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What About Me: Understanding the Relationship Between Gender Identity and Social Anxiety

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WHAT ABOUT ME: UNDERSTANDING THE RELATIONSHIP BETWEEN GENDER IDENTITY AND SOCIAL ANXIETY

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ABSTRACT

WHAT ABOUT ME: UNDERSTANDING THE RELATIONSHIPBETWEEN GENDER IDENTITY AND SOCIAL ANXIETY

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Anxiety disorders have been researched primarily in cisgender populations until very recently. A clear gap in the literature exists for gender diverse individuals in this research. Through analysis of transgender and gender-diverse individuals' accounts of their experiences with social anxiety, this study developed a scale specifically aligned with these encounters, titled the Allen Scale. Further, this study examined whether body dysmorphia symptoms have any correlation with social anxiety symptoms in either gender-diverse or cisgender populations. Results uncovered no clear statistical difference between the gender diverse group and the cisgender group on ratings of experienced discrimination, social anxiety or body dysmorphia as they were measured on the Allen Scale. There was no relationship uncovered between the body dysmorphia and social anxiety sections of the Allen Scale in this sample. There was also no relationship between the previously established scales relating to body dysmorphia and social anxiety. Further research should examine the relationship between body dysmorphia and social anxiety more in depth. Additionally, research should continue to examine the impact that certain types of experienced discrimination have on the health and well-being of gender minorities.

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TABLE OF CONTENTS

TABLE OF CONTENTS (CONTINUED)

Chapter Page

LIST OF TABLES

CHAPTER I

INTRODUCTION

Anxiety disorders are the most prevalent mental illness in the United States, affecting nearly a fifth of the population according to the Anxiety and Depression Association of America (2021). When discussing mental health, many groups can often be left out of the conversation, especially in psychological research. One population that has been underrepresented in mental health research are transgender people. The Human Rights Campaign (2021) estimates that there are some two million transgender individuals in the United States currently. Even still, the traditional binary gender system (i.e., male/female) is almost always used when conducting or reporting research. The purpose of this study is not only to include transgender individuals in the research, but to help specifically understand their unique experiences. Assuming that mental illness affects every population and every individual to the same extent can prevent those in need from getting proper, targeted treatment. To begin to get a picture of the experiences of transgender people, their place in the history of the United States would be a great place to start.

A few of the first documented cases of transgender individuals in the United States were Mary Henly, Mary Jones, and Christine Jorgenson. To begin, Mary Henly was assigned female at birth (AFAB) and was arrested simply for wearing men's clothes in public in 1692 (Beemyn, 2014). The arresting officer explained their reasoning was that Mary "was disrupting the course of nature" (Beemyn, 2014). Secondly, in 1803, Mary Jones was born as a free African American child who was assigned male at birth

(AMAB; America on Stone, 2019; Katz, 2001; Nyong'o, 2009; Snorton, 2017). Mary Jones, though free at birth, was arrested several times around 1836, served five years in prison for dressing as a woman, prostitution, and pickpocketing, and then was arrested again in 1845 (America on Stone, 2019; Katz, 2001; Nyong'o, 2009; Snorton, 2017).

Although she is another example of very early documented cases of transgender individuals, Christine Jorgenson was unique in that she was one of the first publicized cases of male to female (MTF) gender-alignment (formerly called sex reassignment) surgery in the mid twentieth century (Mcquiston, 2014). Even though Ms. Jorgenson had the then privilege to sexually transition to female she was still denied a marriage license and her fiancé lost his job because of his association with Christine, a transgender person (Mcquiston, 2014). Even in these early times, the law was used to exclude transgender people.

Legally, transgender people are rarely protected from discrimination. Since 2016, some legal discriminatory actions that have been taken according to the Discrimination Administration (2021) include: protection being withdrawn in schools, businesses, hospitals, homeless shelters, adoption agencies, private institutions, no longer being supported in the Title IX law; prisoners being assigned to prison based on their assigned sex at birth, regardless of whether the individual has gotten gender-alignment surgery; and more. Some states, Arkansas being the first in early 2021, have even started banning gender-alignment surgery for transgender youth, which has been considered to contribute to a potential increase in the transgender youth suicide rate (Schmidt, 2021). So far this year at least 21 states have attempted to pass similar bans (American Civil Liberties Union, 2022).

This historical evidence supports the idea of normalized disdain for the transgender community. Since the beginning of documented history in western cultures, transgender people have been cast away for disrupting a normalized gender binary system and the most unfortunate part is that it has hardly gotten much better in the current day. Transgender people are still cast out of their families, social groups, relationships, and schools (Grant et al., 2011).

To this day, discrimination remains prevalent by many systemic groups: institutional, familial, interpersonal, and intrapersonal. Discrimination for the purposes of this study and according to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; 5th ed.) refers to the act of, usually intentionally, treating a person differently from *the norm* (American Psychiatric Association, 2019) whereas prejudice refers to the sole *belief* that someone is different from *the norm* (American Psychiatric Association, 2019).

CHAPTER II

LITERATURE REVIEW

Institutional Discrimination

Institutional discrimination encapsulates differential treatment of an individual based on their social categories being against *the norm* and is performed in large-scale settings (Pincus, 1996). Every adult member of the public has likely been exposed to institutional systems at one point or another, whether that be through the workforce, schooling, or other relevant systems.

Healthcare Discrimination

One of the most prevalent health conditions in the transgender population is human immunodeficiency virus (HIV) which at least 50% are at risk of developing (Edwards et al., 2011; Nemoto et al., 2004). To compare, the general population of the United States has a risk rate at only 0.3% of contracting HIV (Centers for Disease Control and Prevention [CDC], 2020). This means that transgender folks are at least 166 times more likely to develop HIV than the general population. Despite this unfortunately high rate of risk, transgender people are much less likely to seek healthcare. Hibbert et al. (2018) compared cisgender and transgender participants in the United Kingdom and found that nearly half (i.e., 45%) of transgender individuals avoided healthcare compared to roughly a quarter (i.e., 28%) of cisgender people. In the same study, transgender subjects were much more likely to experience negative comments about HIV (i.e., 31%), to be treated differently than non-HIV patients (i.e., 48%), or to be delayed or refused treatment (i.e., 41%) compared to cisgender subjects with the same experiences (i.e., 13%, 30%, and 16%, respectively) in the United Kingdom according to Hibbert et al.

(2018). Other research indicates that about 69% of transgender participants had experienced some form of mistreatment in a healthcare setting at least once before the age of 27 and a half years of age (Hughto et al., 2018).

Housing Discrimination

Another form of institutional discrimination occurs in housing settings. Nearly a fifth of transgender individuals had been denied a place of residence based on their gender identity, and a tenth were evicted on the same basis (Grant et al., 2011). Further, those who were homeless were more likely to be incarcerated (i.e., 34%), participate in sex work as a means of income (i.e., 33%), be HIV-positive (i.e., 7%), and attempt suicide (i.e., 69%), according to Grant et al. (2011). Even though being homeless seems to increase risk factors for a multitude of other unfortunate struggles, it is not surprising that so many transgender folks turn to homelessness as a result of or as an attempt to avoid housing discrimination (O'Neill et al., 2020).

According to James et al. (2016), 26% of transgender homeless individuals avoided going to homeless shelters because they feared discrimination. Those who attempted to seek asylum in homeless shelters were turned away 29% of the time, and 42% of them were forced into rooms based on their assigned sex at birth (Grant et al., 2011). Of those successfully admitted to homeless shelters, over half experienced harassment, 25% had been physically assaulted, and 22% were sexually assaulted (Grant et al., 2011). A different survey found that 70% of transgender people reported experiencing mistreatment at homeless shelters on the basis of their gender identity/expression (James et al., 2016).

Law Enforcement Discrimination

Usually to protect oneself or others, people entrust law enforcement. For most of the general public, police are seen as helpful, caring, and sometimes generous individuals. For transgender people, however, and much of the lesbian, gay, bisexual, transgender, or queer/questioning (LGBTQ+) community and other minority groups law enforcement can be a primary source of danger, discrimination, and prejudice. According to the National Center for Transgender Equality (2016), half of transgender individuals have reported feeling uncomfortable around police. In fact, 22% of transgender persons who received police assistance have reported police harassment, and 6% reported bias-motivated assault (National Center for Transgender Equality, 2016). Transgender sex workers are also at increased risk for violence by the hand of law enforcement and are up to four times as likely as non-sex workers to report said sexual assault (National Center for Transgender Equality, 2016).

Grant et al. (2011) found that assault in prison settings is also high in transgender populations. That is, 37% of transgender individuals who served time in jail reported harassment by correctional officers and 35% experienced harassment by peers within the jail. Around 15% of those in jail reported having been physically and/or sexually assaulted in jail (Grant et al., 2011). Many (i.e., 17%) were also denied basic healthcare, including hormone treatment (Grant et al., 2011). This research surrounding law enforcement and law enforcement settings suggests that discrimination is prevalent even in those institutions which are thought to be protective and supportive.

Employment Discrimination

Employment discrimination is another important factor in the daily struggles of the transgender community. According to Grant et al. (2011), 26% of surveyed transgender people experienced losing their job directly due to their gender identity and/or expression thereof. Furthermore, 44% of participants reported not getting a job they applied for due to their gender identity, even though transgender people have been surveyed as being more likely to have higher level college degrees than the general population with 30% of transgender people have a graduate degree compared to 9% of the general population (Grant et al., 2011).

If a transgender individual was granted a position of employment, 23% of them were then denied a promotion on the basis of their transgender identity (Grant et al., 2011). It has also been found that 15% of transgender people report making under $10,000 per year compared to 4% of the general population (Movement Advancement Project, 2013). They also are less likely to receive health insurance benefits (i.e., 57%) compared to heterosexual cisgender people, (i.e., 82%) according to the Movement Advancement Project (2013). Not only are they denied benefits, fair living wages, and promotions, but nearly 80%, or 4 out of 5 individuals, within a transgender sample of workers at various institutions have reported some type of direct mistreatment or discrimination in the work-place such as being harassed by someone, sexually or physically assaulted, or denied access to appropriate bathrooms (Grant et al., 2011).

Discrimination in employment and professional settings and opportunities creates a barrier for upward social mobility for this population. Preventing transgender people from being accepted for jobs, getting promotions, or even being granted benefits confines

transgender individuals to the lower-class, and keeps them from receiving expensive gender-affirming treatment such as hormone therapy or surgery. Research by Gugushvili et al. (2022) found that, in fact, perceived social mobility has impacts not only on psychological well-being, but physical health as well.

Preventing transgender individuals from getting proper healthcare can have drastic impacts on their mental health. In fact, Murad et al. (2009) found in their research that of transgender individuals who had undergone gender-affirming treatment, 80% reported drastic improvement in gender dysphoria as well as in quality of life, and 78% reported improvement in psychological symptoms. Further, Bailey et al. (2015) discovered that access to gender-affirming treatment acted as a protective factor for transgender people at risk for suicidal ideation in the United Kingdom.

Educational Discrimination

For many children and young adults, school is a place where one comes to learn and grow academically. For transgender children, though, educational settings become unsettling and hostile environments. In fact, James et al. (2016) explains that 77% of participants in a survey of transgender students in grades K-12 who were out as transgender to their school had at least one negative experience (e.g., verbal harassment, being dress coded, assaulted), and 13% had reported being sexually assaulted. Examining several studies conducted with K-12 children, 6% of transgender students have been expelled based on their gender identity, 31% reported harassment by teachers or other staff members, 78% experienced some form of harassment in general by someone from school, and 15% of students left the school entirely due to experiences of discrimination (Grant et al., 2011).

As has been thoroughly discussed so far, institutional discrimination is harmful in many ways and is experienced at a high rate in the transgender community. This type of discrimination affects the daily lives of every transgender person, whether due to personal experience or that of acquaintances or friends.

Familial and Interpersonal Discrimination

Discrimination by Family Members

Familial discrimination refers to the different acts one may experience initiated by family members. As children, transgender youth experience maltreatment and neglect from their families. Bandini et al. (2011) found that more than a quarter of transgender participants had experienced maltreatment during childhood, including either emotional, physical, or sexual abuse. Additionally, researchers have found that out of all adverse childhood experiences, emotional abuse was most common in transgender youth, reported by 53.6% of them (Schnarrs et al., 2019). Schnarrs et al. (2019) also found that compared to cisgender lesbian, gay, and bisexual (LGB) participants, transgender individuals were 60.7% more likely to report an adverse childhood experience (ACE) score of higher than four, which indicates a higher quantity of traumatic experiences. Grant et al. (2011) further found that over half (i.e., 57%) of transgender people had experienced some form of rejection from their family members. In fact, 40% of family members reportedly refused to speak to and/or spend time with their transgender relatives based on their gender identity or expression.

When transgender individuals have children, this can be another source of great pain and discrimination for them. Grant et al. (2011) explained that 29% of transgender parents have experienced limited contact with their children based on their gender

identity, and 29% of respondents have experienced their past partner completely stopping contact or limiting the relationship between the transgender parent and their child. Additionally, 30% of transgender participants in the survey reported that their children had decided to cease all contact with them due to their gender identity/expression (Grant et al., 2011). Interestingly, AMAB transgender individuals experienced child rejection slightly more often (i.e., 37%) than AFAB transgender individuals (i.e., 33%; Grant et al., 2011). The cause of this gap could be false myths that transgender women specifically are pedophiles who just want to be closer to children (Gay and Lesbian Alliance Against Defamation, 2017).

Discrimination by Domestic Partnerships

Direct family are not the only source of discrimination for transgender people. Interpersonal discrimination is like familial discrimination in that they both occur between individuals, although the familial branch is particular to the family unit and interpersonal is not restricted in that way. Rogers (2019) explains that there is a public acceptance of a certain story of what domestic violence looks like, where heterosexual cisgender men are the perpetrator against heterosexual cisgender women based on the history of female oppression and male governing of women's bodies. This accepted narrative can be harmful for transgender people. It has been theorized that some transgender individuals might not report or even recognize abuse that comes from the hand of their significant other. Transgender participants in a study by Rogers (2019) said they felt that the abuse they experienced was wrong but not a crime, and nearly a fifth of participants (i.e., 18%) felt that the abuse they experienced was justified and normal.

There have been several studies that assess the frequency of domestic violence experienced by transgender people. Grant et al. (2011) observed that 55% of those who transition sexually to align their gender identity lose an intimate partnership, 45% of relationships end when one comes out as transgender, and around 19% of transgender people report experiencing domestic violence. The Scottish Transgender Alliance (2008) also has found that transgender participants in Scotland have reported experiencing threatening behavior (i.e., 17%), physical abuse (i.e., 11%), and/or sexual abuse (i.e., 6%) by a partner in the past. So clearly, these acts are not *just something that happened*, but instead they represent a much larger phenomenon of domestic violence in the transgender community.

Discrimination by Friends

A critical source of interpersonal discrimination to consider are a transgender person's friends or acquaintances. In fact, 58% of transgender people reported experiencing the loss of close friendships as a result of announcing their gender identity/expression (Grant et al., 2011). This happens more often for AMAB people (i.e., 67%) than AFAB people (i.e., 51%). This can create a harsh severing of a transgender person's main support system and source of social interaction.

Intrapersonal Prejudice

Due to the nature of discrimination being physical and of referring to physical acts, intrapersonal struggles are described in this paper as prejudice instead (i.e., differential thoughts or beliefs about someone). Intrapersonal prejudice, for the purposes of this study, then, has to do with what biases or prejudices are being experienced within oneself. Widespread and generally accepted negative attitudes/beliefs about the

transgender community or prejudice can cause internal conflict within transgender people themselves.

Minority Stress Theory, developed by Testa et al. (2015), can be helpful for understanding transgender attitudes about oneself and their resilience to prejudice about transgender people/general public views. An important distinction between experiences of LGB and transgender individuals is non-affirmation, which occurs when an aspect of one's identity is not supported by others (e.g., calling a transgender man "ma'am" or "miss"; Testa et al., 2015). The general premises of the gender minority stress and resilience measure is that distal stress factors such as discrimination, rejection, victimization, and prejudice impact proximal stress factors such as internalized transphobia and concealment of one's gender identity (Testa et al., 2015). The way these factors are associated with mental and physical outcomes also takes into account one's resilience as a mediating factor (Testa et al., 2015).

A qualitative study by Nadal et al. (2014) examined several themes of reactions by transgender people regarding microaggressions, which are everyday often subtle forms of prejudice or discrimination (e.g., deadnaming someone or asking them if they've had "the surgery"). Some interesting themes were experienced by transgender participants in response to being asked what it is like to experience microaggressions. These themes included feelings of anger, betrayal, distress, hopelessness, exhaustion, invalidation, and/or being misunderstood (Nadal et al., 2014).

All the research aforementioned underscores that transgender people are at high risk of experiencing discrimination and/or prejudice in every aspect of their lives. Since the cases of Mary Henly, Mary Jones and Christine Jorgensen, the United States has

failed to improve the freedom and protection that transgender people desperately require in order to survive and thrive. This can create intense conflict within transgender individuals who have to experience a society daily that invalidates them and lacks affirmation. Undoubtedly, self-hatred, depression, anxiety, and suicide may result.

Mental Health

Indeed, there is evidence in the literature that supports the existence of mental health issues in those with certain high-risk experiences. Pflum et al. (2015) has explained that social support is negatively associated with symptoms of depression and anxiety. This means that a lack of social support, which transgender people often experience, could put this group at an elevated risk for developing anxiety and depression disorders. Additionally, several studies have indicated that children who leave educational settings because of discrimination are at higher risk for suicide, possibly up to 51% (Bränström & Pachankis, 2019; Grant et al., 2011; Virupaksha et al., 2016). This is concerning especially when considering the aforementioned statistic regarding that 15% of transgender students leave their schools due to discrimination.

Since the focus of the current research is specific to social anxiety and body dysmorphia, other mental health issues disorders will not be discussed hereafter. Anxiety in the transgender community seems to occur at a much higher rate when compared to the general population. In fact, one study suggests that transgender people are up to three times more likely to have received anti-anxiety prescriptions, which is especially interesting given the previous research on their decreased access to healthcare (Bränström & Pachankis, 2019). Further, an interesting article by Griffin et al. (2018) suggests that a

transgender person's high rate of past assault experiences could significantly increase their odds for developing anxiety.

There is little research on social anxiety including transgender individuals, although there are a couple worth mentioning herein. Research completed by Butler et al. (2019) found that transgender individuals who had gone through gender alignment surgery reported significantly less social anxiety than those who had not or were only in the planning stage. Another study in Spain found that depression, cannabis use, hospitalization of parents during childhood, and nationality as factors significantly correlated with social anxiety in transgender individuals (Bergero-Miguel et al., 2016). This research helps support the idea that past trauma impacts manifestations of social anxiety.

To understand further the risk factors for developing social anxiety, research not inclusive of gender diverse individuals must be included. There are many articles that suggest that a child's experiences hold great weight for being put at risk for developing social anxiety (Hayward et al., 2008; Kuo et al., 2011). The first factors we take into account in childhood are compliance with peers and teacher support. Researchers have found that parent and youth reports of compliance are correlated with indicators of social anxiety symptoms in children as young as 10 to 12 years of age (Weymouth & Beuhler, 2018). When connecting this back to transgender youth, this suggests that their lack of support both in social groups and with teachers may make them feel like they are unable to publicly be accepted as gender diverse, and/or they may feel the excessive need to pass in public as cisgender, which in turn may lead to them developing anxiety about being in social situations.

Additional factors that influence a child's development of social anxiety are their family support systems and experiences within the home. Experiences in youth of higher parental hostility and overcontrol has been thoroughly linked to the development of social anxiety in adults (Bandelow et al., 2004; Gulley et al., 2014; Rapee & Spence, 2004; Spokas & Heimberg, 2009; Weymouth & Buehler, 2018). Additionally, several studies support the link that childhood emotional abuse, neglect, trauma, and/or emotional maltreatment are likely associated with increased chance of developing social anxiety disorder (Bandelow et al., 2004; Bruce et al., 2012; Simon et al., 2009).

One additional factor that has been consistently suggested as being one of the strongest indicators of developing social anxiety disorder is relational victimization (Norton & Abbott, 2017; Siegel et al., 2009; Storch et al., 2005). Relational victimization explains the prevalence of behaviors in which the goal is to inflict damage onto the victim's social relationships and/or reputation and can include social exclusion, rumors, and social manipulation (Rudolph et al., 2010). Peer victimization and social trauma can strongly impact those who are in critical periods of social and emotional development and has been associated strongly with development of social anxiety disorder more often than any other anxiety disorders (Cohen & Kendall, 2015). Norton and Abbott (2017) even suggest that social trauma can create a conditioning effect as an explanation for why those with experiences of social trauma may be more likely to develop social anxiety disorder.

The research presented thus far has suggested risk factors such as parental hostility/overcontrol, emotional abuse, neglect, social trauma, and relational victimization could dramatically increase the likelihood of a transgender person to develop social

anxiety disorder. To add to this foundation, a study by Olson et al. (2016) found that transgender children who are supported in their gender identity not only by their family but that also receive gender affirmative care have significantly lower experiences of anxiety. Additionally, Bergero-Miguel et al. (2016) found a rate as high as 31.4% in their study of social anxiety in transgender individuals in Spain.

Intersectionality

Another factor that must be taken into account when considering research within the transgender community is how their other marginalized identities might play a role or put them at higher risk for certain experiences or for increased possibility of developing mental health disorders. According to Grant et al. (2011), multiracial transgender people are at higher risk (i.e., 71%) compared to the overall sample average of transgender people (i.e., 61%) to experience mistreatment at school such as harassment, assault, or expulsion. Additionally, compared to the overall sample (i.e., 26%), Native American, Black, and Multiracial transgender individuals lost their position of employment at higher rates (i.e., 36%, 32%, and 36%, respectively) according to Grant et al. (2011). Furthermore, Native American transgender people (i.e., 36%) are twice as likely as the overall sample (19%) to have been refused medical care (Grant et al., 2011). This pattern continues for family violence, lost friendships, and homelessness with Black, Multiracial, and Native American persons being at highest risk (Grant et al., 2011).

A pattern is also observed with income status, where those making over $20,000 per year are at least twice as likely to own their own home compared to those making under $20,000 (Grant et al., 2011). Those in lower income brackets (i.e., under $10-$20,000 in annual income) are also at highest risk for experiencing family violence,

breaches in confidentiality and misuse of pronouns in a work environment, to be denied gender-appropriate access to restrooms, and to be sexually assaulted at work (Grant et al., 2011). This information paints a picture about the experiences of the transgender community as well as those with intersecting marginalized identities and this is important information to remember moving forward and whenever one is doing research with a marginalized population.

Cultural Differences

Another factor that could affect one's mental health is culture. Several studies have found that those with Asian heritage have generally higher scores on social anxiety scales compared to those with European heritage (Krieg & Xu, 2015; Woody et al., 2015). In terms of body dissatisfaction, it has become apparent that one's identification with Asian culture is associated with a thinner body ideal, whereas one's identification with Black culture is associated with a thicker body ideal (Guan et al., 2012). Interestingly, Warren (2008) found that awareness of Western ideals positively predicted having internalized those ideals, which then positively predicted body dissatisfaction. This suggests that Westernization and modernization of society might affect one's body ideals and satisfaction. More broadly, this research taken together infers that cultural differences likely play a strong role in one's experiences of social anxiety and body dysmorphia.

Body Dysmorphic Disorder

According to the Mayo Clinic (2022), body dysmorphic disorder is one in which the person experiencing it cannot stop thinking about flaws in their appearance and whether or not those flaws are detectable by others. Symptoms include being preoccupied

by one's appearance, belief that others think negatively about you or your appearance, attempting to hide perceived flaws, comparing one's appearance to others, seeking reassurance, perfectionism, and attempting to avoid social situations (Mayo Clinic, 2022). Interestingly, there are several risk factors that overlap between body dysmorphic disorder and those previously mentioned regarding social anxiety disorder, such as childhood neglect or abuse, relational victimization, and societal pressure (Feusner et al., 2010; Mayo Clinic, 2022).

Further, there are a few studies that suggest a strong link between social anxiety disorder and body dysmorphic disorder (Damercheli et al., 2017; Fang & Hofmann, 2010; Pinto & Phillips, 2005). One study found that the fear of positive and negative evaluation together mediates the relationship between social anxiety and body dysmorphia (Damercheli et al., 2017). Pinto and Phillips (2005) found that social anxiety was significantly correlated with severity of body dysmorphic disorder. Further, they found that greater depression and avoidant personality disorder symptoms were associated with higher social anxiety (Pinto & Phillips, 2005). Of great interest to this study, another review found that not only do social anxiety disorder and body dysmorphic disorder have a high comorbidity rate, but they also have similar age of onset as well as similar cognitive biases for interpreting ambiguous social information negatively (Fang & Hofmann, 2010).

Current Study

Social anxiety is a specific mental health concern within the transgender community mainly because of the trauma, daily discrimination and prejudice they experience. For the purposes of this study, social anxiety symptoms were examined

because of the experiences transgender persons have with society and close social interactions (e.g., family, partners, friends). As mentioned previously, social anxiety has to do with daily anxiety regarding social interactions.

The main gaps in research that this study attempted to address were social anxiety in transgender persons, as well as whether discrimination had an effect on social anxiety in this population. As previously mentioned, Butler et al. (2019) studied social anxiety in this population and found that gender alignment treatments were indicative of lower social anxiety ratings. The goal of the current research was to provide a better understanding of the connection between social anxiety and body dysmorphia in gender diverse individuals specifically, as well as whether everyday discrimination had an impact on these variables. Further, these gender diverse individuals' experiences were compared to cisgender participants to examine whether any phenomena observed were specific to the gender diverse group.

There were several hypotheses developed for this study. First, I hypothesized that transgender people would have higher ratings of body dysmorphia and social anxiety compared to cisgender participants on the portion of the questionnaire which they both took. Second, I expected higher ratings on the Everyday Discrimination Scale to correlate with higher overall ratings on the Allen Scale to measure the relationship between experienced discrimination and social anxiety or body dysmorphia. Third, I expected that transgender participants would have higher ratings on the Everyday Discrimination Scale compared with cisgender participants. Fourth, if there was a correlation between social anxiety and body dysmorphia, this relationship would be more strongly associated in transgender populations compared to cisgender populations on the portion of the

questionnaire which they both took. Fifth, the Allen Scale developed herein would be strongly correlated with scores on other developed measures for the appropriate disorder, social anxiety or body dysmorphia. Sixth, certain racial identities intersecting with a transgender identity would produce the highest rates on the Everyday Discrimination Scale.

CHAPTER III

METHOD

Participants

Participants were recruited using a snowball sampling method at Central Washington University, which began with the Equality Through Queers and Allies group (EQuAl), SONA, as well as through Facebook groups which are unassociated with the University such as "LGBTQ Allies", "Tri-Cities LGBTQ", and "Trans People and the Allies Who Support Them." All participants, regardless of gender identity, were welcome to complete the survey. Central Washington University's Human Subjects Research Council (HSRC) approval was obtained prior to data collection.

Participants were excluded if they were over age 40 or not raised primarily in the U.S. because experiences may be different for those groups, compared to those raised primarily in the U.S. and between 18 and 40 years old. For those over 40 years old, they were raised in a time where hormone treatment and gender-alignment surgery were largely unavailable. In terms of accessibility to gender-alignment surgery, there was not a movement to normalize this treatment until the 1980s and it was not approved to be covered by Medicaid until 2014 (Khan, 2016). Those not raised in the United States may have also had different experiences growing up based on another country's norms and values. It is not yet safe to assume that what is experienced in LGBTQ+ young adults in the United States is also experienced in other countries. In fact, a review of 23 countries' attitudes by Flores et al. (2016) found that although majorities in most countries supported transgender rights, each country was unique. For example, Russia and Spain

were most different from each other on the scale of attitudes towards transgender rights (Flores et al., 2016).

Materials

All questionnaires provided in this study were administered through Qualtrics in an online format.

Body Dysmorphic Disorder Questionnaire (BDDQ)

The BDDQ is a scale developed by Phillips (2005) and includes four main questions, with question three branching off into more specific ones. This questionnaire was available for public use (The Aesthetic Guide, 2022). For almost all questions, "yes" and "no" are the only potential answers; number four is different in that the responses are a-c (a = less than 1 hour a day, b = 1-3 hours a day, c = more than 3 hours a day; Dyl et al., 2006). The first question asked, "Are you worried about how you look?" (Dyl et al., 2006). Follow-up question asked, "Do you think about your appearance problems a lot and wish you could think about them less?" (Dyl et al., 2006). The next follow-up question was, "Is your main concern with how you look that you aren't thin enough or that you might get too fat?" (Dyl et al., 2006). Question two asked, "How has this problem with how you look affected your life?" with branching questions, "has it often upset you a lot?" or, "has it caused you any problems with school, work, or other activities?" (Dyl et al., 2006). Question four asked, "On an average day, how much time do you usually spend thinking about how you look?" (Dyl et al., 2006). The scale suggests the participant has body dysmorphic disorder if the participant says yes to both parts of question one, says yes to any of the sub-questions on question 3, and answers b or c on question 4 (Dyl et al., 2006). When being developed, the BDDQ was validated

using a structured clinical interview with a high sensitivity of 94% as well as a high specificity of 90% for observing body dysmorphic disorder in Swedish female individuals (Brohede et al., 2013).

Body Dysmorphic Disorder Symptom Scale (BDD-SS)

The BDD-SS was developed by Wilhelm and colleagues (2016) and includes 54 symptoms divided into seven symptom groups (i.e., checking rituals, grooming rituals, shape/weight-related rituals, hair pulling/skin picking rituals, surgery/dermatology-seeking rituals, avoidance, and BDD-related cognitions). For each symptom, participants rated whether they have experienced it within the last week on a "yes" or "no" response scale (Wilhelm et al., 2016). If participants have experienced at least one symptom in the symptom group, they are asked to rate the overall (combined) severity of symptoms on a 0 to 10 scale (0 = *no problem*, 10 = *very severe*; Wilhelm et al., 2016). The results from the BDD-SS are a severity rating calculated by measuring the sum of all severity ratings on a 0 to 70 range, as well as a symptom score calculated by measuring the total number of symptoms endorsed on the scale with a 0 to 54 range (Wilhelm et al., 2016). Higher scores indicate more severe experiences of body dysmorphic disorder (Wilhelm et al., 2016). The interitem reliability of this measure was found to be $\alpha = .75$ (Wilhelm et al., 2016). The correlation between the BDD-SS and a similar measure of body dysmorphic disorder was found to be 0.64 in a group of cisgender adults (Wilhelm et al., 2016). Written permission was obtained from the authors of this scale through email communication.

Liebowitz Social Anxiety Scale (LSAS)

The LSAS was developed by Liebowitz (1987). This scale was available for free public use (National Social Anxiety Center, 2022). This scale assesses 24 situations of which participants rate the fear or anxiety as well as avoidance they experience during these situations on a scale of 0 to 3 for fear or anxiety (0 = none, 1 = mild, 2 = moderate, 3 = severe) and a scale of 0 to 3 for avoidance (0 = never, 1 = occasionally, 2 = often, 3 = usually; Liebowitz, 1987). Example situations that were used are "telephoning in public" or "going to a party" (Liebowitz, 1987). Possible scores range from 0 to 144 with higher scores indicating more severe social anxiety (Liebowitz, 1987). The LSAS has been found to have a high degree of internal consistency in a group of Brazilian and Portuguese individuals with $\alpha = 0.96$ (dos Santos et al., 2013). The test-retest reliability has been reported at a Pearson's value of 0.82 with a period of 15 days between tests in a sample of Brazilian and Portuguese individuals (dos Santos et al., 2013).

Severity Measure for Social Anxiety Disorder (SMSAD) - Adult

The SMSAD scale was developed by Craske et al. (2013). This scale was available for free use for researchers (American Psychiatric Association, 2022). This scale includes ten experiences participants may have felt within the last seven days, rated on a scale of 0 to 4 (0 = never, 1 = occasionally, 2 = half of the time, 3 = most of the time, 5 = all of the time; Craske et al., 2013). Each statement begins with "during the past 7 days, I have…" and example experiences include, "had thoughts of being rejected, humiliated, embarrassed, ridiculed, or offending others" or, "distracted myself to avoid thinking about social situations" (Craske et al., 2013). The total score can range from 0 to 40 with higher scores being indicative of greater severity of social anxiety disorder

(Craske et al., 2013). The internal consistency of this scale is α = .92 (Ollendick et al., 2019).

Everyday Discrimination Scale

The Everyday Discrimination Scale (see Appendix A) was developed by Williams et al. (1997). This scale was available for free public use (The Child, Youth and Family Database, 2022). This measure includes 9 items scaled from 0 to 5 (0 = never, 1 = less than once a year, 2 = a few times a year, 3 = a few times a month, 4 = at least once a week, 5 = almost everyday). For this study, the scale used is a Likert 1 to 7 (1 = never, 2 = once per year or less, 3 = twice per year, 4 = once per month, 5 = twice per month, 6 = once per week, 7 = twice or more per week; Williams et al., 1997). The reason for slightly adjusting the scale for this study was to provide a more detailed assessment, as there were several large gaps between scale points (e.g., one rating higher than "less than once a year" is "a few times a year") in the original scale (Williams et al., 1997). Statements used on this scale include: "You are treated with less courtesy than other people are" or "You are threatened or harassed" (Williams et al., 1997). Higher scores on the scale are representative of more experienced discrimination (Williams et al., 1997). If participants rated having experienced any discrimination more than a couple times per year, they were asked a follow-up question on why they thought this may be happening to them with possible answers including: weight, sexual orientation, education level, income level, height, ancestry or national origin, gender, race, age, religion, other aspect of physical appearance or other (Williams et al., 1997). Cronbach's alpha was found to be 0.74 or greater and test-retest reliability after a period of two to four weeks was demonstrated as 0.70 for this scale (Krieger et al., 2005).

Allen Scale

This is a questionnaire I developed to attempt to understand social anxiety in the transgender population. This measure was developed with some inspiration by transgender-related Reddit threads and transgender YouTubers who have discussed their experiences being transgender and with social anxiety, whom I will not cite directly because I do not have prior permission to expose them publicly as transgender. Mostly these videos and threads contained an actual experience of a transgender person going through an anxiety attack or reporting their experiences directly after the attack. A common theme that appeared in many of the videos and comment threads were symptoms of body dysmorphia. Although the term body dysmorphia was not usually directly mentioned, common experiences associated with body dysmorphia appeared more than once, such as worrying about how one's body looks in public or feeling like they have to expel a lot of effort to pass as cisgender. Interestingly, many transgender people's experiences of social anxiety which I observed online seemed not to be fully aligned with experiences of cisgender people in that body dysmorphia seems present, as well as the fact that many of the transgender people reported fear of being harmed physically or sexually as a result of their gender identity.

Using this information, a measure was created with five sections totaling 34 items. The measure was developed into seven sections based on non-gender specific body dysmorphia-based questions, non-gender specific social anxiety-based questions, gender-specific social anxiety-based questions, gender-specific body dysmorphia-based questions, and open-ended questions for gender diverse people. The non-gender specific body dysmorphia-based portion includes ten statements that the participants were asked

to rate on a Likert scale of 0 to 6 (0 = *not applicable*, 1 = *strongly disagree*, 6 = *strongly agree*). Examples of statements in the body dysmorphia portion are: “My body image prevents me from going out” or “I have no control over my appearance.” There are also two reverse-scored questions on this section: “I love purchasing clothes” and “I love my face.”

The non-gender specific social anxiety-based portion includes eight statements that the participants were also asked to rate on a Likert scale of 0 to 6 (0 = *not applicable*, 1 = *strongly disagree*, 7 = *strongly agree*). Example statements in the social anxiety portion are: “My friends pity me” or “I feel awkward in public.” There are two reverse-scored statements on this section: “I have a great support system” and “How I feel about social situations does not impact my ability to function.”

The gender-specific body dysmorphia section includes five statements that the participants rated on a Likert scale of 0 to 6 (0 = *not applicable*, 1 = *strongly disagree*, 7 = *strongly agree*). Example statements in this portion are: “I envy cisgender people” or “There are barriers keeping me from being able to get hormone treatment.” There are two reverse-scored statements in this section: “I don’t care about whether I appear passing (as cisgender) when going out” and “I do fit into society’s expectation of gender norms.”

The gender-specific social anxiety section include seven statements that the participants rate on a Likert scale of 0 to 6 (0 = *not applicable*, 1 = *strongly disagree*, 7 = *strongly agree*). Example statements in this portion are: “I avoid social situations because I have personally experienced discrimination based on my gender identity” or “I worry that if I do not pass as cisgender in public that something bad will happen to me.” There

are two reverse-scored statement in this section: “I never worry when I come out to new people as transgender” and “I never avoid social situations based on my gender identity.”

The next portion included four open-ended questions where participants provided as much or little detail as they prefer. Example questions used in this portion are: “How do you feel about yourself?” or “What usually triggers your social anxiety?” A copy of this measure is provided in Appendix B.

Demographic Questionnaire

Demographic information (see Appendix C), apart from gender identity, was collected immediately after consent to the study. Demographics included in the measure were race, sex, religion, age, whether they had ever been diagnosed with social anxiety or body dysmorphia, and whether they used marijuana or alcohol to help them cope with anxiety.

Design

The primary variables in this study were body dysmorphia, social anxiety, past experiences, and gender identity. This was both a correlational and qualitative study to observe the relationship between social anxiety and body dysmorphia, as well as to better understand the experiences of transgender and non-binary individuals.

Procedures

Participants recruited to the study were provided a link to the Qualtrics survey, a copy of this recruitment document is attached in Appendix D. Participants were first prompted with an informed consent screen, a copy of which will be provided in Appendix E. Individuals were also informed that they are welcome to exit the survey at any point. Once consent was given, the demographic survey was prompted. When

participants completed the demographic measure, they were forwarded on to the Allen Scale. To clarify, all participants regardless of gender identity completed all sections except the gender-specific and open-ended questions on the Allen Scale. Following the gender non-specific portion of the Allen Scale, participants were asked about their gender identity. Those who marked anything other than "cisgender" in this section were prompted with the gender-specific questions and some open-ended questions. All participants then, whether they skipped over the gender-specific portions or not, completed the BDDQ, BDD-SS, LSAS, and SMSAD. When completed, participants were thanked for their participation and encouraged to share the Qualtrics link with others who might have been interested in participating in this study.

Statistical Analyses

In order to prepare for analysis, data were first cleaned. This included removing any test trials from the data sheet, as well as anyone who consented but did not answer any questions. Next, the BDDQ was coded from qualitative data to quantitative data mostly using a yes/no (0 = no, 1 = yes) scale. The exception was the question asking, "On an average day, how much time do you usually spend thinking about how you look? (Add up all the time you spend in total in a day)" which was coded on a three-point scale (0 = less than one hour a day, 1 = one to three hours a day, 2 = more than three hours a day). Each of the Allen Scale reverse-scored measures was then reversed. Finally, means, standard deviations, and totals were calculated for both the cisgender and gender diverse group for each measure. For analyses, an averaged score for each participant was used.

CHAPTER IV

RESULTS

Data were analyzed using Jamovi software. The number of initial participants who consented to the survey was 38, though three participants were removed due to 0% completion of the survey thereafter. Final n = 35 (female = 24, male = 4, gender non-binary = 4, transgender female = 1). The age range was between 18 and 40 (M = 22.30, SD = 4.65). Out of these individuals, there was little variety in sexual orientation (straight = 20, bisexual = 7, gay = 2, pansexual = 2, lesbian = 3) or race (White = 22, Native American = 1, Hispanic or Latinx = 5, Native Hawaiian or Pacific Islander = 2, Asian = 1, Black or African American = 2, 2 did not select a choice). There were 11 participants who reported having been diagnosed with social anxiety disorder and 7 who reported having been diagnosed with body dysmorphic disorder. In terms of substance or alcohol use, 14 individuals reported using marijuana to cope with anxiety and 11 reported using alcohol to cope with anxiety. Most participants had been recruited through Central Washington University's SONA system (i.e., 28) with the remaining six, recruited through Facebook groups and one recruited through Central Washington University's EQuAl group.

Out of the five gender diverse individuals who completed the survey, there was a fairly high degree of diversity in sexual orientation (bisexual = 2, gay = 1, lesbian = 2). The entire population of gender diverse participants reported white as their race. There were three participants who reported having been diagnosed with social anxiety disorder and one who reported being diagnosed with body dysmorphic disorder. None in this

group reported any alcohol use in order to cope with anxiety, and marijuana use was reported by two individuals to cope with anxiety.

Hypothesis Testing

The first hypothesis to be tested in this study assumed that transgender and gender non-binary individuals would have higher ratings of body dysmorphia and social anxiety compared to cisgender participants on the portions of the Allen Scale in which they could both take. Mann-Whitney U Tests were conducted to determine whether there were differences in social anxiety or body dysmorphia levels between the gender diverse and cisgender groups. Results indicated that there was not a significant difference for social anxiety between the gender diverse (M = 3.03, SD = 0.85) and cisgender (M = 2.99, SD = 0.91) individuals, U = 71, p = 0.96. Further, there was not a significant difference for body dysmorphia between the gender diverse (M = 3.92, SD = 0.75) and cisgender participants (M = 3.78, SD = 0.99), U = 62, p = 0.63. These data do not support the first hypothesis.

The second hypothesis expected higher ratings on the Everyday Discrimination Scale would correlate with higher ratings on the Allen scale. To examine this, a correlation matrix was generated, presented in Table 1. Each of the four quantitative portions of the Allen Scale were compared against the Everyday Discrimination Scale. The Everyday Discrimination Scale did not correlate with either of the Allen Scale body dysmorphia gender-specific or gender non-specific portions, nor with the gender-specific social anxiety portion. There was a small positive relationship between the Allen Scale social anxiety gender non-specific portion and the Everyday Discrimination Scale, which indicated that as scores on this portion of the Allen Scale went up, so too did scores on

the Everyday Discrimination Scale. When all quantitative portions of the Allen Scale were combined and compared with the Everyday Discrimination Scale, there appeared to be a marginal trend so that as reports of everyday discrimination increased, scores on the Allen Scale did too. These data suggest there is not a statistically significant correlation between the Allen Scale and the Everyday Discrimination Scale. These data do not support the second hypothesis. It is worth noting, though, that the social anxiety gender non-specific portion of the Allen Scale and the full Allen Scale both appeared to approach significance in their relationship to the Everyday Discrimination Scale.

Table 1

Pearson's Correlations Evaluating Hypothesis Two (n = 34 for gender non-specific analyses; n = 5 for gender specific analyses)

	Everyday Discrimination Scale Score Averages
Allen scale - body dysmorphia (gender non-specific) averages	-0.007
Allen scale - social anxiety (gender non-specific) averages	0.237*
Allen scale - social anxiety (gender-specific) averages	0.420
Allen scale - body dysmorphia (gender-specific) averages	0.026

*Note. *p < 0.05.*

The third hypothesis examined if gender diverse individuals would have higher ratings than cisgender participants on the Everyday Discrimination Scale. A Mann-Whitney U test was completed to determine if there was a significant difference between the cisgender and gender diverse group on scores on the Everyday Discrimination Scale. Results of that analysis showed that there was not a significant difference in experiences

of everyday discrimination between the gender diverse (M = 3.22, SD = 1.85) and cisgender individuals (M = 2.79, SD = 0.99), U = 58, p = 0.50. There was no statistically significant difference observed between the two groups on ratings of experienced everyday discrimination.

Next, the fourth hypothesis examined if there was a relationship between social anxiety and body dysmorphia as measured in the Allen Scale. Further, I had hypothesized that if this relationship existed, the relationship would be more strongly associated in the gender diverse group than in cisgender participants. Correlation matrices revealed no significant relationships between cisgender or gender diverse totals on the Allen Scale gender non-specific portions of social anxiety and body dysmorphia, rs < .2. These data did not support the fourth hypothesis.

Another test was conducted to check for a correlation between the other measures of social anxiety and body dysmorphia. There were no significant relationships between the BDDQ and the SMSAD or with either of the LSAS, avoidance or fear, portions. There was also no significant relationship between the BDSS and the SMSAD. Finally, there were no significant relationships between the BDSS and either portion of the LSAS, avoidance or fear. These data also did not support the fourth hypothesis.

The fifth hypothesis examined whether the Allen Scale was correlated with scores on other developed measures. Correlation matrix results are provided in Tables 2 and 3. There was a marginal positive relationship between the social anxiety gender non-specific portion of the Allen Scale and the LSAS fear portion, which indicated that increased scores on this portion of the Allen Scale predicted increased scores on the LSAS fear portion. Comparatively, the social anxiety gender non-specific portion of the

Allen Scale and the LSAS avoidance portion had a moderate positive relationship. Further, the moderate relationship was also positive between the social anxiety gender non-specific portion of the Allen Scale and the SMSAD. These data show that as scores on the gender non-specific social anxiety scale went up, scores on the LSAS avoidance portion as well as the SMSAD increased. Comparing the gender non-specific portions of the Allen Scale with the LSAS and SMSAD suggests the relationships trend positively and often to a statistically significant degree.

When comparing the gender-specific portion of the Allen Scale with the LSAS fear portion, there was no significant relationship. Similarly, there was no relationship when comparing this portion of the Allen Scale to the LSAS avoidance portion. A final comparison for social anxiety, there was no significant relationship between the social anxiety portion of the gender-specific Allen Scale and the SMSAD. This indicated no correlational trends between the social anxiety portion of the gender-specific Allen Scale and either the LSAS or SMSAD.

The body dysmorphia portions of the Allen Scale are presented in Table 3. The body dysmorphia gender non-specific portion of the Allen Scale did not have a relationship with the BDDQ. In comparison, the body dysmorphia gender non-specific portion of the Allen Scale had a positive statistically significant relationship with the BDSS. This correlation indicates that as scores on the body dysmorphia gender non-specific portion of the Allen Scale increased, so too did scores on the BDSS. The body dysmorphia gender-specific portion of the Allen Scale did not have a relationship with either the BDDQ or the BDSS. This information indicates that although scores on the body dysmorphia gender non-specific Allen Scale might predict, to an extent, scores on

the BDSS, this is not true for the BDDQ or for either of the gender-specific body dysmorphia portions. Worth mentioning here is that the BDSS and the BDDQ were correlated with one another, $r(7) = 0.72$, $p < 0.05$. So, the fact that the gender non-specific body dysmorphia Allen Scale did have a significant relationship with BDSS but not the BDDQ is curious.

Table 2

Pearson's Correlations Evaluating Hypothesis Five (n = 34 for gender non-specific analyses; n = 9 for gender specific analyses)

	SMSAD	Allen scale - social anxiety (gender non-specific) averages	Allen scale - social anxiety (gender-specific) averages	LSAS avoidance
Allen scale - social anxiety (gender non-specific) averages	0.745*	–		
Allen scale - social anxiety (gender-specific) averages	0.462	0.426	–	
LSAS avoidance	0.916*	0.687*	0.436	–
LSAS fear	0.793*	0.633^{T}	0.389	0.944**

*$p < 0.05$; **$p < 0.001$, $^{T}p = 0.067$

Table 3

Pearson's Correlations Evaluating Hypothesis Five (n = 34 for gender non-specific analyses; n = 5 for gender-specific analyses)

	BDDQ	Allen scale - body dysmorphia (gender non-specific) averages	Allen scale - body dysmorphia (gender-specific) averages	BDSS
BDDQ	–			
Allen scale - body dysmorphia (gender non-specific) averages	0.503	–		
Allen scale- body dysmorphia (gender-specific) averages	0.518	0.365	–	
BDSS	0.717*	0.818*	0.268	–

*$p < 0.05$

Overall, comparing all these relationships, it appears that statistically significant relationships were apparent only in the gender non-specific portions of the Allen Scale. This phenomenon supports part of the fifth hypothesis in that there were a few statistically significant relationships observed. The Allen Scale social anxiety gender non-specific portion had positive, statistically significant relationships with both the LSAS and SMSAD. The Allen Scale body dysmorphia gender non-specific portion, however, only had a statistically significant positive relationship with the BDSS, not the BDDQ. Further, none of the gender-specific portions of the Allen Scale had relationships with any measure.

The sixth hypothesis was that when observing scores on the Everyday Discrimination Scale, that certain individuals with intersecting racial minority and gender diverse identities would produce the highest scores. Unfortunately, this hypothesis could not be tested because all of the gender diverse individuals in the sample identified as white/not a racial minority.

Exploratory Analysis

A factor analysis was unable to be run due to an insufficient participant pool size; it has been generally accepted that factor analyses should be reserved for over 100 participants (Mundfrom et al., 2005). A factor analysis would have been useful to better understand the structure of the Allen Scale as well as the fitness of the variables.

Reliability analyses were also conducted to better understand the reliability of this new Allen Scale. For the body dysmorphia gender non-specific portion of the Allen Scale, the Cronbach's alpha was at an unacceptable level, $\alpha = 0.43$. If the first item (i.e., eating disorder) on this measure was removed, Cronbach's alpha would improve to $\alpha = 0.63$. The social anxiety gender non-specific portion was at an acceptable level of reliability, $\alpha = 0.76$. No items were suggested to be removed from this analysis. The gender-specific body dysmorphia portion of the Allen Scale was also at an acceptable level of reliability, $\alpha = 0.71$. It was suggested that the last item be removed from this measure, this would be the one questioning cisgender envy, Cronbach's alpha would then be 0.80. The gender-specific social anxiety portion of the Allen Scale was at an acceptable level of reliability, $\alpha = 0.74$. If the first item on this measure were removed (i.e., coming out), the interitem reliability would be $\alpha = 0.81$. These items were not removed prior to the analyses aforementioned although it would have been beneficial and

interesting to see whether there might have been different outcomes had these items been removed prior to hypothesis analyses.

Qualitative Analysis

There were five responses from gender diverse individuals for the open-ended portion of the Allen Scale. Each of these will be listed as this could be useful information for future research.

The first open-ended question asked, "If you experience social anxiety, what usually triggers it?" The following were responses gathered by gender diverse individuals in response to this question:

"*An uncomfortable or negative interaction*." -Participant A

"*The fear that I will be confronted for being Trans and that something bad will happen to me*." -Participant B

"*Crowds, having to have communication with someone I don't personally know, feeling out of place or awkward around other people, people talking to me and being rude*." -Participant C

"*Meeting new people, being alone with people I don't know very well*." – Participant D

"*Too many people around, crowding*." – Participant E

The second open-ended question asked, "If you have an anxiety attack, what thoughts go through your head?" The following are the responses collected in response to this question:

"*That I am out of control of my body*." -Participant A

"*I'm not enough, I can't handle this, I'm all alone, everyone is looking at me, everyone around me thinks I'm weird, I did something wrong, I can't fix this*." - Participant C

"*I'm stupid, I'm fat, no one likes you, you're so awkward*." -Participant D

"*This always happens, how do I deal with this, what am I going to do*?" - Participant E

The third question asks, "How do you feel about yourself?" The following are responses collected in response:

"*Fairly good*." -Participant A

"*I'm not always happy with my appearance and I do worry about being read*." - Participant B

"*I feel pretty confident in myself most of the time, I usually am constantly riding on a state of content but when I do experience lows they are very low lows and that's when my image on myself and my situations begin to plummet. I am still trying to figure out what I want in life and that also causes me to experience lows of stress and anxiety*." – Participant C

"*I'm OK and that has taken 30 years to get to*." -Participant D

"*Trying to feel more positively*." – Participant E

The fourth and final question on this portion asked, "Is there anything else you would like to share about your experiences as a transgender or gender non-binary person?" The following were the responses collected:

"*I find that most people struggle to understand what exactly it means to be nonbinary or gender fluid. Especially if you pass as cisgender, they just don't understand it. People may try to respect it but they are confused*." -Participant A

"*I'm mostly open about being Trans and since coming out I have had a lot of positive feedback. I even give public talks about gender expansive people. However, I live in a conservative area and I still sometimes worry about my safety. I use to have a partner and I was confronted about holding hands with her in public. Also, although it's been a long time ago, I have been stared at and confronted about being Trans*." -Participant B

"*I have only come out as non-binary about a year ago and I wasn't able to put labels and words to how I was feeling about my nonbinaryness till a couple months before I came out. So it's still pretty new but I've experienced undiagnosed anxiety for as long as I can remember*." -Participant C

"*It's difficult being non binary in a conservative area and there is a lot more fear*." -Participant D

CHAPTER V

DISCUSSION

The purpose of this research study was to challenge the assumption that cisgender research, phenomena, and treatment apply to every gender. In order to accomplish this, transgender and gender non-binary experiences were emphasized not only in data collection but in the background research on this topic. Another motivation was to create a scale that better encapsulates experiences of social anxiety among gender diverse people by looking into direct accounts from them prior to building the scale itself. Further, by better understanding the way anxiety and other mental illnesses manifest for gender diverse people, it was hoped that evidence-based clinical treatments could be developed for those with these unique experiences.

Gender Diverse Experiences

Contrary to what was expected by the first hypothesis, gender diverse individuals did not experience higher degrees of social anxiety or body dysmorphia compared to cisgender participants as measured by the Allen Scale social anxiety gender non-specific portion and the Allen Scale body dysmorphia gender non-specific portion. This is in contrast to what has been supported by several studies, which have found not only that gender diverse individuals are more likely to develop anxiety, but that they are also more likely to receive anti-anxiety prescriptions compared to cisgender individuals (Bränström, & Pachankis, 2019; Griffin et al., 2018). Further, gender diverse individuals also did not record a higher degree of experiences of discrimination in the current study which was unexpected. There are a few possibilities worth mentioning as to why this phenomenon was not observed from the current study.

First, the measure used to calculate experiences of discrimination in participants was not gender specific. This is to say that all of those who have experienced any kind of regular mistreatment would have higher ratings on the Everyday Discrimination Scale, whether it be related to their race, gender, disability status, weight, or other factors. It is more difficult to determine then whether gender discrimination alone has impact on social anxiety and body dysmorphia. Higher ratings on the Everyday Discrimination Scale did not necessarily indicate higher experiences of gender discrimination. Research by Takeda et al. (2021) found that at least five forms of discrimination, including racism and heterosexism, impact both anxiety and depression. This supports my finding that increased scores on the Everyday Discrimination Scale were likely not indicative of gender discrimination alone.

Further, Puckett et al. (2020) found that when observing experienced institutional discrimination, that higher experiences of this type of discrimination specifically were correlated with symptoms of both anxiety and depression in gender diverse individuals. Future research, then, should examine the different types of gender discrimination such as microaggressions, hate crimes, and institutional discrimination, and if there is differential impact between these discrimination types and the mental well-being of gender diverse individuals. The discrimination measure used for the current study primarily observed interpersonal experiences or direct threatening or mistreatment. It would be interesting, then, to observe other types of gender discrimination.

Second, a clear potential complication was the limited sample size of gender diverse individuals. It is much less likely to find statistically significant data patterns when working with an objectively small sample, such as five gender diverse participants.

A similar study comparing gender minorities with cisgender LGB individuals did in fact find higher rates of depression and anxiety in the gender minority group (Bauerband, 2018).

The second hypothesis was also not supported by the data developed in the current study. There were no correlations between experienced discrimination and social anxiety or body dysmorphia. These relationships were compared within the Allen Scale, against other scales, and already validated scales were compared with each other as well and no significant relationships were found. What would be interesting for further research to explore could be what types of discrimination experienced by gender minorities predicts social anxiety or body dysmorphia to the strongest degree. Research supports that major event discrimination may have a substantial impact on development of social anxiety (Bendelow et al., 2004; Weymouth & Buehler, 2009).

Social Anxiety and Body Dysmorphia

There were no significant correlations between social anxiety and body dysmorphia in this study, neither with the Allen Scale or with previously established scales. This is contrary to what was expected by the fourth hypothesis. There are several studies that exist which have suggested a strong connection between body dysmorphia and social anxiety in cisgender populations (Damercheli et al., 2017; Fang & Hofmann, 2010; Pinto & Phillips, 2005). It is possible that the small number of total participants may not have allowed us the statistical power to achieve significant correlations. It is also possible that participants may have been primed to think about social anxiety because of some of the demographic questions. This priming could have allowed participants to adjust their responses according to what they think the study may be attempting to

observe. It is further possible that there were other factors not measured in the present study that moderated the severity of social anxiety or body dysmorphia. Familial support and gender affirmative care have both been identified as factors influencing anxiety severity in past research (Olson et al., 2016).

Validity

The fifth hypothesis expected the Allen Scale body dysmorphia portions to correlate with the BDSS and BDDQ while the social anxiety portions would correlate with the LSAS and SMSAD. In this study, the social anxiety gender non-specific portion did, in fact, have a positive, statistically significant relationship with both the LSAS and SMSAD although neither of the gender-specific portions of the Allen Scale approached any relationship with other measures. Interestingly, the gender non-specific body dysmorphia portion of the Allen Scale only had a positive significant relationship with the BDSS and not the BDDQ. Part of this significant correlation only in the gender non-specific group could be due, in part, to the gender-specific portions only being completed by five participants and thus not having enough statistical power to detect significant effects.

Limitations

As with most research, there were limitations experienced herein. The first limitation of course was participant pool size, which turned out to be 35 individuals. It is worth noting here, as well, that the rate of attrition was much higher than anticipated. Out of the 35 who consented to and finished the first questionnaire, only eight participants filled out all of the non-gender specific measures. It is possible that mental exhaustion took a more extreme toll than expected. It is also worth noting that since there were also

four already established scales added onto the survey, that this may have been part of the reason for dropout. The questions may have seemed repetitive.

Another issue experienced was with Qualtrics' skip software. It appears that a couple cisgender identifying individuals were forwarded on to the gender-specific portion of the Allen Scale after being provided the gender identity question. It is possible there was an error with the skip logic since this was not a common occurrence in the data, though it is worth noting. Another issue in terms of survey order was having potentially primed participants with a gender identity question halfway through the study. This prime may have let participants in on the purpose of the study or allowed for confirmation bias to present itself. This was one possibility.

An issue that became clear within the analyses was that the gender-specific portion of the Allen Scale was not highly correlated with any other scale or with the other portions of the Allen Scale. It is possible that this is due to the much smaller participant pool size for this section of the questionnaire, which dropped down to eight individuals from 35. It is also a possibility that the gender-specific portions of the Allen Scale are not measuring social anxiety or body dysmorphia as well as previously developed measures.

Future Research

Future research should examine other vulnerable/minority populations such as people of color, disabled peoples, other LGB individuals and whether their experiences of mental wellness phenomena are consistent with what we already know given research on the majority populations. In addition, research should continue to explore how discrimination does or does not impact experiences of mental wellbeing. Also, it is possible different types of discrimination have an impact on mental health specifically.

For example, it is curious whether microaggressions or hate crimes have a larger impact on the mental health of gender diverse individuals. Finally, other mental health phenomena should be examined to assess whether past research done with cisgender populations are relevant to gender diverse populations.

In general, more open-ended and qualitative research is needed in gender diverse groups. The more we can examine gender diverse individuals' experiences from their point of view and in their own words, the more this field will learn about these individuals.

Applications and Conclusions

The conclusions brought forward in this study are interesting. As we in psychology seek to understand mental wellness of gender diverse and LGBTQ+ groups, it is more likely the truth will be uncovered. As we reveal patterns, phenomena, and experiences of gender diverse individuals, clinical treatment will be better equipped to provide better targeted treatments for these groups. It is possible it will also help normalize inclusivity in psychological research in general. This was one of the first studies to examine the relationship between experienced discrimination, body dysmorphia and social anxiety in gender diverse groups specifically. In all, future qualitative and replicative research should be completed in order to better understand how these phenomena apply more broadly.

REFERENCES

The Aesthetic Guide. (2022). Researchers validate BDD screening tool. Available at: https://www.theaestheticguide.com/cosmetic-surgery/researchers-validate-bdd-screening-tool

American Civil Liberties Union (ACLU). (2022). Legislation affecting lgbtq rights across the country. Available at: https://www.aclu.org/legislation-affecting-lgbtq-rights-across-country

"'America on Stone' The Harry T. Peters Collection." Smithsonian National Museum of American History. Retrieved August 20, 2019.

American Psychological Association. (2019). *Discrimination: What it is, and how to cope.* http://www.apa.org/topics/racism-bias-discrimination/types-stress

Anxiety and Depression Association of America (ADAA). (2021). Available at: https://adaa.org/understanding-anxiety/facts-statistics#:~:text=Did%20You%20Know%3F,of%20those%20suffering%20receive%20treatment

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

American Psychiatric Association. (2022). Severity measure for social anxiety disorder. Available at: https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/DSM/APA_DSM5_Severity-Measure-For-Social-Anxiety-Disorder-Adult.pdf

Bailey, L., Ellis, S.J., & McNeil, J. (2015). Suicide risk in the UK trans population and the role of gender transition in decreasing suicidal ideation and suicide attempt.

Mental Health Review Journal, 19(4), 209-220. https://doi.org/10.1108/MHRJ-05-2014-0015

Bandelow, B., Charimo, T.A., Dirk, W., Andreas, B., Göran, H., & Eckart, R. (2004). Early traumatic life events, parental rearing styles, family history of mental disorders, and birth risk factors in patients with social anxiety disorder. *European Archives of Psychiatry and Clinical Neuroscience, 254*(6), 397-405. https://doi.org/10.1007/s00406-004-0521-2

Bandini, E., Fisher, A.D., Ricca, V., Ristori, J., Meriggiola, M.C., Jannini, E.A.,… & Maggi, M. (2011). Childhood maltreatment in subjects with male-to-female gender identity disorder. *International Journal of Impotence Research, 23*, 276-285. https://doi.org/10.1038/ijir.2011.39

Bauerband, L.A. (2018). Investigation of health risk patterns across sexual and gender minority identities. *Dissertation Abstracts International, 78*(9-B). Available at: http://gateway.proquest.com.ezp.lib.cwu.edu/openurl?url_ver=Z39.88-2004&rft_val_fmt=info:ofi/fmt:kev:mtx:dissertation&res_dat=xri:pqm&rft_dat=xri:pqdiss:10262523

Beemyn, G. (2014). *Transgender history in the United States*. Oxford University Press. Available at: https://www.umass.edu/stonewall/sites/default/files/Infoforandabout/transpeople/genny_beemyn_transgender_history_in_the_united_states.pdf

Bergero-Miguel, T., Garcia-Encinas, M.A., Villena-Jimena, A., Perez-Costillas, L. Sanchez-Alvarez, N., Diego-Otero, Y., & Guzman-Parra, J. (2016). Gender

dysphoria and social anxiety: An exploratory study in Spain. *The Journal of Sexual Medicine, 13*(8), 1270-1278. https://doi.org/10.1016/j.jsxm.2016.05.009

Bränström, R. & Pachankis, J.E. (2019). Reduction in mental health treatment utilization among transgender individuals after gender-affirming surgeries: A total population study. *The American Journal of Psychiatry, 177*(8), 727-734. https://doi.org/10.1176/appi.ajp.2019.19010080

Brohede, S., Wingren, G., Wijma, B., & Wijma, K. (2013). Validation of the body dysmorphic disorder questionnaire in a community sample of Swedish women. *Psychiatry Research, 210*(2), 647-652. https://doi.org/10.1016/j.psychres.2013.07.019

Bruce, L.C., Heimberg, R.G., Carlos, B., Schneier, F.R., & Liebowitz, M.R. (2012). Childhood maltreatment and social anxiety disorder: Implications for symptom severity and response to pharmacotherapy. *Depression and Anxiety, 29*(2), 131-138. https://doi.org/10.1002/da.20909

Butler, R.M., Horenstein, A., Gitlin, M. Testa, R.J., Kaplan, S.C., Swee, M.B., & Heimberg, R.G. (2019). Social anxiety among transgender and gender nonconforming individuals: The role of gender-affirming medical interventions. *Journal of Abnormal Psychology, 128*(1), 25-31. https://doi.org/10.1037/abn0000399

CDC. (2018). Diagnoses of HIV infection in the United States and dependent area: *HIV surveillance report*. https://www.hiv.gov/hiv-basics/overview/data-and-trends/statistics

The Child, Youth and Family Database. (2022). Measure: Everyday discrimination scale. Available at: https://effectiveservices.force.com/s/measure/a007R00000yFTJvQAO/everyday-discrimination-scale

Cohen, J., & Kendall, P. (2015). Peer victimization among children and adolescents with anxiety disorders. *Child Psychiatry and Human Development, 46,* 393–405.

Craske, M., Wittchen, U., Bogels, S., Stein, M., Andrews, G., & Lebeu, R. (2013). Severity measure for social anxiety disorder (social phobia) - adult. *American Psychiatric Association.* Available at: http://www.psychiatry.org/practice/dsm/dsm5/onlineassessment-measures

Damercheli, N., Kakavand, A.R., & Jalali, M.R. (2017). Proposing a model for analysing relationship between social anxiety and body dysmorphic disorder: Mediating role of fear of positive and negative evaluation. *International Journal of Medical Research & Health Sciences, 6*(2), 91-103.

The Discrimination Administration. (2021). *Trump's record of action against transgender people*. Available at: https://transequality.org/the-discrimination-administration.

dos Santos, L.F., Loureiro, S.R., de Souza Crippa, J.A., & de Lima Osorio, F. (2013). Psychometric validation study of the Liebowitz social anxiety scale: Self-reported version for Brazilian Portugese. *PLoS One, 8*(7). https://doi.org/10.1371/journal.phone.0070235

Dyl, J., Kittler, J., Phillips, K.A., Hunt, J.I. (2006). Body dysmorphic disorder and other clinically significant body image concerns in adolescent psychiatric impatiens:

Prevalence and clinical characteristics. *Child Psychiatry and Human Development, 36*(4), 369-382. https://doi.org/10.1007/s10578-006-0008-7

Edwards, J.W., Fisher, D.G., & Reynolds, G.L. (2011). Male-to-female transgender and transsexual clients of HIV service programs in Los Angeles County, California. *American Public Health Association, 97*(6), 1030-1033. https://doi.org/10.2105/AJPH.2006.097717

Fang, A., & Hofmann, S.G. (2010). Relationship between social anxiety disorder and body dysmorphic disorder. *Clinical Psychology Review, 30*(8), 1040-1048. https://doi.org/10.1016/j.cpr.2010.08.001

Feusner, J.D., Neziroglu, F., Wilhelm, S., Mancusi, L., & Bohon, C. (2010). What causes BDD: Research findings and a proposed model. *Psychiatric Annals, 40*(7), 349-355. https://doi.org/10.3928/00485713-20100701-08.

Flores, A.R., Herman, J.L., Gates, G.J., & Brown, T.N.T. (2016). How many adults identify as transgender in the United States? *The Williams Institute.* Available at: https://williamsinstitute.law.ucla.edu/publications/trans-adults-united-states/

Gay and Lesbian Alliance Against Discrimination (GLAAD). (2017). Debunking the "bathroom bill" myth: Accurate reporting on nondiscrimination. https://www.glaad.org/sites/default/files/Debunking_the_Bathroom_Bill_Myth_2017.pdf

Grant, J.M., Mottett, L.A., Tanis, J., Harrison, J., Herman, J.L., & Keisling, M. (2011). *Injustice at every turn: A report of the national transgender discrimination survey.* National Center for Transgender Equality and National Gay and Lesbian

Task Force. Available at: https://transequality.org/sites/default/files/docs/resources/NTDS_Report.pdf

Griffin, J.A., Drescher, C.F., Eldridge, E.D., Rossi, A.L., Loew, M.M., & Stepleman, L.M. (2018). *American Journal of Orthopsychiatry, 88*(6), 723-731. https://doi.org/10.1037/ort0000363

Guan, M., Lee, F., & Cole, E.R. (2012). Complexity of culture: The role of identity and context in bicultural individuals' bicultural individuals' body ideals. *Cultural Diversity and Ethnic Minority Psychology, 18*(3), 247-257. https://doi.org/10.1037/a0028730

Gugushvili, A., Zelinska, O., Präg, P., & Bulczak, G. (2022). Does perceived social mobility affect health? Evidence from a fixed effects approach. *Social Science & Medicine, 294*. https://doi.org/10.1016/j.socscimed.2022.114705

Gulley, L., Oppenheimer, C., & Hankin, B. (2014). Associations among negative parenting, attention bias to anger, and social anxiety among youth. *Developmental Psychology, 50*(2), 577–585.

Hayward, C., Wilson, K.A., Lagle, K., Kraemer, H.C.,Killen, J.D., & Taylor, C.B. (2008). The developmental psychopathology of social anxiety in adolescents. *Depression and Anxiety, 25*(3), 200-206. https://doi.org/10.1002/da.20289

Hibbert, M., Wolton, A., Crenna-Jennings, W., Benton, L., Kirwan, P., Lut, I., … & Delpech, V. (2018). Experiences of stigma and discrimination in social and healthcare settings among trans people living with HIV in the UK. *AIDS Care, 30*(7), 836-843. https://doi.org/10.1080/09540121.2018.1436687

Hughto, J.M., Pachankis, J.E., & Reisner, S.L. (2018). Healthcare mistreatment and avoidance in trans masculine adults: The mediating role of rejection sensitivity. *Psychology of Sexual Orientation and Gender Diversity, 5*(4), 471-481. https://doi.org/10.1037/sgd10000296

Human Rights Campaign (HRC). (2021). Available at: https://www.hrc.org/resources/transgender

James, S.E., Herman, J.L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). *The report of the 2015 U.S. Transgender Survey*. National Center for Transgender Equality. Available at: https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf

Katz, J. N. (2001). *Love Stories: Sex Between Men Before Homosexuality*. University of Chicago Press.

Khan, F.N. (2016, November 16). *A history of transgender health care.* Scientific American. Available at: https://blogs.scientificamerican.com/guest-blog/a-history-of-transgender-health-care/

Krieg, A. & Xu, Y. (2015). Ethnic differences in social anxiety between individuals of Asian heritage and European heritage: A meta-analytic review. *Asian American Journal of Psychology, 6*(1), 66-80. https://doi.org/10.1037/a0036993

Krieger, N., Smith, K., Naishadham, D., Hartman, C., & Barbeau, E.M. (2005). Experiences of discrimination: Validity and reliability of a self-report measure for population health research on racism and health. *Social Science and Medicine, 61*(7), 1576-1596. https://doi.org/10.1016/j.socscimed.2005.03.006

Kuo, J.R., Goldin, P.R., Werner, K., Heimberg, R.G., & Gross, J.J. (2011). Childhood trauma and current psychological functioning in adults with social anxiety disorder. *Journal of Anxiety Disorders, 25*(4), 467-473. https://doi.org/10.1016/j.janxdis.2010.11.011

Liebowitz, M.R. (1987). Social phobia. *Modern Problems of Pharmacopsychiatry, 22*, 141-173. https://doi.org/10.1159/000414022

Mayo Clinic. (2022). Body dysmorphic disorder. Available at: https://www.mayoclinic.org/diseases-conditions/body-dysmorphic-disorder/symptoms-causes/syc-20353938

Mcquiston, J.T. (2014, June 10). Christine Jorgensen, 62, is dead; was first to have a sex change. *The New York Times*.

Movement Advancement Project, Human Rights Campaign, & Center for American Progress. (2013). *A broken bargain: Discrimination, fewer benefits and more taxes for LGBT workers.* Movement Advancement Project. Available at: https://www.lgbtmap.org/a-broken-bargain-full-report

Mundfrom, D., Shaw, D.G., & Ke, T.L. (2005). Tminimum sample size recommendations for conducting factor analyses. *International Journal of Testing, 5*(2), 159-168. https://doi.org/10.1207/s15327574ijt0502_4

Murad, M.H., Elamin, M.B., Garcia, M.Z., Mullan, R.J., Murad, A., Erwin, P.J., & Montori, V.M. (2010). Hormonal therapy and sex reassignment: A systematic review and meta-analysis of quality of life and psychosocial outcomes. *Clinical Endocrinology, 72*(2), 214-231. https://doi.org/10.1111/j.1365-2265.2009.03625.x

Nadal, K.L., Davidoff, K.C., Davis, L.S., & Wong, Y. (2014). Emotional, behavioral, and cognitive reactions to microaggressions: Transgender perspectives. *Psychology of Sexual Orientation and Gender Diversity, 1*(1), 72-81. https://doi.org/10.1037/sgd0000011

National Center for Transgender Equality. (2016). *Blueprint for equality: A transgender federal agenda for the next presidential administration and congress*. National Center for Transgender Equality. Available at: https://transequality.org/sites/default/files/docs/resources/NCTE%20Federal%20Blueprint%202016%20web_0.pdf

National Social Anxiety Center. (2022). Liebowitz social anxiety scale. Available at: https://nationalsocialanxietycenter.com/liebowitz-sa-scale/

Nemoto T., Operario, D., Keatley, J., Han, L., & Soma, T. (2004). HIV risk behaviors among male-to-female transgender persons of color in San Francisco. *American Journal of Public Health, 94*, 1193-1199. https://doi.org/10.2105/ajph.94.7.1193

Norton, A.R., & Abbott, M.J. (2017). Bridging the gap between aetiological and maintaining factors in social anxiety disorder: The impact of socially traumatic experiences on beliefs, imagery, and symptomatology. *Clinical Psychology and Psychotherapy, 24*, 747-765. https://doi.org/10.1002/epp.2044

Nyong'o, T. (2009). *The Amalgamation Waltz: Race, Performance, and the Ruses of Memory*.

Ollendick, T.H., Ryan, S.M., Capriola-Hall, N.N., Salazar, I.C., & Caballo, V.E. (2019). Evaluation of the reliability and validity of the social anxiety questionnaire for children in adolescents with social anxiety disorder. *Journal of Psychopathology*

and Behavioral Assessment, 41(1), 16-24. https://doi.org/10.1007/s10862-018-9699-x

O'Neill, K.K., Wilson, B.D.M., & Herman, J.L. (2020). *Homeless shelter access among transgender adults.* Williams Institute. Available at: https://williamsinstitute.law.ucla.edu/publications/trans-homeless-shelter-access/

Olson, K.R., Durwood, L., DeMeules, M., & McLaughlin, K.A. (2016). Mental health of transgender children who are supported in their identities. *Pediatrics, 137*(3), e20153223. https://doi.org/10.1542/peds.2015-3223

Pflum, S.R., Testa, R.J., Balsam, K.F., Goldblum, P.B., & Bongar, B. (2015). Social support, trans community connectedness, and mental health symptoms among transgender and gender nonconforming adults. *Psychology of Sexual Orientation and Gender Diversity, 2*(3), 281-286. https://doi.org/10.1037/sgd0000122

Phillips, K. (2005). *The broken mirror: Understanding and treating body dysmorphic disorder.* Oxford University Press.

Pincus, F.L. (1996). Discrimination comes in many forms: Individual, institutional, and structural. *The American Behavioral Scientist, 40*(2), 186-194. https://doi.org/10.1177/0002764296040002009

Pinto, A., & Phillips, K.A. (2005). Social anxiety in body dysmorphic disorder. *Body Image, 2*(4), 401-405. https://doi.org/10.1016/j.bodyim.2005.10.003

Puckett, J.A., Maroney, M.R., Wadsworth, L.P., Mustanski, B., & Newcomb, M.E. (2020). Coping with discrimination: The insidious effects of gender minority stigma on depression and anxiety in transgender individuals. *Journal of Clinical Psychology, 76*(1), 176-194. https://doi.org/10.1002/jclp.22865

Rapee, R., & Spence, S. (2004). The etiology of social phobia: Empirical evidence and an initial model. *Clinical Psychology Review, 24,* 737–767. https://doi.org/10.1016/j.cpr.2004.06.004

Rogers, M. (2019). Challenging cisgenderism through trans people's narratives of domestic violence and abuse. *Sexualities, 22*(5-6), 803-820. https://doi.org/10.1177/1363460716681475

Rudolph, K.D., Troop-Gordon, W., & Flynn, M. (2010). Relational victimization predicts children's social-cognitive and self-regulatory responses in a challenging peer context. *Developmental Psychology, 45*(5), 1444-1454. https://doi.org/10.1037/a0014858

Schmidt, S. (2021, March 29). Arkansas passes bill restricting access to medical treatments for transgender children. *The Washington Post*. Available at: https://www.washingtonpost.com/dc-md-va/2021/03/29/arkansas-passes-bill-restricting-access-medical-treatments-transgender-children/.

Schnarrs, P.W., Stone, A.L., Salcido Jr., R., Baldwin, A., & Nemeroff, C.B. (2019). Differences in adverse childhood experiences (ACEs) and quality of physical and mental health between transgender and cisgender sexual minorities. *Journal of Psychiatric Research, 199,* 1-6. https://doi.org/10.1016/j.jpsychires.2019.09.001

Scottish Transgender Alliance. (2008). Transgender experiences in Scotland. Available at: http://www.scottishtrans.org/Uploads/Resources/staexperiencessummary03082.pdf

Siegel, R., La Greca, A., & Harrison, H. (2009). Peer victimization and social anxiety in adolescents: Prospective and reciprocal relationships. *Journal of Youth and Adolescence, 38,* 1096–1109. https://doi.org/10.1007/s10964-009-9392-1

Simon, N., Herlands, N., Marks, E., Mancini, C., Letamendi, A., Zhonghe, L., … Stein, M. (2009). Childhood maltreatment linked to greater symptom severity and poorer quality of life and function in social anxiety disorder. *Depression and Anxiety, 26,* 1027–1032. https://doi.org/10.1002/da.20604

Snorton, C. R. (2017). *Black on both sides: A racial history of trans identity*. University of Minnesota Press.

Spokas, M., & Heimberg, R. (2009). Overprotective parenting, social anxiety, and external locus of control: Cross-sectional and longitudinal relationships. *Cognitive Therapy and Research, 33,* 543–551. https://doi.org/10.1007/s10608-008-9227-5

Storch, E.A., Masia-Warner, C., Crisp, H., & Klein, R.G. (2005). Peer victimization and social anxiety in adolescence: A prospective study. *Aggressive Behavior, 31*(5), 437-452. https://doi.org/10.1002/ab.20093

Takeda, K. Rosenthal, L., & Arora, P.G. (2021). Internalizing symptoms, intersectional discrimination, and social support among Asian-Pacific Islander sexual and gender minority adults. *Cultural Diversity and Ethnic Minority Psychology, 27*(3), 418-430. https://doi.org/10.1037/cdp0000442

Testa, R.J., Habrath, J., Peta, J., Balsam, K., & Bockting, W. (2015). Development of the gender minority stress and resilience measure. *Psychology of Sexual Orientation and Gender Diversity, 2*(1), 65-77. https://doi.org/10.1037/sgd0000081

Virupaksha, H.G., Muralidhar, D., & Ramakrishna, J. (2016). Suicide and suicidal behavior among transgender persons. *Indian Journal of Psychological Medicine, 38(6),* 505-509. https://doi.org/10.4103/0253-7176.194908

Warren, C.S. (2008). The influence of awareness and internalization of western appearance ideals on body dissatisfaction in Euro-American and Hispanic males. *Psychology of Men & Masculinity, 9*(4), 257-266. https://doi.org/10.1037/a0012472

Weymouth, B.B., & Buehler, C. (2018). Early adolescents' relationships with parents, teachers, and peers and increases in social anxiety symptoms. *Journal of Family Psychology, 32*(4), 496-506. https://doi.org/10.1037/fam0000396

Wilhelm, S., Greenberg, J.L., Rosenfield, E., Kasarskis, I., & Blashill, A.J. (2016). The body dysmorphic disorder symptom scale: Development and preliminary validation of a self-report scale of symptom specific dysfunction. *Body Image, 17,* 82-87. https://doi.org/10.1016/j.bodyim.2016.02.006

Williams, D.R., Yu, Y., Jackson, J.S., & Anderson, N.B. (1997). Racial differences in physical and mental health: Socioeconomic status, stress, and discrimination. *Journal of Health Psychology, 2*(3), 335-351. https://doi.org/10.1177/135910539700200305

Woody, S.R., Miao, S., & Kellman-McFarlane, K. (2015). Cultural differences in social anxiety: A meta-analysis of Asian and European heritage samples. *Asian American Journal of Psychology, 6*(1), 47-55. https://doi.org/10.1037/a0036548

Appendix A

Everyday Discrimination Scale

In your daily life, how often have any of the following things happened to you?

1	2	3	4	5	6	7
Never	Once per year or less	A couple times per year	Once per month	A couple times per month	Once per week	Twice per week or more

1. You are treated with less courtesy than other people: _____
2. You are treated with less respect than other people: _____
3. You receive worse service than other people in restaurants or stores: _____
4. People act as though they think you are not intelligent: _____
5. People act as though they are afraid of you: _____
6. People act as though they think you are dishonest: _____
7. People act as though they are better than you: _____
8. They call you names or insult you: _____
9. You are threatened or assaulted: _____

Follow-up Questions (Ask them only if they responded "A couple times per year" or higher frequency for at least one question): What do you think is the main reason for these experiences?

Weight	Sexual orientation	Education level	Income level	Other aspect of your physical appearance	Height
Ancestry or national origin	Gender	Race	Age	Religion	Other (please specify):

Appendix B

Allen Scale

Scale for Parts 1 and 2:

1	2	3	4	5	6
Strongly disagree	Somewhat disagree	Slightly disagree	Slightly agree	Somewhat agree	Strongly agree

PT.1. - Body-related items.

1. I think about my body constantly: _____
2. My body image prevents me from going out: _____
3. I worry about how others see my body all the time when I am out: _____
4. I love my face: _____
5. I wish I could change my height: _____
6. I have struggled with an eating disorder either in the past or currently: _____
7. I love purchasing clothes: _____
8. I don't like what I see when I look in the mirror: _____
9. I am unhappy with my appearance: _____
10. I have no control over my appearance: _____
11. Thinking about my body stresses me out: _____
12. I never think about my weight: _____

PT.2. - Anxiety-related items.

13. I avoid social situations altogether: _____
14. I make excuses to get out of going out: _____
15. People look at me whenever I am out in public: _____
16. My friends pity me: _____
17. I feel awkward in public: _____

18. I don’t have any friends:_____

19. I am a burden to those around me: _____

20. I have a great support system: _____

21. Thinking about socializing causes me distress: _____

22. I have had anxiety about social situations for at least the last six months: _____

23. How I feel about social situations does not impact my ability to function: _____

Drop-Down Trans Questions

Scale For Parts 1 and 2

1	2	3	4	5	6
Strongly disagree	Somewhat disagree	Slightly disagree	Slightly agree	Somewhat agree	Strongly agree

PT.1. - Body-Related:

24. There are barriers keeping me from being able to get hormone treatment: _____
25. There are barriers keeping me from being able to get gender alignment surgery: _____
26. I don't care about whether I appear passing (as cisgender) when going out: ____
27. I do fit into society's expectation of gender norms: _____
28. I envy cisgender people: _____

PT.2. - Anxiety-Related:

29. I worry that if I do not pass as cisgender in public that something bad will happen to me: _____
30. I avoid social situations because I have personally experienced discrimination based on my gender identity: _____
31. I avoid social situations because my transgender or gender non-conforming friends have experienced discrimination: _____
32. I feel that if I were on hormone therapy (or if I already am) that it would (or it has) improve(d) my ability to be in social situations: _____
33. I never avoid social situations based on my gender identity: _____
34. I worry that whenever I leave the house I might encounter a harmful, threatening, or dangerous situation because of my gender identity: _____
35. I never worry when I come out to new people as transgender: _____

PT.3. - Open-Ended:

36. If you experience social anxiety, what usually triggers it?

37. If you have an anxiety attack, what thoughts go through your head?

38. How do you feel about yourself?

39. Is there anything else you would like to share about your experiences as a transgender or gender non-binary person?

Appendix C

Demographic Questionnaire

1. How did you find out about this study?

CWU SONA System	Facebook Group	A friend/acquaintance recommended it	EQuAl	Other (please specify): _____

2. How old are you in years? _____.

3. What is your sex?

Male	Female	Intersex	Transitioning	Other (please specify)

4. What is your sexual orientation?

Straight	Questioning	Bisexual	Pansexual	Gay	Lesbian	Asexual	Other

5. What is your race/ethnicity?

Native American	Asian	Black or African American	Native Hawaiian or Pacific Islander	White (not hispanic)
Hispanic or Latinx	Multiracial	Biracial	Prefer Not to Answer	Other (please specify):

6. Have you ever been diagnosed with social anxiety disorder? YES NO

7. Have you ever been diagnosed with body dysmorphic disorder? YES NO

8. Do you use marijuana to cope with stress or anxiety? YES NO

9. Do you drink alcohol to cope with stress or anxiety? YES NO

Appendix D

Recruitment Script

To whom it may concern,

My name is Jessica Allen, and I am a second-year graduate student in the Experimental Psychology Program at Central Washington University. I am conducting a research study examining experiences of social anxiety and you are invited to participate in the study. The series of surveys is anticipated to take no more than an hour.

Participation in this study is voluntary. Your identity as a participant will remain during and after the study's completion. To ensure confidentiality, each participant's responses will be labeled with a randomized number code. Each document of qualitative responses will be printed and kept safe in a locked file cabinet in a locked room of which only the researchers for this study have access. Again, these files will not contain any identifying information.

If you have questions or would like to participate, please contact me at [email] or follow the link provided:https://qfreeaccountssjc1.az1.qualtrics.com/jfe/form/SV_40Wh5mCJSknFjcW .

Thank you for your participation,

Jessica Allen

Central Washington University

Experimental Psychology Program

Second-Year Graduate Student

Appendix E

CENTRAL WASHINGTON UNIVERSITY RESEARCH PARTICIPANT INFORMED CONSENT

Study Title: Social Anxiety in Eastern Washington.

Principal Investigator: *Jessica Allen, Graduate Student of Experimental Psychology, CWU, [Jessica's email]*

Faculty Sponsor: *Dr. Susan Lonborg, Professor of Psychology, CWU*

Free Resources:

866-4-U-TREVOR (866-488-7386) for support.
800-273-TALK (8255) National suicide prevention hotline.
877-565-8860 trans lifeline.
741741 crisis text line.
800--656--HOPE (4673) National sexual assault hotline.
1-844-9-NO-HATE to report a hate crime.
http://www.nafcclinics.org/ National Association of Free and Charitable Clinics offers basic health care for those without insurance
https://www.radremedy.org/ list of trans-affirming healthcare providers by RAD Remedy.
https://out2enroll.org resources to help enroll in insurance by Out2Enroll.
https://transcendlegal.org/ help with transgender-related healthcare by Trascend Legal
https://pointofpride.org/annual-transgender-surgery-fund/ financial assistance for transgender individuals who cannot afford treatment by the Point of Pride Annual Transgender Surgery Fund.
http://transgenderlawcenter.org/ advocacy and legal support by the Transgender law Center.
http://tldef.org/ Transgender Legal Defense and Education Fund.
http://www.blackandpink.org/resources-2/national-prisoner-resource-list/ support for LGBTQ+ individuals who have been or are currently incarcerated.
https://transgenderlawcenter.org/programs/tide information on pro-bono attorneys and legal service provides for transgender immigrants by The Transgender Law Center's Trans Immigrant Defense Effort (TIDE)
http://forge-forward.org/anti-violence/ FORGE is a national transgender antiviolence organization.
https://www.eeoc.gov/eeoc/newsroom/wysk/enforcement_protections_lgbt_workers.cfm enforces federal protection for LGBTQ+ workers by U.S. Equal Employment Opportunity Commission (EEOC).

1. What you should know about this study:

- You are being asked to join a research study.
- This consent form explains the research study and your part in the study.
- Please read it carefully and take as much time as you need.
- Ask questions about anything you do not understand now, or when you think of

them later.

- You are a volunteer. If you do join the study and change your mind later, you may quit at any time without fear of penalty.
- While you are in this study, the study team will keep you informed of any new information that could affect whether you want to stay in the study.

2. Why is this research being done?

This research is being done to understand social anxiety more thoroughly and what contributes to it in a more detailed sense than has been studied before. The goal is that doing research in a population that has not been included in research until recently will allow for more targeted therapies and treatments for trauma and mental illnesses for these individuals in the future.

3. Who can take part in this study?

Transgender or non-binary individuals are encouraged to participate. Cisgender individuals are included in this study as well. Those who were not born in the U.S. and who are currently 40 years old or older are excluded from this study as well.

We hope for at least 50 participants to complete this study.

4. What will happen if you join this study?

If you agree to be in this study, we will ask you to do the following things: You will be asked to fill out several questionnaires assessing social anxiety symptoms, personal feelings about oneself or others, and personal experiences. After you finish this questionnaire if you should choose to continue, you will be forwarded to a short demographic questionnaire to help us understand the overall population of participants better. The entire study should take about an hour to complete.

5. What are the risks or discomforts of the study?

This study may be slightly uncomfortable or psychologically challenging for some due to the types of personal questions being asked. It is possible that this study could be emotionally triggering for those who may have gone through traumatic events or psychological troubles in the past. If this study begins to make you feel uncomfortable to any degree, you should immediately exit the survey regardless of level of completion. Our priority is your safety and well-being.

6. Are there benefits to being in the study?

There is no direct benefit to you from being in this study. You will not be diagnosed with anything if you complete this study for that is not the purpose herein.

If you take part in this study, you may help transgender people in the future in helping to understand their social anxiety so treatments and therapies can be

better targeted for them/you.

7. What are your options if you do not want to be in the study? For students at CWU, you **do not have to join this study. If you do not join, it will not affect your grade in any class or any of your privileges as a CWU student.**

Students not enrolled at CWU, you **do not have to join this study. If you do not join, it will not affect any benefits to which you are entitled**.

8. Will you be paid if you join this study?

Financial compensation will not be offered in this study.

9. Can you leave the study early?

You can agree to be in the study now and change your mind later. If you wish to stop at any time, please tell us right away. For those enrolled at CWU, leaving this study early will not affect your standing at CWU in any way. If you leave this study early, the investigator may use information already collected from you.

10. What information about you will be kept private and what information may be given out?

Any and all information provided in this study will be carefully kept private and anonymous. This is a completely anonymous survey and there are no identifying questions being asked or taken from your completion in the survey.

11. What other things should you know about this research study? a. What is the Institutional Review Board (IRB) and how does it protect you?

This study has been reviewed by the CWU Human Subject Review Council. HSRC is made up of faculty from many different departments, ethicists, nurses, scientists, non-scientists and people from the local community. The HSRC's purpose is to review human research studies and to protect the rights and welfare of the people participating in those studies. You may contact the HSRC if you have questions about your rights as a participant or if you think you have not been treated fairly. The HSRC office number is (509) 963-3115.

b. What do you do if you have questions about the study?

E-mail or call the principal investigator, Jessica Allen, at [Jessica's email] or [Jessica's phone] or you can contact her Faculty Advisor, Dr. Susan Lonborg, at [Susan's email].

c. What should you do if you are injured, ill or emotionally upset as a result of being in this study?

If you think you are injured or ill as a result of being in this study, call the principal investigator, Jessica Allen, at [Jessica's phone].

If you are a CWU student and have an urgent problem related to your participation in this study, call the Student Medical and Counseling Clinic at 963-1881 (medical) or 963-1391 (counseling). This study is not able to offer financial compensation nor to absorb the costs of medical treatment should you be injured as a result of participating in this research. However, the services at the Student Medical and Counseling Clinic will be open to you as they are to all students.

12. What does your signature on this consent form mean?

By signing this consent form, you are not giving up any legal rights. Your signature means that you understand the study plan, have been able to ask questions about the information given to you in this form, and you are willing to participate under the conditions we have described.

A copy of the form will be given to you.

Participant's Name (print): _____

Participant's Signature: _____
Date:____

Signature of Investigator: _____
Date:____