

The Moderating Effect of Internalized Transphobia on the Association Between Gender
Congruence and Sexual Satisfaction in Transgender Men

by

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ABSTRACT

Despite the population of transgender individuals in the United States doubling from 2011 to 2016, this population is one of the most understudied in psychological science. Of the available research, the associations between gender congruence, defined as an individual's body matching their gender identity, and well-being have been examined, particularly demonstrating positive associations between gender congruence and overall life satisfaction. However, there remains a dearth of research on the possible associations between gender congruence and relational well-being - particularly sexual satisfaction - and possible moderating effects of the internal negative feelings regarding one's identity (internalized transphobia). To address these gaps in the literature, this study gathered data from 165 binary transgender men. While there was not an effect of gender congruence on sexual satisfaction, internalized transphobia was found to moderate this association such that individuals who reported high internalized transphobia and high gender congruence reported the highest sexual satisfaction. Results of this study highlight the existing literature on the negative associations between internalized transphobia and well-being for transgender individuals. Implications for counselors are discussed, including advocacy efforts and implementation of techniques to facilitate growth and resilience to help transgender clients navigate the negative effects of internalized transphobia.

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CHAPTER 1

INTRODUCTION

As of 2016, transgender individuals make up approximately 0.6% of the population in the United States (U.S.), equating to roughly 1.4 million people. This estimation has doubled since 2011 (Flores et al., 2016), emphasizing the growing visibility of this population. Transgender is an umbrella term that refers to individuals whose gender identity does not match their sex assigned at birth (Connolly et al., 2016). A variety of identities exist under the transgender umbrella including binary and non-binary identities. *Binary* refers to the socially constructed identities of man and woman while *non-binary* may include an identity somewhere in between man and woman or outside the binary completely (i.e. identifying as neither a man nor a woman; Connolly et al., 2016). Individuals can identify as binary or non-binary transgender.

Although documented cases of individuals identifying as transgender have been around for centuries, it was not until the 1980's when issues related to this population arose in the medical and psychological literature (e.g. Glicksman, 2013; Satterfield, 1988). One of the largest outcomes of this research was the notable health disparities transgender individuals may experience as a result of their gender dysphoria. *Gender dysphoria* is categorized as the distress transgender individuals may experience in response to the incongruence of their physical appearance and gender identity (Bockting et al., 2016). Gender dysphoria is a diagnosable disorder in the Diagnostic and Statistical Manual, 5th edition (DSM-5), and is typically treated with hormone replacement therapy (HRT), social transition, surgery, or a combination of the three (Bockting et al., 2016). Per the DSM-5, the prevalence for natal females (transgender men) ranges from 0.002% -

0.003%, while highlighting the likelihood of these rates being modest underestimates (American Psychiatric Association, 2013).

Although in recent decades researchers have seen strides in the advancement of research with transgender individuals, the field is still extremely young. While research has examined the (negative) association between gender congruence and indices of individual well-being, such as anxiety, depression, and body satisfaction (Jones et al., 2018; Owen-Smith et al., 2018), limited research exists on the associations between gender congruence and indices of relationship well-being, such as sexual satisfaction (Glicksman, 2013). Recent research by Feinstein, Rusbult, and colleagues suggest that a satisfying romantic relationship, defined as an interpersonal evaluation of the positivity of feelings for one's partner and attraction to the relationship, is positively associated with well-being for adult LGB individuals (Feinstein et al., 2016; Rusbult & Buunk, 1993).

Given that sexual satisfaction is associated with overall relationship satisfaction and is considered an important factor for romantic relationship functioning (Simpson, 2016), the present study examines how gender congruence may be positively associated with sexual satisfaction for transgender men. Furthermore, as internalized transphobia has been found to be negatively associated with positive sexual experiences (Reisner et al., 2010), the present study examined whether internalized transphobia moderates the association between gender congruence and sexual satisfaction.

Gender Congruence

Gender congruence is when an individual's body matches their gender identity (Jones et al., 2018), whereas gender incongruence can be conceptualized as when an individual's body does not match their gender identity. Gender congruence has been

referred to as both appearance congruence (Chodzen et al., 2018) and transgender congruence (Kozee et al., 2012). Kozee et al. (2012) describes transgender congruence as, “the degree to which transgender individuals feel genuine, authentic, and comfortable with their external appearance” (p. 181). They expanded this definition to include how much a transgender individual accepts their genuine identity, instead of settling for a more socially constructed identity. Gender congruence involves aspects of self-image, self-reflection, and self-expression, all of which combine to form either a feeling of overall congruence or incongruence (Kozee et al., 2012). As such, the lack of gender congruence, defined here as gender incongruence, can play a major role in a transgender individual’s experience of gender dysphoria or the distress experienced in response to the incongruence of physical appearance and gender identity (Bockting et al., 2016).

Gender Affirming Health Services (GAHS) are often sought by transgender individuals to alleviate distress associated with gender incongruence, and these services have seen a marked increase in referrals in recent years (Jones et al., 2018). Hormone replacement therapy, chest reconstruction, and genital reconstruction are the most common services provided to transgender individuals. Specifically, in reference to transgender men, HRT has been utilized since the 1930’s and produces physical effects such as increased muscle mass, deepening of the voice, facial and body hair, and weight gain (Davis & Meier, 2014). These physical changes can help to create feelings of gender congruence. Gender congruence has been found to be positively associated with feelings of body satisfaction and quality of life, and negatively associated with psychological distress (Jones et al., 2018). Interestingly, Davis and Meier (2014) also found a positive association between testosterone intake (HRT) and increased sexual satisfaction. Given

that HRT is common within medical transitions and produces effects that often increase gender congruence, examination of the association between gender congruence and sexual satisfaction in a sample of transgender men is warranted.

Sexual Satisfaction

Sexual satisfaction is impacted by many factors, including sexual communication and frequency of sex (Simpson, 2016). Lack of sexual communication and dissatisfaction with sexual frequency are negatively associated with overall relationship satisfaction (Lyons et al., 2011). Conversely, sexual satisfaction has been found to be a prominent component of relationship satisfaction (Lyons et al., 2011). Sexual satisfaction research in cisgender populations is abundant; however, research on sexual satisfaction for transgender individuals is lacking, especially for female to male (FtM) transgender individuals. For male to female (MtF) transgender individuals, slightly more research has been conducted in the area of sexual relationships. Weyers, Elaut, and De Sutter (2009) conducted a study with transgender women that found an association between appearance and sexual satisfaction, such that transgender women who were more satisfied with their appearance reported higher levels of sexual satisfaction. De Cuypere et al. (2005) found that transgender women reported significantly improved sex lives after sex reassignment surgery, suggesting a link between sexual satisfaction and body satisfaction and/or congruence. Similarly, a review of the literature conducted by Klein and Gorzalka (2009) concluded that transgender women have significantly higher rates of sexual satisfaction after sex reassignment surgery than pre-surgery. Adding to this limited field of research, Mendelson (2015) conducted qualitative research examining the sexual satisfaction of transgender women and found that a majority of participants reported increased sexual

satisfaction, and many attributed the increase to higher levels of comfort with their bodies. While gender congruence may be associated positively with sexual satisfaction, other factors may be negatively associated with sexual satisfaction. For example, Rood and colleagues (2017) found a negative association between positive sexual experiences and internalized transphobia. Participants reported fear that their sexual partner would not find their body attractive, which then decreased the pleasure of the sexual experience. Rood et al. (2017) suggest that the participants' reported fear may be attributed to internalized transphobia. As such, it was hypothesized that gender congruence will be positively associated with sexual satisfaction. Furthermore, there are additional variables that may moderate the association between these constructs, such as one's negative beliefs about their transgender identity.

Possible Moderating Effects of Internalized Transphobia

Internalized transphobia, defined as the internalization of negative social messages that minimize and devalue a person's identity as transgender or gender non-conforming, is a relatively new term within psychological science (Rood et al., 2017). While internalized transphobia is a relatively new term, perhaps more common is the term internalized homophobia, which is defined as the negative feelings associated with one's sexual identity (e.g., Rood et al., 2017; Totenhagen et al., 2018). Unlike internalized homophobia, empirical research examining internalized transphobia is scarce (for notable exceptions, see Rood et al., 2017). As such, researchers have called for more empirical research to better understand the association between internalized transphobia and its associations with well-being (Hendricks & Testa, 2012). Heeding that call, recent research has found perceptions of internalized transphobia to be positively associated

with psychological distress and uncertainty with self-image, while inversely associated with resilience (Rood et al., 2017). Transgender men have reported their sexual lives have been negatively affected by internalized feelings regarding their identities and bodies (Reisner et al., 2010). Additionally, Rood et al. (2017) found a negative association between internalized transphobia and positive sexual experiences, such that higher levels of internalized transphobia were associated with less reports of positive sexual experiences. As such, the present study examined the potential moderating effect of internalized transphobia on the association between gender congruence and sexual satisfaction.

Present Study

Approximately 1.55 million people in the United States identify as being transgender (Herman et al., 2017). Despite growing numbers, research on associations between gender congruence and relational well-being, in particular sexual satisfaction, remains understudied. For both heterosexual and LGBT populations, romantic relationship involvement, specifically the expression of current or anticipated sexual behavior, is found to be a protective factor for psychological well-being (Collins et al., 2009; Meier et al., 2013; Whitton et al., 2018). While sexual satisfaction has been heavily researched in cisgender populations (e.g. Simpson, 2016; Sprecher, 2002), limited research with transgender populations exists, particularly among binary transgender men. Specifically, current literature on sexual satisfaction in transgender participants tends to focus only on individuals who have had some form of gender-confirming treatment (GCT), specifically sex reassignment surgery (Nikkelen & Kreukels, 2018) and transgender women (Mendelson, 2015). Expanding research to include transgender men

and those without GCT may allow clinicians and researchers alike to emphasize the importance and benefits of medical transitioning for some transgender individuals.

Taken together, the goal of the present study was to gather cross-sectional self-report data from 165 transgender men to examine the possible positive associations between gender congruence and sexual satisfaction. It was hypothesized that gender congruence would be positively associated with sexual satisfaction (Hypothesis 1). Additionally, as internalized transphobia is negatively associated with personal well-being, (Cronin et al., 2019; Scandurra et al., 2016), it was hypothesized that internalized transphobia would moderate the positive association between gender congruence and sexual satisfaction (Hypothesis 2), such that higher levels of internalized transphobia would weaken the positive association between gender congruence and sexual satisfaction.

CHAPTER 2

METHODS

Recruitment and Participants

Participants were recruited through from national online support groups (e.g., Metoidioplasty Discussion Facebook group, Transgender Support Group), Instagram pages of prominent transgender men and transgender support accounts (e.g., Cody Harman, Matt Miller, Trans and Shirtless), and flyers posted at a LGBTQ event (i.e., Rainbows Fest) in a Southwest region of the United States. Additionally, snowball sampling was utilized by asking participants upon completion to share the study with their social group and on their social media accounts. Participants had to meet the following criteria in order to participate: 1) over the age of 18, 2) identity as a transgender man, 3) on hormone replacement therapy for at least 1 year, 4) currently in a romantic relationship, and 5) sexually active within their current romantic relationship.

Two hundred and 52 transgender men expressed interest in participating in the current study. Sixty-five were excluded because they did not meet the eligibility criteria (defined above) and 22 were excluded due to missing data. The final sample included 165 individuals. The mean age of participants was 26.21 years ($SD = 6.39$). The majority of participants identified as White ($n = 100$), followed by Hispanic/LatinX ($n = 22$), Multiracial/Other ($n = 18$), Black/African American ($n = 8$), Asian American ($n = 5$), and Native American or American Indian and Native Hawaiian/Pacific Islander ($n = 1$ for both). Overall, the sample was highly educated with 81.8% ($n = 135$) reporting at least some college experience, an undergraduate, or a graduate degree. Approximately 78.8% ($n = 130$) reported a yearly household income of less than \$49,999, 15.8% reported a

yearly household income of \$50,000 - \$74,999, and 4.2% reporting a yearly household income of over \$75,000 (1.2% did not respond).

A majority of participants described their sexual orientation as heterosexual or bisexual ($n = 52$, $n = 47$, respectively). Surprisingly, 67.3% ($n = 111$) of participants reported having at least one gender-affirming surgery (i.e., hysterectomy, chest reconstruction, metoidioplasty, phalloplasty). Participants reporting being in their current romantic relationship for an average of 3.58 years ($SD = 3.88$). Fifty one participants reported they were in a committed relationship and not living together, fifty-five reported they were in a committed relationship and living together, three were engaged and not living together, twenty-five were engaged and living together, twenty-six were married, and five described their relationship status as 'Other'.

Procedure

Interested participants contacted the researcher via e-mail address (kklineresearch@gmail.com), at which point the researcher sent participants a link to the Qualtrics survey containing a consent form and a screening survey (see Appendix A). Participants were also able to access the survey link directly from social media posts. Eligible participants were automatically directed to the study survey (see Appendix C). Participation took approximately 20 minutes for completion. Participant had a chance to be compensated by choosing to opt into a raffle at the end of the survey. One hundred and eight participants opted into the raffle and 60 participants were randomly awarded a \$10 Amazon gift card.

Measures

Screening. Interested participants took an initial screening questionnaire to determine their eligibility (see Appendix A).

Demographics. Participants answered standard demographic questions that assessed characteristics such as age, sex assigned at birth, sexual orientation, race, education, and income, and regarding their hormone use and gender affirming surgical history (see Appendix B). Additionally, participants were asked questions about their romantic relationship (i.e., relationship length, relationship status, partner's sex assigned at birth, partner's perceived gender identity, and partner's sexual orientation).

Gender congruence. Gender congruence was assessed utilizing the Transgender Congruence Scale (TCS; Kozee, et al., 2012; see Appendix C). The TCS contains 2 subscales: the 9-item *Appearance Congruence* subscale and the 3-item *Gender Identity Acceptance* subscale. For the purpose of this study, the *Appearance Congruence* subscale was administered, which measures perceived gender congruence. An example item from this subscale is "I experience a sense of unity between my gender identity and my body." Participants responded to these nine items utilizing a 5-point Likert scale ranging from 1 = *Strongly Disagree* to 5 = *Strongly Agree*. For scoring purposes, a mean score was calculated by averaging the responses of the 9 items with a higher score indicating more gender congruence. The subscale reliability was Cronbach's $\alpha = .89$ based on the study sample.

Sexual satisfaction. Sexual satisfaction was assessed utilizing the New Sexual Satisfaction Scale (NSSS; Stulhofer et al., 2010; see Appendix C). The NSSS is a 20-item scale containing 3 subscales; *Ego-focused* (10-items), *Partner and activity focused* (10-

items), and the 12-item *short version* (NSSS-S), which includes items for both the *Ego-focused* and *Partner and activity focused* subscales. For the purpose of this study, the *Ego-focused* subscale was administered, which examined individuals' sexual experience rather than the partner's sexual experience. An example item from this subscale asks participants to rate "The quality of my orgasms". Participants were asked to rate items on a 5-point Likert scale ranging from 1 = *Not at all Satisfied* to 5 = *Extremely Satisfied*. For scoring purposes, a mean sexual satisfaction score was calculated by averaging the responses of the 10 items with higher scores indicating more sexual satisfaction. The subscale reliability was Cronbach's $\alpha = .91$ based on the study sample.

Internalized transphobia. Internalized transphobia was assessed utilizing the Gender Minority Stress and Resilience scale (GMSR; Testa et al., 2015; see Appendix C). The GMSR Measure contains the 8-item *Internalized Transphobia* subscale, which measures perceived levels of internalized transphobia. An example item from this scale is "I resent my gender identity or expression". Participants rated items on a 5-point Likert scale ranging from 1 = *Strongly Disagree* to 5 = *Strongly Agree*. A total internalized transphobia score was calculated by summing the responses of the 8 items with higher scores indicating higher levels of internalized transphobia. The subscale reliability was Cronbach's $\alpha = .91$ based on the study sample.

Control variables. Control variables are used to minimize the effect of variable(s) other than the independent variable(s) on the dependent variable(s) (Nelson, 2017). Given the well-documented negative association between relationship length and sexual satisfaction (e.g., Miller, 2017; Schmiedeberg & Schroder, 2016), relationship length was controlled for in the present study. Additionally, given that genital dysphoria

has been found to decrease sexual satisfaction, genital dysphoria was also controlled for with 3-item *Genital* subscale of the Body Image Scale (BIS; Lindgren & Pauly, 1975; see Appendix C) wherein participants rated their satisfaction with the given body part (e.g., “Vagina”). Participants responded to the BIS items by utilizing a 5-point Likert scale ranging from 1 = *Very Satisfied* to 5 = *Not at all Satisfied*. For scoring purposes, a mean score was calculated by averaging the responses of the 3 items with a higher score indicating more genital dysphoria. The subscale reliability was Cronbach’s $\alpha = .76$ based on the study sample. Lastly, history of gender-affirming surgery(ies), such as chest reconstruction, metoidioplasty, phalloplasty, hysterectomy, or a combination of the four, was controlled for given an established positive association between gender-affirming surgeries and sexual satisfaction (De Cuypere et al.,2005).

Data Analysis

Prior to running the analysis, data were checked for missing values and normalcy (i.e., skewness and kurtosis). Skewness and kurtosis fell within the acceptable range for all variables. A hierarchical multiple regression analysis was conducted using SPSS 25 (IBM Corp., 2017) to test for the possible main effect of gender congruence on sexual satisfaction (H1), and the interaction of internalized transphobia and gender congruence on sexual satisfaction (H2). BIS scores, gender congruence, internalized transphobia, and the interaction term (gender congruence X internalized transphobia) were standardized prior to running regressions to allow for comparison among scores from different scales (Martin & Bridgmon, 2012).

Based on recommendations from Martin and Bridgmon (2012), gender-affirming surgical history and BIS scores were entered into Model 1 as control variables. Model 1

was significant, $R = .25$, adjusted $R^2 = .05$, $F(2,140) = 4.55$, $p = .012$. BIS scores predicted significant change in sexual satisfaction, $\beta = -.23$, $p < .01$, but gender-affirming surgical history did not, $\beta = -.08$, $p > .05$. For parsimony, gender-affirming surgical history was not retained in subsequent models.

To test H1, gender congruence and internalized transphobia were entered into Model 2 to examine possible main effects on sexual satisfaction. To test H2, the interaction term (internalized transphobia X gender congruence) was entered into Model 3. Entering the interaction term by itself in Model 3 allowed for the interaction of internalized transphobia and gender congruence to be examined for significant additional variance accounted for in sexual satisfaction above and beyond the main effects of these variables. See Table 4.

CHAPTER 3

RESULTS

Descriptives

Descriptive statistics for the study variables can be found in Table 1. Interestingly, participants reported high mean scores for both gender congruence and sexual. Results showed significant negative correlations between gender congruence and internalized transphobia ($r = -.40, p < .001$) and sexual satisfaction and internalized transphobia ($r = -.21, p < .01$), such that higher scores in gender congruence and sexual satisfaction were associated with lower internalized transphobia scores (See Table 2).

H1: Association Between Gender Congruence and Sexual Satisfaction

It was hypothesized that gender congruence would be positively associated with sexual satisfaction, such that higher gender congruence would predict higher sexual satisfaction. Conversely, results showed that there was not a significant main effect of gender congruence on sexual satisfaction, $\beta = .14, p > .05$. As such, H1 was not supported.

H2: Moderating Effects of Internalized Transphobia

It was hypothesized that internalized transphobia would moderate the association between gender congruence and sexual satisfaction, such that internalized transphobia would influence the strength of the possible association between gender congruence and sexual satisfaction.

Results showed that there was a significant interaction between gender congruence and internalized transphobia on sexual satisfaction [$F(3,138) = 6.10, p < .001$], indicating that the interaction term of gender congruence by internalized

transphobia predicted a significant portion of variance in sexual satisfaction above and beyond gender congruence. Conversely, gender congruence was not related to sexual satisfaction in participants who reported low internalized transphobia ($b = -0.14$, 95% CI[-0.36, 0.09]).

After decomposing the significant interaction, results showed that high levels of internalized transphobia strengthened the effect of gender congruence on sexual satisfaction. There was no effect of low levels of internalized transphobia (see Table 3). Simple slope analyses indicated that high internalized transphobia and high gender congruence was associated with greater sexual satisfaction ($b = 0.24$, 95% CI[0.05, 0.43]), compared to those with low internalized transphobia (see Figure 1). This suggests that high levels of internalized transphobia moderated the association between gender congruence and sexual satisfaction as predicted, such that participants who reported high levels of internalized transphobia had the strongest association between gender congruence and sexual satisfaction.

CHAPTER 4

DISCUSSION

With the population of individuals identifying as transgender continuing to trend upward, the need for empirical research on how their unique experiences (e.g., internalized transphobia, gender congruence) may impact their well-being the mental health of this population is heightened (Meerwijk & Sevelius, 2017). For example, gender incongruence - when an individual's body does not match their gender identity (Jones et al., 2019) - has been positively correlated with gender dysphoria (van de Grift et al., 2016), which is a contributing factor to the DSM-5 diagnosis of Gender Dysphoria (American Psychiatric Association, 2013). As a salient factor in many transgender individuals' experiences, further empirical research is needed to help clinicians better understand how to help transgender clients experiencing a lack of gender congruence and more importantly other interaction factors that may impact their individual and relationship functioning.

Internalized transphobia, defined as the internalization of negative social messages that minimize and devalue a person's identity as transgender or gender non-conforming, is a contributing factor to the experiences of transgender individuals (Hendricks & Testa, 2012). Internalized transphobia is positively associated with psychological distress, uncertainty with self-image, and negatively associated with positive sexual experiences (Rood et al., 2017). Perceptions of internalized transphobia and gender congruence and their associations with well-being are important to examine given their salience in the lives of transgender individuals.

Examining the associations between gender congruence and internalized transphobia on relational aspects, such as sexual satisfaction provides a promising future direction to understanding how the individual experiences of transgender individuals may affect other aspects of their lives. Sexual satisfaction has been found to be positively associated with appearance and body satisfaction for transgender individuals (De Cuypere et al., 2005; Klein & Gorzalka, 2009; Mendelson, 2015). Results of the present study support a moderating effect of internalized transphobia on the positive association between gender congruence and sexual satisfaction.

Gender Congruence and Sexual Satisfaction

Gender Dysphoria, a diagnosable disorder in the DSM-5, is a major contributor to psychological distress in transgender individuals, and results from the incongruence between one's physical appearance and gender identity (Bockting et al., 2016). For transgender individuals who are currently in a relationship, the association between gender congruence and sexual satisfaction is an understudied phenomenon, despite sexual satisfaction being a protective factor to mental distress in cisgender populations (Karimi et al., 2019). Given that higher satisfaction with physical appearance has been found to be associated with higher levels of sexual satisfaction in heterosexual samples (Holt & Lyness, 2007; Wiederman, 2000), it was hypothesized that gender congruence would be positively associated with sexual satisfaction. Contrary to the hypothesis, gender congruence was not found to be significantly associated (positively or negatively) with sexual satisfaction for individuals in this study.

There are several potential explanations for the non-significant association between gender congruence and sexual satisfaction. First, participants in this study

reported high levels of gender congruence which suggests that participants in this study have a favorable view of their physical body. Similarly, participants in this study reported high levels of sexual satisfaction. Although not examined in the present study, there may be additional factors that may be contributing to these results. For example, Walters, Lykins, and Graham (2019) found perceived partner's appreciation of one's body and relationship quality were positively associated with sexual functioning. As such, it is possible that participants in this study were in satisfied relationships, as inferred by the average relationship length. Future research may benefit from examining these mechanisms within the current association.

Additionally, the non-significant association between gender congruence and sexual satisfaction may be related to the current mental health treatment participants endorsed. Approximately 73% of participants reported receiving mental health services (see Table 5). The implications of this are two-fold: (1) it is possible that participants have worked on coping skills to mitigate decreased gender congruence and sexual satisfaction, and (2) receiving mental health services may inherently skew perceptions of oneself in a positive direction, since a major component of mental health services is decreasing distress and increasing strengths (Tedeschi & Kilmer, 2005). Overall, the majority of participants receiving or having received mental health services is a possible contributing factor for the non-significant association between gender congruence and sexual satisfaction in this study.

Moderating Effect of Internalized Transphobia

Internalized transphobia is associated with more psychological distress, lower resilience and self-image, and lower sexual satisfaction in transgender men (Reisner et

al., 2010; Rood et al., 2017). Based on this, it was hypothesized that internalized transphobia would moderate the (positive) association between gender congruence and sexual satisfaction. As predicted, internalized transphobia did moderate the association between gender congruence and sexual satisfaction. Specifically, when participants reported high levels of internalized transphobia there was a significant effect on the positive association between gender congruence and sexual satisfaction. Said differently, for participants who reported high levels of internalized transphobia there was a significant positive effect of gender congruence on sexual satisfaction, such that high levels of internalized transphobia strengthened the positive association between gender congruence and sexual satisfaction. Based on prior literature that found a negative association between internalized transphobia and sexual satisfaction (Rood et al., 2017), it was hypothesized the moderation effect would predict a decrease in sexual satisfaction, rather than an increase.

Results from this study showed that when participants reported high levels of internalized transphobia and high levels of gender congruence they experienced the greatest sexual satisfaction. The implications of these findings are two-fold. First, there may be additional third variables that can better explain the current findings (e.g., higher comfort in one's body may lead to more experiences of disclosing one's identity, opening up the possibility for more negative interactions), although examining these associations are beyond the scope of the present cross-sectional study. Second, although beyond the scope of the current manuscript given its design, gender congruence may serve as a buffering effect to internalized transphobia. Future research examining these proposed associations is encouraged.

Limitations

Study sample and methodology. Despite strengths of this study, it is not without its limitations. Most of the recruitment occurred through national, online support groups. As such, the demographics of these support groups were not examined and may have influenced who participated in the present study. Second, the inclusion criteria for the present study did not require the presence or absence of gender-affirming surgery. As such, a majority of participants reported having at least one gender-affirming surgery, potentially limiting the ability of the present study to examine low levels of gender congruence.

The demographics of the sample indicate that majority of the participants were Non-Hispanic White (66.7%) and held some college education (81.9%), which may limit the generalizability of the findings. For example, Rood et al. (2017) found differential impacts of internalized transphobia on transgender people of color compared to White transgender individuals, specifically noting that intersectionality of gender identity and race plays a vital role in higher perceptions of internalized transphobia. Therefore, it is important that future research utilizes a diverse sample including transgender people of color. Additionally, more than half of participants reported having at least one form of gender-affirming surgery. As gender-affirming surgery is positively associated with sexual satisfaction and body appearance (Klein & Gorzalka, 2009), future research may focus on transgender individuals without a gender-affirming surgical history to better examine the association between gender congruence and sexual satisfaction.

Furthermore, participants scored relatively high on gender congruence indicating participants may have a more favorable view of their physical appearance. The limited

variability in gender congruence in the present sample may have affected the results, such that the present study was unable to examine the effects of low gender congruence on sexual satisfaction, and the moderating effect of internalized transphobia on a low baseline level of gender congruence. Additionally, the majority of participants reporting previous or current involvement in mental health services may have affected the variance in the results. Those who receive(d) mental health services may be less distressed about their physical appearance through the acquisition of coping skills, and therefore had higher gender congruence scores. Similarly, participants may have discussed and worked through experiences of internalized transphobia, diminishing the moderating effect of internalized transphobia in the current study.

Measures. Additionally, limitations may exist regarding the study measurements. While internal validity for the present study was strong, ($\alpha = 0.91$), Stulhofer and colleagues' (2010) *New Sexual Satisfaction Scale* has not been previously validated to measure sexual satisfaction exclusively in transgender men. Similarly, Testa and colleagues' (2015) *Gender Minority Stress and Resilience* scale ($\alpha = 0.91$ for the present study) has not been previously validated to measure exclusively transgender men. Both scales pose a threat to external validity, and as such future research is needed to validate these or similar scales for use with transgender populations.

Study design. Despite providing anonymity for participants' responding, along with speed and ease of data collection (Tuten, 2010), cross-sectional online surveys can also result in nonresponse and measurement error. As such, the present study is limited in its inability to examine associations over time (e.g., as medical transitioning progresses, etc.) and its inability to assess for the associations between partner reports, which would

be possible with the use of longitudinal dyadic data. The use of dyadic data in future research is encouraged, as this allows researchers to understand the relational impact of experiences for both partners (Kenny et al., 2006).

Future Directions

Results from this study provide promising implications for future research. Given the increase in individuals reporting transgender identities, it is important to better understand the unique factors that affect transgender individuals (Flores et al., 2016). This is one of only a few studies that focuses exclusively on the experiences of transgender men (for exceptions see Costantino et al., 2013). A better empirical understanding of the factors in the present study (i.e., gender congruence, sexual satisfaction, internalized transphobia) along with additional factors (e.g., gender dysphoria, mental health outcomes, etc.) may facilitate more comprehensive and inclusive clinical mental health care for transgender individuals. Even more so, expanding research on the unique experiences of transgender individuals, specifically of transgender men, may be able to facilitate better physical and mental health care for this understudied group.

Additionally, future research may examine a more diverse sample of transgender men, specifically transgender men of color and transgender men without a history of gender-affirming surgery. Sadika and colleagues (2020) highlighted how LGBT people of color experienced microaggressions two-fold; racial microaggressions within their LGBT community and sexual and gender identity microaggressions within their family and community. Exploration of intersectionality between race and gender identity and the perception of internalized transphobia is necessary for future research to expand the

clinical implications of working with transgender people of color, specifically the compounding effects of multiple minority identities. Exploring variations in levels of gender congruence (i.e., low levels, average levels, high levels) in relation to the present study outcome variable will provide valuable insight into the interaction between these variables that the present study was unable to examine.

Future research is also encouraged to examine whether gender congruence may be a protective factor against internalized transphobia. Internalized transphobia is an individual experience that has been found to negatively affect aspects of one's relationship (e.g., sexual satisfaction; Rood et al., 2017). It is possible that gender congruence may moderate the association between internalized transphobia and sexual satisfaction. Future research can continue to explore the moderating effect of gender congruence, perhaps by conducting a longitudinal study of transgender men, women, or non-binary individuals, especially across the transition period (pre- and post-medical transition).

Implications for Mental Health Counselors

While empirical research with LGBTQ samples hints at implications for mental health counselors working with sexual and gender minority clients (e.g., Kashubeck-West, Szymanski, & Meyer, 2008), specific implications for working with transgender clients are scarce. The present study indicates that internalized transphobia and gender congruence are experiences unique to transgender individuals. The salience of internalized transphobia in the lives of transgender individuals has been identified as a factor positively associated with increased psychological distress, uncertainty with self-image, and decreased sexual satisfaction (Rood et al., 2017). Similar to other types of

minority stress (Meyer, 2013), for individuals seeking mental health services, counselors are paramount in facilitating growth and resilience in clients experiencing the adverse effects of internalized transphobia. For example, it is important that counselors working with transgender clients understand the negative association between internalized transphobia and gender congruence, and potential protective factors that can be facilitated within a therapeutic environment. Additionally, despite results of this study, counselors can facilitate sexual satisfaction among their transgender clients, as sexual satisfaction is a documented protective factor (Karimi et al., 2019). Specifically, counselors can facilitate the use various techniques (e.g., cognitive self-disclosure, heighten emotional experiences in session, relationship enhancement training, empathy training; Dandeneau & Johnson, 1994) to help to foster open communication in an effort to build intimacy and trust for the client and their romantic partner.

Education and Training. Perhaps the biggest implication of the present study is acknowledging the complexity of experiences unique to transgender individuals (i.e., gender congruence, internalized transphobia). Counselors working with transgender clients must take the necessary steps to acquire competence in both transgender mental health care and gain an understanding of the various legal and political systems in place regarding transgender medical care. Counselors have access to a wealth of information regarding transgender health care competence, including the Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling (ALGBTIC, 2009) division of *ACA Competencies for Counseling Transgender Clients* and the APA's (2015) *Guidelines for Psychological Practice With Transgender and Gender Nonconforming People*. In addition to complying with various ethical standards, counselors may seek

information regarding various policies, legislation, and current issues within the transgender community by utilizing resources such as the National Center for Transgender Equality. The foundation of clinical work with transgender client rests within the ACA statement that “multicultural counseling competency is required across all counseling specialties” (ACA, 2014). As such, it is the duty of counselors to be informed, educated, and competent in the field of transgender mental health care.

In an effort to increase multicultural competence, counselors are encouraged to educate themselves on current legislature pertaining to transgender individuals. In this way, counselors can work with their transgender clients to increase gender congruence. Gender congruence is often achieved by hormone replacement therapy and gender-affirming surgeries (HRT; Jones et al., 2018), and current legislation makes access and affordability to HRT difficult for many. For example, Alabama, Illinois, Montana, South Dakota, and West Virginia state legislature have recently attempted to pass bills related to the treatment of transgender youth. These house bills all include a felony charge to any doctor who provides any type of transition-related medical interventions to youth, regardless of parental consent (Freedom for All Americans, 2020). Additionally, a recent report of transgender men found that 97% wanted chest-reconstruction surgery (James et al., 2016). Chest-reconstruction is one type of gender-affirming surgery, which may increase gender congruence. Private insurance is not currently required to cover this procedure and a recent evaluation found that only two of 57 insurance companies had criteria consistent with WPATH recommendations (Ngaage et al., 2019). For those with the ability to pursue transgender related medical care, many states require a licensed mental health care provider to provide documentation before a transgender individual can

start hormone replacement surgery or receive gender-affirming surgery (Ngaage et al., 2019). Issues such as these highlight the current gap in accessibility for transition related medical care.

Taken together, it is likely that counselors may be involved in the medical transition process of their transgender clients. Using the results of the present study, paired with education around accessibility to medical transitioning (e.g., anti-transgender legislation; Freedom for All Americans, 2020), counselors may better understand the importance of helping to facilitate their clients' access to HRT. Additionally, as advocacy is already a major component of counselors' duties (Meyers, 2014) the addition of empirical data (from the present study and future research) supporting the necessitation of policy change can add support to counselors' advocacy efforts.

Conclusion

The results from this study may provide new context for counselors working with transgender clients, highlighting the positive interaction between internalized transphobia and gender congruence on sexual satisfaction. Internalized transphobia may result from experiences with discrimination, so highlighting the effects provides direction for counselors to continue with a focus on experiences of discrimination and appropriate coping strategies, such as a focus on tangible, strength-based interventions which may provide more therapeutic benefits for clients. Additionally, it is important that counselors working with transgender clients assess for feelings associated with internalized transphobia, which has been shown to be associated with both individual and relational well-being. Despite these promising results, additional research within the transgender

community is warranted, particularly as it applies to health disparities for this marginalized population.

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Table 1
Descriptive Statistics for Study Variables

	M	SD
Demographics		
Age	314.53	76.64
Relationship Length	43.01	46.59
Hormone Use Length	40.09	26.60
Gender Congruence	3.82	0.83
Sexual Satisfaction	3.52	0.88
Internalized Transphobia	21.21	8.57

Note. Age, relationship length, and hormone use length are presented in months.

Table 2
Correlations among Study Variables

	1.	2.	3.	4.	5.
1. Gender-affirming surgical history	-	-.00	.33***	-.11	0.22**
2. BIS score	-.00	-	-.13	-.23**	.37***
3. Gender Congruence	.33**	-.13	-	.13	-.40***
4. Sexual Satisfaction	-.11	-.23**	.13	-	-.21**
5. Internalized Transphobia	-.22**	.37***	-.40***	-.21**	-

Note. * = $p < .05$; ** = $p < .01$; *** = $p < .001$.

Table 3

Gender Congruence and Internalized Transphobia on Sexual Satisfaction

	Unstandardized Coefficients		Standardized Coefficients	t	Sig.
	B	Std. Error	Beta		
Intercept	3.60	.08	-	47.88	< .001
<i>Control</i>					
BIS score	-.19	.07	-.22	-2.70	.008
<i>Main Effect</i>					
Gender congruence	.10	.07	.12	1.47	.145
<i>Interaction</i>					
Gender congruence x internalized transphobia	.18	.07	.21	2.57	.011

Note. BIS = Body Image Scale

Table 4

Regression Model Summaries

	Model Significance	Adjusted R^2	F Change	df1	df2	Significant F Change
Model 1	.005	.05	8.04	1	140	.01
Model 2	.004	.07	2.90	2	138	.06
Model 3	< .001	.11	6.76	1	137	.01

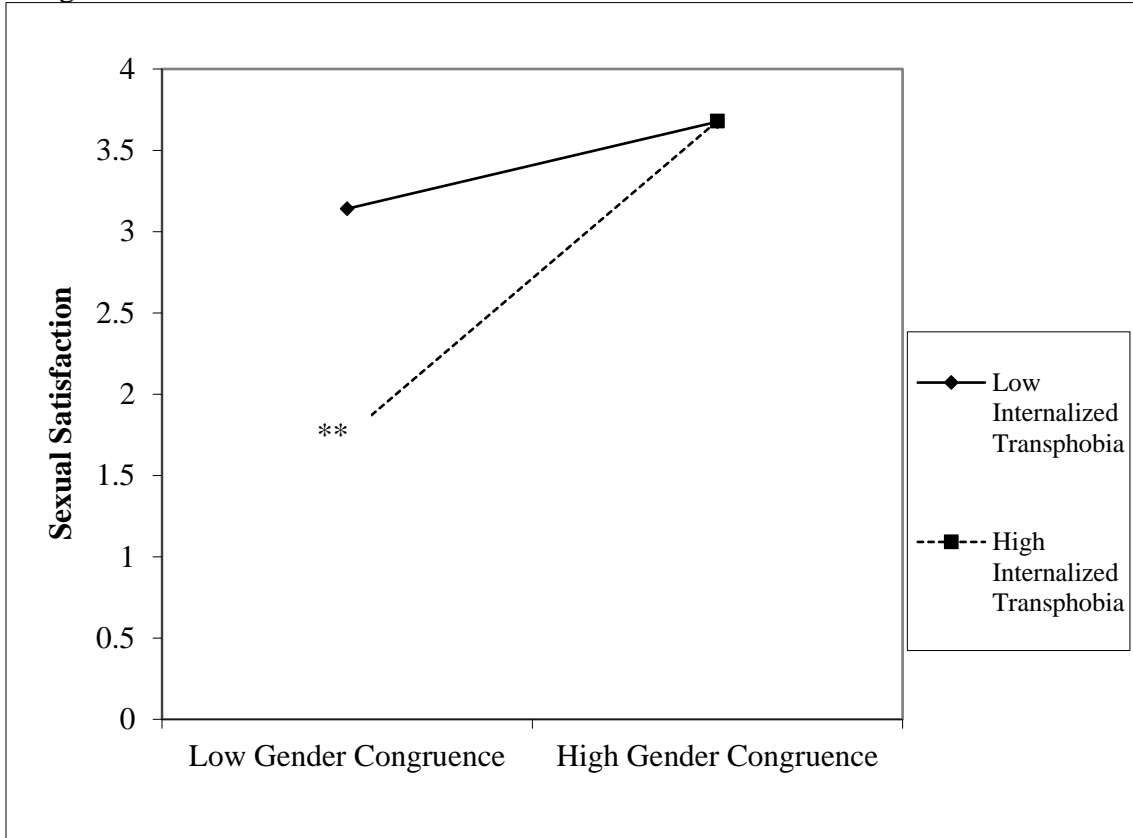
Note. Model 1: BIS scores; Model 2: BIS scores, Gender congruence; Model 3: BIS scores, Gender congruence, Gender congruence X Internalized transphobia

Table 5
Descriptive Statistics for Qualitative Study Questions

	Percentage
Has your primary care provider ever asked you questions about your romantic relationship, specifically related to your sexual health?	
Yes	66.7%
No	19.4%
Did not respond	13.9%
If yes, then how satisfied were you with the quality of support you received from your primary care provider while discussing these topics?	
Satisfied	44.8%
Neutral	13.3%
Dissatisfied	8.5%
Did not respond	33.3%
Have you ever or are you currently receiving mental health services?	
Yes	72.7%
No	13.3%
Did not respond	13.9%
If yes, then have you ever discussed your romantic relationship or sexual health with your mental health provider?	
Yes	54.5%
No	18.2%
Did not respond	27.3%
How satisfied were you with the quality of support you received from your mental health provider while discussing these topics?	
Satisfied	40.6%
Neutral	8.5%
Dissatisfied	4.2%
Did not respond	46.7%

Note. Lack of response to items is related to only 142 of 165 participants completing the qualitative section of the survey.

Figure 1. Internalized Transphobia Moderates the Positive Association between Gender Congruence and Sexual Satisfaction



Note. Low Internalized Transphobia = -1 SD; High Internalized Transphobia = +1 SD; ** = significant simple slope.

APPENDIX A
SCREENING QUESTIONNAIRE

1. Are you at least 18 years of age? Y/N
2. Do you identify as a female-to-male transgender man? Y/N
3. Are you currently on hormones? Y/N
 - 3a. If so, how long?
 - a. 0-3 months
 - b. 3-6 months
 - c. 6-9 months
 - d. 9-12 months
 - e. 12 months or more
4. Are you in a romantic relationship? Y/N
5. Are you sexually active within your romantic relationship? Y/N
6. Have you had any form of genital surgery (i.e. metoidioplasty, phalloplasty, etc.)? Y/N

*If participants indicate “No” on questions 1-5 or do not indicate “e” for question 3a, they will be ineligible.

APPENDIX B
DEMOGRAPHICS

1. How old are you? __ Years __ Months
2. What is your sex assigned at birth?
 1. Male
 2. Female
 3. Intersex
3. How would you describe your sexual orientation?
 1. Heterosexual
 2. Gay
 3. Lesbian
 4. Bisexual
 5. Pansexual
 6. Other, namely
4. Which label best describes your racial background?
 1. Asian American
 2. Black/African American
 3. Hispanic/Latin American origin/
 4. Native American/American Indian
 5. Native Hawaiian/Pacific Islander
 6. Non-Hispanic White
 7. Multiracial/Other
5. What is the highest level of education you have completed?
 1. Less than high school
 2. High school

3. Professional program
 4. Some college
 5. Undergraduate degree
 6. Graduate degree
6. What is your typical yearly individual income before taxes?
1. \$0-\$24,999
 2. \$25,000-\$49,999
 3. \$50,000-\$74,999
 4. \$75,000-\$99,999
 5. \$100,000-\$149,999
 6. \$150,000 or more
7. How long have you been on hormones? __Years __Months
8. Which of the following gender-affirming surgeries have you had (check all that apply)? Chest
Reconstruction/Hysterectomy/Metoidioplasty/Phalloplasty/Other, namely
9. How long have you and your partner been in a romantic relationship together?
__Years/ __Months
10. How would you describe your relationship status?
1. In a committed relationship – not living together
 2. In a committed relationship – living together
 3. Engaged – not living together
 4. Engaged – living together
 5. Married

6. Other, namely

11. What is your partner's sex assigned at birth?

1. Male

2. Female

3. Intersex

12. What is your partner's gender?

1. Male

2. Female

3. Non-binary

4. Gender fluid

5. Don't know

6. Other, namely

13. How would you describe your partner's sexual orientation?

1. Heterosexual

2. Gay

3. Lesbian

4. Bisexual

5. Pansexual

6. Don't know

7. Other, namely

APPENDIX C
RESEARCH SURVEY

Transgender Congruence Scale
(TCS; Kozee, Tylka, & Bauerband, 2012).

Directions: Gender identity is defined as the gender/genders that you experience yourself as; it is not necessarily related to your assigned gender at birth. For the following items, please indicate the response that best describes your experience over the past 2 weeks:

1. My outward appearance represents my gender identity.
2. I experience a sense of unity between my gender identity and my body.
3. My physical appearance adequately expresses my gender identity.
4. I am generally comfortable with how others perceive my gender identity when they look at me.
5. My physical body represents my gender identity.
6. The way my body currently looks does not represent my gender identity.
7. I am happy with the way my appearance expresses my gender identity.
8. I do not feel that my appearance reflects my gender identity.
9. I feel that my mind and body are consistent with one another.

Scaling: 1 (strongly disagree); 2 (somewhat disagree); 3 (neither agree nor disagree); 4 (somewhat agree); 5 (strongly agree).

Scoring: Reverse score items 6 and 8 (where 1 = 5, 2 = 4, 3 = 3, 4 = 2, 5 = 1). To arrive at the total scale score, average the responses to item 1-9.

New Sexual Satisfaction Scale
(NSSS; Stulhofer, Busko, and Brouillard, 2010)

Directions: Thinking about your sex life during the last six months, please rate your satisfaction with the following aspects:

1. The intensity of my sexual arousal
2. The quality of my orgasms
3. My “letting go” and surrender to sexual pleasure during sex
4. My focus/concentration during sexual activity
5. The way I sexually react to my partner
6. My body’s sexual functioning
7. My emotional opening up in sex
8. My mood after sexual activity
9. The frequency of my orgasms
10. The pleasure I provide to my partner

Scaling: 1 (not at all satisfied); 2 (a little satisfied); 3 (moderately satisfied); 4 (very satisfied); 5 (extremely satisfied).

Scoring: To arrive at a total scale score, average the responses of items 1-10.

Gender Minority Stress and Resilience scale
(GMSR; Testa et al., 2015)

Directions: Please indicate how much you agree with the following statements:

1. I resent my gender identity or expression.
2. My gender identity or expression makes me feel like a freak.
3. When I think of my gender identity or expression, I feel depressed.
4. When I think about my gender identity or expression, I feel unhappy.
5. Because of my gender identity or expression, I feel like an outcast.
6. I often ask myself: Why can't my gender identity or expression just be normal?
7. I feel that my gender identity or expression is embarrassing.
8. I envy people who do not have a gender identity or expression like mine.

Scaling: 1 (strongly disagree); 2 (somewhat disagree); 3 (neither agree nor disagree); 4 (somewhat agree); 5 (strongly agree).

Scoring: Total scores are calculated based on the summed values (0-4) of items 1-8.

Body Image Scale
(BIS; Lindgren & Pauly, 1975)

Circle the number which best expresses your feelings about the item mentioned as it applies to you.

1. Vagina

0. N/A 1. Very Satisfied 2. Satisfied 3. Neutral 4. Dissatisfied 5. Very Dissatisfied

2. Clitoris

0. N/A 1. Very Satisfied 2. Satisfied 3. Neutral 4. Dissatisfied 5. Very Dissatisfied

3. Ovaries/Uterus

0. N/A 1. Very Satisfied 2. Satisfied 3. Neutral 4. Dissatisfied 5. Very Dissatisfied

Scoring: To arrive at a final score, average the responses of items 1-3.

APPENDIX D
IRB APPROVAL



EXEMPTION GRANTED

[Ashley Randall](#)
[CISA: Counseling and Counseling Psychology](#)
480/727-5312
Ashley.K.Randall@asu.edu

Dear [Ashley Randall](#):

On 10/11/2019 the ASU IRB reviewed the following protocol:

Type of Review:	Initial Study
Title:	The Moderating Effect of Internalized Transphobia on the Association Between Gender Congruence and Sexual Satisfaction in Transgender Men
Investigator:	Ashley Randall
IRB ID:	STUDY00010875
Funding:	None
Grant Title:	None
Grant ID:	None
Documents Reviewed:	<ul style="list-style-type: none">• IRB Revised, Category: IRB Protocol;• Measures, Category: Measures (Survey questions/Interview questions /interview guides/focus group questions);• Flyer Revised, Category: Recruitment Materials;• Consent Revised, Category: Consent Form;

The IRB determined that the protocol is considered exempt pursuant to Federal Regulations 45CFR46 (2) Tests, surveys, interviews, or observation on 10/11/2019.

In conducting this protocol you are required to follow the requirements listed in the INVESTIGATOR MANUAL (HRP-103).

Sincerely,

IRB Administrator

cc:

Kai Kline
Kai Kline
Ashley Randall