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Specialists in Name or Practice? The Inclusion of Transgender and Gender Diverse Identities in Online Materials of Gender Specialists

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Abstract

Recommendations for health care providers working with transgender and gender diverse (TGD) individuals emphasize affirming clients' identities, such as using correct pronouns and name, however it is unknown how often gender specialists adhere to such recommendations. Websites and intake forms of gender specialists were coded for use of affirming language, asking for pronouns and chosen name, and mention of TGD specialties and resources. Most websites identified the provider's specialty to work with TGD individuals, though much fewer provided additional resources concerning TGD issues and only half of intake forms included affirming language. Given previous research that has demonstrated providers working in states with legal protections for TGD individuals use affirming language more often than providers in locales without protections, association with state legal climate is also examined.

Keywords

gender-affirmative practices; legal climate; intake forms; provider websites; behavioral health providers

Introduction

Transgender and gender diverse (TGD) individuals interact with healthcare settings or desire access to care, both physical and behavioral health, at high rates (James, Herman, Rankin, Keisling, Mottet, & Anafi, 2016). Heng, Heal, Banks, and Preston (2018) completed a systematic review of TGD individuals' report of their experiences with healthcare systems,

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finding many experiences can be marginalizing and stigmatizing but also identifying methods that lead to positive experiences. Heng and colleagues identified frequent themes, including healthcare provider knowledge and communication. Important components to positive communication were normalizing TGD experiences and affirming patients' identity, such as using patients' preferred name and ensuring medical documentation affirm the patients' gender and identity. In fact, providers were deemed as more professional, and thus sensitive and respectful, when pronouns and preferred names were used. Negative experiences with provider communication occurred when patients' TGD identities were ignored or undervalued, as well as overvalued such as assuming a patient's TGD identity was influential in a health concern when the purpose of a health care visit was not TGD related. The Heng et al. (2018) review also summarized TGD individuals' recommendations to health care providers. Amongst these recommendations were attention to healthcare environments, including physical spaces and online websites (e.g. Ross & Castle Bell, 2017) and adapting intake forms to be inclusive of TGD identities. Inclusive language can include providing a blank space for patients to write their gender identity, asking for patients' pronouns, and clearly distinguishing between gender identity and gender assigned at birth (Holt, Hope, Mocarski, & Woodruff, 2019). These recommendations largely concur with several other sources (e.g., Cochran, Reed, & Gleason, 2018; Holt et al., 2019).

Online materials are often the first point of contact for TGD individuals with their healthcare providers (Ross & Castle Bell, 2017) meaning provider websites are an opportunity to communicate expertise in TGD health. In addition to provider websites, intake forms (whether posted online or completed in the waiting room) are another initial point of contact patients have with their providers. Intake forms request patient information, such as demographics, and may include patient health history or a description of why the patient is seeking services. Just as an intake form is an initial point of contact for patients, it is often the first information source relayed to the provider. Hosting intake forms on provider websites can save patients time in waiting rooms by completing paperwork ahead of time and also can be a source of information regarding provider attitudes. For TGD individuals, intake forms can communicate positive or negative messages regarding gender and respect for their identities (Ross & Castle Bell, 2017). The language used by providers not only can convey providers' respect for diversity, but also their competency to work with clients and their level of education. The speed at which appropriate language related to gender diversity changes adds another competency dimension that can be visible in provider materials. Staying current on terminology or matching a patient's language can suggest that a provider demonstrates communicative competency needed to work with TGD individuals (Rossi & Lopez, 2017). These online materials and initial points of contact are important to understanding TGD peoples' experiences with health care providers.

There have been several calls for providers to use affirming language on forms and specify their expertise with TGD patients (American Psychological Association, 2015; Makadon, Mayer, Potter, & Goldhammer, 2015). For example, the APA Guidelines for Psychological Practice with Transgender and Gender Nonconforming People offers examples of applications of the broader guidelines, such as using inclusive demographic questionnaires as a way to enact the guideline "Psychologists strive to recognize the influence of institutional barriers on the lives of TGNC people and to assist in developing TGNC-

affirmative environments". Attention to these recommendations is vital to reduce instances of microaggressions and stigma, like misgendering, in healthcare fields and further deconstruct binary notions of gender (Ansara & Hegarty, 2014; Hyde, Bigler, Joel, Tate, & van Anders, 2019; Mizock & Lundquist, 2016). However little is known regarding how often these recommendations are implemented by providers. Goins and Pye (2013) conducted a content analysis of sexual health intake forms and identified limited inclusion of LGBT identities. Turning to behavioral health, Holt, Hope, Mocarski, and Woodruff (2019) completed a content analysis of mental healthcare providers' websites and intake forms who advertised online as working with TGD clients by adapting coding schemes from Wright and McKinley (2011) and related follow-up study (McKinley, Luo, Wright, & Kraus, 2015).

Holt et al. (2019) collected intake forms and websites from 25 U.S. states using Google searches meant to mimic how a TGD person may seek a TGD-affirming therapist. The authors examined how providers' intake forms asked about gender/sex and inclusion of questions for chosen name and pronouns. Additionally, Holt and colleagues explored how many providers' websites indicated a provider specialty to work with TGD clients, that the provider offered group counseling for TGD clients, linked to a TGD or LGBT resource, provided additional information about TGD issues, and indicated the provider belonged to a professional organization related to TGD issues or expertise. Results of the content analysis indicated only a slight majority of providers (56.6%) indicated on their websites that they specialized in working with TGD clients, despite being identified in Google searches for "gender therapist." Additionally, 32.1% of the websites were devoid of any mention or reference to TGD services or resources. On intake forms, 56.8% of providers who included questions about gender and/or sex presented these questions in an affirming manner. In addition to identifying the frequency at which TGD-inclusive practices were implemented, Holt and colleagues examined differences in inclusive practices based on the legal climate for TGD individuals in states where providers practiced. A greater proportion of intake forms from states with protections for TGD people used affirming language and included pronoun questions than intake forms from states without legal protections. There were no differences in website coding categories based on state legislation climate which may be attributable to the small number of providers who included resources on their websites.

One important limitation of the Holt et al. (2019) study is while providers advertised as working with TGD clients, there was no vetting process to determine providers' knowledge or experience working with TGD clients. All that a TGD person could surmise based on the Google search approach is that a provider demonstrated a willingness to work with TGD clients, leaving it unknown how many providers with advanced training or certification, sometimes known as *gender specialists*, were included in the Holt et al. sample.

Gender specialists can work in primary care settings or specialized LGBT clinics such as Fenway Health in Boston (Reisner et al., 2015). Given that many TGD people do not have access to specialty clinics, programs such as the World Professional Association for Transgender Health's (WPATH) Global Education Initiative are seeking to increase the number of providers who could be considered gender specialists. Holt et al. (2019) identified WPATH's "Find a Provider" feature as an online search option to help TGD individuals identify providers with expertise to work affirmatively with TGD individuals. Individuals

accepted into WPATH membership, which requires adhering to WPATH governing documents and policies such as the Standards of Care (SOC; Coleman et al., 2012), are listed on the public "Find a Provider" feature. Following Holt and colleagues' findings that only half of their sample of providers who advertised working with TGD clients used affirming language on intake forms and very few mentioned TGD resources on their websites, it is important to determine if TGD people can find more affirming resources from gender specialists and if TGD people in states with few legal associations are exposed to greater stigma in provider resources.

The first purpose of the current study was to assess how gender specialists (providers listed on WPATH's "Find a Provider" online feature) include mention of TGD resources and specialties on their websites and address TGD identities on their intake forms using a modified version of the coding method by Holt and colleagues (2019). The second purpose was to examine the relationship between state legal climate and inclusion of TGD services, resources, and affirming language in the products of gender specialists. Hypothesis 1 was that most gender specialists would address their expertise with TGD individuals on their websites, provide resources, and be inclusive of TGD identities on their intake forms. Hypothesis 2 was that we would replicate the surprising finding of Holt et al. (2019) that state legal climate is associated with the inclusion of TGD identities on intake forms but not websites.

Methods

Sample selection

Providers, including medical and behavioral health care, were identified for potential inclusion in the study by their presence on WPATH's "Find a Provider" feature in January through March of 2018. Providers were included in the final sample if they were from the United States, had identifiable websites (either linked from their WPATH profile or via a Google search) and if they provided a downloadable intake form on their website. Both websites and intake forms were used to ensure multiple data sources were available from each included provider. Eight hundred and eighteen providers were considered for inclusion. Websites were identifiable for 527 providers but only 114 providers had intake forms available and were selected for the study.

Provider demographics

Professional demographics, including field, size of practice, and education level, of the 114 providers included in the sample were collected. Seventy-seven (67.50%) providers were behavioral health care providers including psychology, counseling, and social work, 36 (31.58%) worked in the medical field, including physicians and physical health nurse practitioners, and 1 provider (1.8%) worked in another field (speech pathology). The sample included 56 providers (49.10%) working in an individual practice and 58 (50.90%) working in a group setting. Fifty-nine providers (51.75%) held doctorate level degrees, including PhDs and MDs, and 55 providers (48.25%) had Master's level degrees. Providers were from 31 states. See Table 1 for a list of the number of providers from each state.

Coding

Providers' websites were coded for mention of a provider specialty to work with TGD individuals and for linking to a TGD resource. Intake forms were coded for inclusion of TGD-affirmative language, asking for patients' pronouns, and asking for patients' preferred or chosen name. These coding categories were adapted from Holt et al.'s (2019) coding scheme, which was informed by provider recommendations in previous literature, the Trans Collaborations Local Community Board, and content analyses of university counseling center websites (Holt et al., 2019; McKinley et al., 2015; Wright & McKinley, 2011). Websites and intake forms were coded by the first and second author. One third of the sample was coded by both raters to determine interrater reliability. Cohen's K was used to determine interrater reliability. Discrepancies were discussed amongst raters until they reached agreement.

Websites.

Each coding category was assigned a dichotomous variable of "yes" or "no" after raters assessed the presence of TGD-affirming information on websites, specifically for mention of a Provider Specialty and presence of any Links to Resources. For websites, Provider Specialty was coded "yes" if providers mentioned providing services for TGD individuals, noted a specialty to work with TGD individuals, or identified they belonged to a professional organization dedicated to TGD individuals, such as WPATH. Interrater reliability for Provider Specialty was good (Cohen's $K = 0.78$).

Link to Resource was coded "yes" if the providers' websites provided a link to an additional site on TGD issues, organizations, or community resources. This could include a link to WPATH Standards of Care, a local support group, or referrals to other TGD-affirming providers in the area (e.g. a therapist referring to a local physician who prescribes hormone therapy). Raters examined homepages and available subpages of provider websites. For Link to Resource, interrater reliability was low (Cohen's $K = 0.56$). The "Additional Information" coding category in Holt et al. (2019) was not used in this study due to low interrater reliability.

Intake forms.

The coding categories for intake forms included use of Affirmative Language and inquiring about Pronouns and Chosen Name. The coding for Pronouns and Chosen Name were dichotomous variables of "yes" or "no." Pronouns was coded as "yes" if intake forms included a question that allowed patients to record their preferred pronouns. Interrater reliability for Pronouns was excellent (Cohen's $K = 1.00$). Similarly, Chosen Name was coded "yes" if there was dedicated space on the intake forms for clients to record their preferred name, chosen name, or nickname. Interrater reliability was good (Cohen's $K = 0.87$).

Affirmative Language (dichotomous variable of "yes" or "no") was slightly adapted from the Holt et al. (2019) coding scheme to be a global assessment of how the intake forms addressed gender rather than solely considering how gender and sex questions were asked given feedback from the Trans Collaborations Local Community Board that it is not vital for

providers (particularly behavioral health providers) to ask for gender on an intake form. For example, asking about a patient's gender but not including the presence of pronouns and chosen name would be scored as "yes" for inclusion of affirming language as would an intake form that did not ask about gender or sex but did allow space for patients to record their pronouns and chosen name. Intake forms that employed a binary notion of sex (e.g. asking for a patient's sex and only offering "male" and "female" as options) without considering gender/gender identity would be coded as "no" for inclusion of affirming language. Interrater reliability for Affirming Language was good (Cohen's $K = 0.79$).

State legal climate was assessed in several categories: Employment, Conversion Therapy, Education, Gender Marker on ID, Hate Crimes, Housing, Public Accommodations, School Anti-Bullying, and Trans Healthcare. The Human Rights Campaign's (HRC; 2018) State Maps (were used to identify the level of legal protections for TGD people in each state included in the sample. Similar approaches using HRC data to classify state legal climate have been used in previous research (e.g. Blosnich et al., 2016). State legal climate in each category was assessed as a binary variable, "Protections" or "No Protections," to describe if there were protections based on gender identity in each policy category. See Table 2 for detailed descriptions of laws and policies deemed as Protections or No Protections.

Data analysis

Frequencies described the occurrence of each website and intake form category in the whole sample. X^2 analyses were used to examine differences in website and intake form categories across provider demographics. Patterns of difference in intake and website codings and different levels of legal protections amongst the whole sample were tested with X^2.

Results

Frequencies

Websites.—Most websites (82.50%) included mention of a provider specialty to work with TGD individuals and the remaining 17.50% of websites did not indicate a provider specialty. For Link to Resource, only 36.00% of the sample included a link to additional TGD resources, information, or organizations but most of the sample, 64.00%, did not include such links.

Intake forms.—About half of the providers, 53.50%, used TGD-affirmative language on intake forms but 46.50% did not. Only 18.40% of the intake forms included a pronoun question and 32.50% of the intake forms included space for patients to record their preferred, chosen, or nickname.

Provider demographics and affirming language and resources

Provider field.—X^2 analyses examining relationships between provider field (mental health or medicine) and intake and website categories demonstrated significant findings for identifying a provider specialty on websites ($X^2(2) = 9.13$, $p = .01$). Specifically, a larger proportion of mental health providers identified a provider specialty on their website

(88.31%) compared to medical providers (72.22%). There were no other significant relationships between intake and website categories and provider field (all *p*s > .05).

Size of practice.—For size of practice (individual or group), there was a marginally significant relationships for provider specialty on websites ($X^2(2) = 3.55$, $p = .06$) such that providers from individual practices identified their specialty to work with TGD individuals on their websites more often (89.29%) than providers from group practices (75.86%). There were no other significant relationships between intake and website categories and size of practice (all *p*s > .05)

Education level.—There were no significant relationships between intake and website coding categories and provider education level (Masters or Doctorate; all *p*s > .05).

State legal climate and affirming language and resources

Websites of whole sample.—Based on X^2 analyses, there was no relationship between mention of a provider specialty or link to resource on websites and state legal climate (all $p > 0.05$). This was consistent with Hypothesis 2 and replicates Holt et al. (2019).

Intake forms of whole sample.—Using X^2 analyses, intake form codes for affirmative language (pronouns, chosen name, and affirmative language) were compared for states with and without legal protections for TGD people. A larger proportion of intakes forms from states with legal protections including conversion therapy ($X^2(1) = 5.54$, $p = 0.02$), gender marker on IDs ($X^2(1) = 3.74$, $p = 0.05$), hate crimes ($X^2(1) = 4.20$, $p = 0.04$), housing ($X^2(1) = 4.93$, $p = 0.03$), public accommodations ($X^2(1) = 4.93$, $p = 0.03$), and school anti-bullying ($X^2(1) = 3.86$, $p = 0.05$) included pronoun questions than states without legal protections for TGD people. Sample size and percentages are available in Table 3. There was also a similar pattern for whether states included legal protections for TGD healthcare, but this did not reach conventional statistical cutoffs ($X^2(1) = 3.54$, $p = .06$). There were no significant relationships between legal climate and chosen name questions nor use of affirmative language on intake forms (all *p*'s > .05). In addition, there were no significant relationships between legal climate for employment or education and asking for pronouns in intake forms. These results partially support Hypothesis 2.

Discussion

The current study applied an adapted coding scheme from Holt et al. (2019) to examine how gender specialists from WPATH's "Find a Provider" list include TGD identities and resources in their online materials and whether online materials were more TGD-affirmative in states with more legal protections. These providers not only are approved for WPATH membership and pay a yearly fee, but agree to adhere to WPATH ethical standards and policies, including recommendations such as "mental health professionals develop and maintain cultural competence to facilitate their work" in the SOC (Coleman et al., 2012), increasing the caliber of providers in this sample compared to the Holt et al. sample (2019). Overall, most providers identified a specialty to work with TGD individuals. This means TGD individuals using WPATH's list feature will have further verification on providers' own websites that they serve TGD clients. However, beyond mention of provider specialty,

many providers did not integrate other recommendations for intake forms and websites. Only 36.00% of providers offered a link to a TGD resource. On intake forms, barely a majority of providers (53.50%) used inclusive and affirming language and less than a third of providers offered space for patients to write their chosen names (32.1%) or their pronouns (18.40%). The proportion of providers who used inclusive language on intake forms is similar to findings from the Holt et al. (2019) study. Gender specialists in this sample identified themselves as such on their websites, but not all integrated their expertise and affirming nature into their intake forms.

As expected, there were no significant relationships between state legal climate and website codings, similar to the findings of Holt et al. (2019). On intake forms, providers in the entire sample from states with legal protections for TGD individuals asked for pronouns more often than providers from states without legal protections. There were no relationships between use of affirming language on intake forms and state legal climate as hypothesized. Instead, asking for pronouns, which was still rarely included on intake forms, seem to be part of a higher level of affirming practices that is related to legal climate.

This study offered a needed follow-up to Holt et al. (2019) to investigate how gender specialists address TGD identities and resources in their online materials. However, the results should be considered in light of limitations of the study. First, only 13.93% of providers who were screened included intake materials on their websites so it is unknown what TGD patients will encounter if they complete paperwork in the office. Second, while the initial goal of the study was to perform a census of the WPATH Find a Provider tool, changes to the website halted search efforts after the letter R for last name. A complete sample would have been ideal, but A – R represents over two-thirds of the alphabet and there is no reason to think that this sample is unrepresentative of the entire list. Additionally, lower interrater reliability may have occurred on the website category Link to Resource due to raters accessing webpages at different timepoints and thus website content can change or due to the complexity of several websites which made links difficult to locate. In contrast, the intake forms were downloaded upon initial searches and thus identical sources of data for raters to code and less complex than websites. Finally, the WPATH list was utilized given the organization’s high profile for providing training and leadership in TGD health. However, WPATH does not monitor providers’ online materials and these results cannot be interpreted to evaluate the quality of services the providers may offer or the quality of any training they may have received from WPATH or other sources.

These results offer a first look at how often gender specialists integrate their knowledge into websites and intake forms, often the initial point of contact for potential patients. Nevertheless, it was expected that gender specialist would be more consistent in respecting and affirming TGD identities in all interactions with the providers and health care systems. It is unknown why providers in this study were not more proactive about examining their materials and making necessary changes to capture the wide variety of TGD experiences and identities. Perceived barriers, such as electronic health records or working in a large healthcare system, may contribute to some lack of affirming practices by gender specialists. However, working with TGD individuals in health care necessitates a component of advocacy (Collazo, Austin, & Craig, 2013; Goldberg, 2006; Mayer, Bradford, Makadon,

Stall, Goldhammer, & Landers, 2008). When these barriers occur, gender specialists can advocate within their healthcare system to implement TGD-inclusive procedures. Some TGD patients may feel empowered to give feedback about stigmatizing practices to their care providers, but this responsibility should not lie with the patient. Future research should explore gender specialists' knowledge of recommendations for inclusive language and affirming resources and what contributes to these recommendations being enacted.

TGD individuals regularly have negative experiences with medical and behavioral health providers (Meyer, Mocarski, Holt, Hope, King, & Woodruff, 2020; Mizock & Lundquist, 2016) and many TGD individuals report avoiding healthcare visits due to fear of mistreatment (James et al. 2016). Seeking providers who identify themselves as specialists should be one method for TGD individuals to vet providers and ensure they can access affirming care. As potential patients encounter initial points of contact, such as intake forms and websites, they can glean the presence of heteronormative and cisnormative assumptions (Goins & Pye, 2013). This study demonstrates that even seeking highly specialized TGD healthcare providers does not eliminate potential stigma which may create a barrier to fully engaging in ongoing care. The leader of our Local Community Board often laments that there need to be more clinically competent providers for TGD individuals with "good brains," not just providers "with good hearts" who want to serve clients. We need to ensure the gender specialists with "good brains" are also implementing TGD-inclusive procedures with "good hearts."

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Table 1

Number of Providers from each State

State	Number of providers
Arizona	7
California	19
Colorado	1
Connecticut	2
District of Columbia	2
Florida	6
Georgia	4
Idaho	1
Illinois	2
Kansas	1
Kentucky	1
Louisiana	1
Maryland	6
Massachusetts	5
Michigan	2
Minnesota	1
Missouri	2
Montana	1
Nebraska	2
New Jersey	1
New York	8
North Carolina	3
Ohio	4
Oregon	7
Pennsylvania	4
Rhode Island	2
South Carolina	1
Texas	7
Virginia	5
Vermont	2
Washington	4
Total	114

Table 2

Coding Categories for State Legal Climate

Legislation Category	Specific Laws and Policies included in Legislation Coding	
	No Protections for TGD People	**Protections for TGD People**
Gender Marker on ID	-No relevant legislation	-Facilitate change in gender marker on driver's licenses -Facilitates change in gender marker on birth certificates -Facilitates change in gender marker on both driver's licenses and birth certificates
Transgender Healthcare	-No relevant legislation	-Bans on insurance exclusions for transgender healthcare -Both bans on insurance exclusions and provide trans-inclusive health benefits for state employees
Employment	-No relevant legislation -Prohibit discrimination based on sexual orientation only for public employees -Prohibit discrimination based on sexual orientation only	-Prohibit discrimination based on sexual orientation and gender identity only for public employees -Prohibit discrimination based on sexual orientation and gender identity
Public Accommodations	-No relevant legislation -Prohibit discrimination based on sexual orientation only	-Prohibit discrimination based on sexual orientation and gender identity
Housing	-No relevant legislation -Prohibit discrimination based on sexual orientation only	-Prohibit discrimination based on sexual orientation and gender identity
Hate Crimes	-No relevant legislation -Address hate or bias crime based on sexual orientation only	-Address hate or bias crime based on sexual orientation and gender identity
School Anti-Bullying	-Prevent school districts from specifically protecting LGBT students -Restrict inclusion of LGBT topics in schools -No relevant legislation	-Address harassment and/or bullying of students based on sexual orientation and gender identity
Education	-No relevant legislation -Address discrimination against students for sexual orientation only	-Address discrimination against students for sexual orientation and gender identity
Conversion Therapy	-No relevant legislation	-Protects LGBT youth form so-called "conversion therapy"

Table 3

X^2 Analyses for Intake Coding Categories by State Legal Climate

	Pronouns?		Chosen Name?		Affirmative Language?	
	No	Yes	No	Yes	No	Yes
State Legislation or Policy	*N* (%)	*N* (%)	*N* (%)	*N* (%)	*N* (%)	*N* (%)
Employment						
No protections	35 (87.50)	5 (12.50)	28 (70.00)	12 (30.00)	19 (47.50)	21 (52.50)
Protections	58 (78.38)	16 (21.62)	49 (66.22)	25 (33.78)	34 (45.95)	40 (54.05)
Conversion Therapy						
No protections	53 (89.83) *	6 (10.17) *	44 (74.58)	15 (25.42)	30 (50.85)	29 (49.15)
Protections	40 (72.73) *	15 (27.27) *	33 (60.00)	22 (40.00)	23 (41.82)	32 (58.18)
Education						
No protections	52 (86.67)	8 (13.33)	43 (71.67)	17 (28.33)	30 (50.00)	30 (50.00)
Protections	41 (75.93)	13 (24.07)	34 (62.96)	20 (37.04)	23 (42.59)	31 (57.41)
Gender Marker on ID						
No protections	28 (93.33) *	2 (6.67) *	23 (76.67)	7 (23.33)	16 (53.33)	14 (46.67)
Protections	65 (77.38) *	19 (22.62) *	54 (64.29)	30 (35.71)	37 (44.05)	47 (55.95)
Hate Crimes						
No protections	45 (90.00) *	5 (10.00) *	38 (76.00)	12 (24.00)	26 (52.00)	24 (48.00)
Protections	48 (75.00) *	16 (25.00) *	39 (60.94)	25 (39.06)	27 (42.19)	37 (57.81)
Housing						
No protections	47 (90.38) *	5 (9.62) *	39 (75.00)	13 (25.00)	27 (51.92)	25 (48.08)
Protections	46 (74.19) *	16 (25.81) *	38 (61.29)	24 (38.71)	26 (41.94)	36 (58.06)
Public Accommodations						
No protections	47 (90.38) *	5 (9.62) *	39 (75.00)	13 (25.00)	27 (51.92)	25 (48.08)
Protections	46 (74.19) *	16 (25.81) *	38 (61.29)	24 (38.71)	26 (41.94)	36 (58.06)
School Anti-Bullying						
No protections	44 (89.80) *	5 (10.20) *	36 (73.47)	13 (26.53)	25 (51.02)	24 (48.98)
Protections	49 (75.38) *	16 (24.62) *	41 (63.08)	24 (36.92)	28 (43.08)	37 (56.92)
Trans Healthcare						
No protections	43 (89.58)	5 (10.42)	35 (72.92)	13 (27.08)	24 (50.00)	24 (50.00)
Protections	50 (75.76)	16 (24.24)	42 (63.64)	24 (36.36)	29 (43.94)	37 (56.06)

* $p < .05$