Theoretical memos retained overleaf.

16/12/21 – Noticed another double bind today – you're more likely to be assaulted early on in transition journey, which seems to represent a particular period of risk generally. But also participants were less likely to report/disclose at this stage due to shame about trans identity/not being out. Does this tether people to vulnerability? Px implied that perpetrators exploit the stigma around trans identity, and there's also something about the impact of not having support on self-esteem. Does this then become a recursive process where not being able to seek help (either due to shame or due to experiences of treatment) plunges people into further vulnerability? How does recurrent assaultive experience impact shame/self-esteem/agency?

05/02/21 – I'm starting to think that there's no room to be both trans and a survivor – if you're a survivor, you get questioned as to whether you're really trans; if it's accepted that you're trans, then you're empathised with less (or you expect to be empathised with less). Or perhaps it's that one is always seen as responsible for the other – i.e. you're trans because you were assaulted/you were assaulted because you're trans. Is this the same thing? Either way, the two identity positions seem to invalidate one another. No wonder seeking help is difficult!

06/03/21 – Had been concerned about what to do with 'trans broken arm' and service-level microaggressions codes, but it seems like they jointly represents another (broader) experience of either being trans foremost (as in the community) or transness being dismissed (as in dissociative/'trauma-response' narrative) outside of the SV-specific context. It's like trans people are always either overseen (see focused code batch on TBA and also invasive questions/touch) or completely invisible (deadnaming references, but also the fact that there's no appropriate service provision).

01/04/21 – Renamed 'Confusing experiences of gender' 'Problematising felt gender' as this seems to better capture the specific impact of SV. This also seems to echo the theme capturing worries about having transition halted because of abuse. I keep wondering if this is the same construct as I'm conscious there was some indication that the former might be an internalised narrative, but this doesn't feel quite right for some participants. Also, it's the only category so far that doesn't fit comfortably into the trans foremost/survivor foremost paradigm – it seems to straddle the two, with

SV undermining the sense of gender-identity, and then the survivor actively prioritising being trans and foregrounding that identity. Need to think about how this can be best represented – feels like it might need to be a both/and conceptualisation.

19/4/21 – I combined two themes today ('distrusting services' and 'coping/not coping') under the overarching theme of 'remaining vulnerable'. Participants' distrust and maladaptive coping seemed speak to this broader maintenance of vulnerability. I also removed the theme that communicated how some participants had not had their concerns realised when they approached services. I'm continuing to grapple with this, and am wondering if this represents a bias towards being critical of services, but as this only came up in two (and a bit) narratives, and these participants still emphasised distrust of services, perhaps I can weave it in by incorporating what was perceived as helpful into the theme about 'needing more'. I also feel like I'll have to compromise lots of detail to fit into the word-count, meaning that some difficult choices need to be made between interesting and dominant themes. (The theme around negotiating femininity as an adult is especially hard to forego – I'm documenting it here to remind me to pop it back in later).

Appendix K. Reflexive diary (abridged)

09/05/20 – Participants are communicating a real urgency for their stories to be told, which feels important and gives me confidence in the research topic, however, I'm also noticing that feels like a huge responsibility – I need to be careful that this doesn't become paralysing.

Px spoke about gender confusion after SV (i.e. the individual questioning whether trans identity is attributable to assault) which I noticed made me feel really uncomfortable. I've particularly been worrying about how to best represent this if it continues to come up, as it feels potentially invalidating and I'm very conscious that the research shouldn't be in any way damaging to trans communities. Discussing this with Louise helped me to consider some of less harmful concepts that this might be communicating (i.e. whether stigmatising/invalidating narratives become internalised). This made me feel a little less nervous to follow-up on it more explicitly in the next interviews.

24/05/20 – Conducted my third interview on Friday and think it went well. I'm noticing a few threads that run through all three, which feels exciting. Ideas of blame and shame are particularly strong, and it's starting to feel as though they have both a trans-specific and general survivor quality to them – have noted to unpick this further with future participants. There was something about shame in having been abused with genitalia that felt alien to the survivor. This echoes Px's statement about services not "knowing what it [SV] means to a trans person", so might be something to query more in future interviews – how is the SV experienced similarly/differently.

I'd been worried about following-up on the unexpected idea of SV "causing" being trans, as this still feels uncomfortable in its potential to invalidate identity – I feel very aware that this argument has been used by trans-exclusionary feminist academics in the past. When I asked Px about this, I noticed myself prefacing it with "some participants have told me…", so as to distance myself from this viewpoint. I wondered if putting it in this way it was leading, but equally didn't want to alienate them by allowing them to think that these were my views. It feels so delicate! I think, despite this feeling uncomfortable, it needs to be incorporated into the interview schedule, as Px mentioned having had similar feelings. However, when probed, they also mentioned feeling that this felt like it might be an internalised societal view, which accords with my discussion with Louise and feels less tricky to

grapple with. I need to remain open to the potential for it to actually be communicating something more uncomfortable though, especially as I noticed myself feeling relieved when it accorded with the 'internalised' hypothesis. Discussed wording and potential implications with Louise via email, which was helpful. We thought together about asking participants who had had this thought how they'd made sense of it in the longer-term and also trying to tease out the circumstances under which someone adopts/rejects the dominant narrative.

28/05/20 – Coding in gerunds is really difficult! I feel as though I'm imposing something onto the narrative, although I guess this may be an inevitable part of analysis. I think my concern for this really speaks to my fear of misrepresenting group that is already so frequently misrepresented, and I'm very aware of being an outsider. [Although I've been querying this – I've been an 'outsider' in all of the research I've done, so what makes this feel so different? Levels of stigma, maybe? Feeling annoyed about recent backlash to GRA modifications?]. Have decided to just jump in and go with the 'feel' of it, rather than trying to perfect initial codes. I can go back and review later, but I think there's some merit in starting with a gut interpretation. I'm also finding it helpful to make notes on tone while I'm transcribing, as I feel able to remain closer to the participants' intention in this way.

I noticed that Px has made lots of distinctions between the help-seeking patterns of "TS women" and "TS men", although she did qualify later that these were perceptions rather than grounded in experience/broader anecdote. It would make sense at this stage to consider interviewing a couple of male survivors next to see where narratives converge/depart. Gendered distinctions haven't felt especially prominent in other accounts so far, except in that there's general agreement that trans women are more at-risk of SV.

06/06/20 – Having received some feedback on my codes, I amended the interview schedule today to incorporate/probe some of the stronger themes that seem to be emerging through analysis and follow up on some tentative assertions. Querying one's gender/having others query gender identity following assault is now quite a robust thread, as is the sense that public perceptions of trans personhood preclude identification in the victim role. Also, asking about coping and resilience feels jarring immediately after stories of assault, so I've moved this to later in the interview.

Participants are talking a lot about prior experience of services, and it feels as though help-seeking avoidance is as much to do with a general distrust of services (and indeed, people) as it is to do with a distrust of services in the specific context of SV. I noticed I'd been feeling frustrated in some of the interviews when participants were talking about the wider experience of being trans and using services, rather than about SV specifically. I'm not sure why I felt that this was less relevant, particularly since when I looked back at my positioning statement, I'd clearly expected it to be the case that prior service use would impact perceptions of help-seeking agency. Decided to go back to early coded transcripts to see that this frustration hadn't led to oversights.

12/09/20 – Finished transcribing my fifth interview today. One of the things Px mentioned was that lots of people may not talk about earlier-occurring trauma because it all gets "rolled-up in the pre-transition phase that people want to forget about". Then in another section, she described it as "traumatic" and "cruel" when services misgender or deadname trans people. This joins Px's account of finding being called by their birth name 'traumatic', plus how they prefer to imagine that the abuse happened to the 'old self'. I wondered if this meant that being misgendered/deadnamed could potentially be retraumatising in that reminders of the pre-transition self are also reminders of the abuse (as well as reminders the trauma of dysphoria)? That feels very poignant to me in terms of how services can be doubly harmful in this context, but I want to make sure I'm not misunderstanding what was meant by this. Plan to look back through other interviews to see if this comes up elsewhere (if so, go back to early participants and clarify).

9/11/20 – I've been making some additional notes on body language when participants are talking about particular experiences. Px was hugging herself when talking about the assault, and I noticed that Px looked tearful when talking about feeling that there were no services available to her and how alone this had made her feel. Px also bashed the table when talking about invasive and irrelevant questions asked by professionals. I'm wondering how to bring this into the analysis. It feels important. When I discussed this with supervisors, we thought about whether this might inform which themes take up more space in the write-up rather than coding these actions themselves. This seems more feasible, but I'd like to think more about it to ensure important data isn't lost.

Also, my flat looks like a scene from Memento! So many Post-its!

18/12/20 – I feel very aware of what's going on politically at the moment re Bell vs Tavistock and this has drawn my attention back to how concerned I am about the potential to do harm through this research. I feel myself drawn to defending areas of participants' stories that I can foresee being used by mal-intentioned readers of the study. Is this affecting how I interpret the narratives? Am I minimising uncomfortable findings? This feels like something to keep an eye on. When I spoke to Px again, I told them the two ways I'd interpreted what they'd said about forgetting the abused self and asked them whether this was correct. Clarification was hugely helpful in getting my head around this, and it now feels similar to other narratives. Should employ this strategy with others, especially where interpretation feels uncomfortable – they'll know best what they meant.

02/02/21 – I noticed this afternoon that there's something going on in terms of trans identity and survivor identity being mutually exclusive in some way. I haven't quite gotten my head around this yet, but depending on the context, participants seem to experience their trans identity cancelling out their trauma or their survivorship cancelling out their trans identity.

TRANS = AT FAULT = TRAUMA INVALIDATED

OR

TRAUMA = PTSD/DISSOCIATIVE = TRANS IDENTITY INVALIDATED

Have been diagramming around this a little, but it feels a bit confused at the moment. There's definitely a thread of 'double binds' going on (see memo re early journey assault more likely/early journey assault disclosure less likely).

19/02/21 – Last night I dreamt that a sexual predator was trying to force entry into my house. On reflection, this feels linked to a similar dream at the weekend, which I hadn't thought to associate with the research until now. I've noticed a particular resistance to analysing Px's interview – I'm taking more breaks, and when I look back at the coding, it seems to me that the newly emerging codes are thin, plus I'm collapsing more into existing codes (Is this indicative of sufficiency, or is something else going on?). I've also realised that I'm coding larger sections at a time, which I'd previously put

down to research fatigue. Thinking about this now, I wonder if my resistance is because this participant spoke about their experience of sexual violence in such detail, which was difficult to hear. Must go back and re-code line-by-line, but also feel that I need some distance from this narrative.

15/04/21 – I ran the latest version of my model past Michael and Louise yesterday which was helpful. Michael referred me to Bettcher (2007) and suggested that the paradoxical cycle might border on her theory (albeit contextually different). I had mixed feelings about this, as it seemed to detract from the originality of the findings. However, it doesn't look as though there have been any empirical studies that have drawn this out, so perhaps finding resonance with Bettcher's theory actually substantiates the model.

Appendix L. Researcher's positioning statement

Positioning Statement

I identify as a cisgender, heterosexual female. That said, gender has never felt important to me, and I continue to grapple with whether this speaks solely to my privilege as a cisgender person (just as one's Whiteness can be ignored as a White person), or whether it also signifies an ambivalence about my gender. I intend to keep the privilege of this not being a painful grappling in mind during my contact with participants, in the hope that this can assist me in remaining conscious to how it might feel to not have this freedom.

I'm adamant that the same mechanisms used to oppress trans people are those used to oppress all minority persons. As a member of a multiple minority cultures, I have a vested interest in the liberation of all minoritised groups and acknowledge that I carry this with me into the research. Moreover, there's something for me that closely aligns my 'in-betweenness' as a mixed-race person to the neither/nor position that trans people occupy in the public imagination. I remember a trans friend describing her experience of speaking from a female position and wondering whether the listener views her as a woman or simply as a "man in a dress", and feeling that I had similar questions of those who hear me speak passionately about the parts of my racial identity that are not visibly communicated. I therefore recognise that my investment in trans-inclusion and equity has roots in something deeply personal, while acknowledging that trans and mixed-race identities are not the same, and will only have elements of shared experience. I wish, therefore, to be careful in not over-identifying and to seek to more accurately understand trans people's experiences as separate to my own. Having often felt misunderstood myself, I enter this research with some trepidation about my ability to authentically represent the life experiences of a community that I do not belong to.

I should acknowledge my long interest in Queer politics, literature and theory. I first became interested in trans rights while studying Queer Theory at university (2005 and 2010) and immersing myself in the work of Judith Butler, Eve Kosofsky-Sedgwick and Julia Serano. My undergraduate and master's dissertations addressed social constructions of gender on the Shakespearian stage and in the literary works of Jean Rhys, respectively. The present research will undoubtedly be influenced by

these works and by a strong commitment to contributing towards the positive visibility of trans people. This will sit alongside a heavy bias towards liberal politics, and a belief that the very act of being in the world is political. As a psychologist, I understand activism and advocacy to be as much as part of my role as therapy, research and consultation, and believe that this has contributed to my interest in this research topic. In saying this, it feels important to hold in mind that I will be tempted to dismiss data that I feel may be received as contrary to the progress of the trans majority, and that I must endeavour to interrogate these biases if necessary, so as to accurately represent the narratives of my participants.

Of course, I come with expectations of what the research will tell us. I anticipate that trans survivors will perceive further violence within the systems of support upon which they are expected to rely, with service-providers lacking the framework/skills to interpret the nuances of trans personhood and service configurations reifying the very binary that upholds gendered-violence. I expect that this is what deters trans people from approaching services, as I imagine I myself would avoid institutions that I suspected would not understand or accept me. I suspect that a strong sense of unbelonging will emerge, and that trans survivors will convey a reliance on community more so than on formal support provision. Finally, I expect that there will be an emphasis on body/gender (in)congruence and how this impacts how sexual violence is experienced and made sense of.

Appendix M. Transcript excerpts with initial coding

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Appendix N. Example table of themes, subthemes and quotes

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Appendix O. Author guideline notes for the Journal of Gender-Based Violence

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