Public Statement to the Education Subcommittee regarding Senate File 224
Directed to Subcommittee members Jim Carlin, Claire Celsi, and Jeff Taylor
1:00pm CST, February 10th, 2021

My name is Aiden Bettine, I am a transgender man and I am an Iowan. I did not have the language or the resources to come out as transgender when I was in elementary or middle school in the late 1990s and early 2000s and I am thankful we live in a world where courageous youth are able to articulate who they are to their families and communities today. Although I did not have the words, I knew who I was and how I felt from a young age and it was clear my peers at school did too. Bathrooms in public and particularly at school were violent places for me, where I experienced endless bullying precisely because I did not conform to societal expectations of girlhood and did not know there were avenues to becoming myself, a young boy certain of his identity.

In middle school I often got pushed and pulled out of both the boys' and girls' restrooms by bullies who also understood that my gender identity and sex assigned at birth did not align. I stopped using the restroom at school entirely because it was where I was harassed most. I challenge any one of our legislators to not use a restroom for at least ten hours, factoring the school day and bussing to and from home. Or twelve hours factoring in after school activities. Not using restroom facilities for ten to twelve hours a day means making choices like not to eat or drink during school. Or in absolute emergencies only using a restroom when classes are in session to minimize the chance of running into peers in the bathroom all while feeling terrified and panicked.

Instead of being able to safely use the restroom at school, which in the world I am fighting for, would have been the boys' restroom, every day in middle school my bus dropped me off a block from my house which was around the corner and up a hill. In the walk up the hill to my home, the minute I laid eyes on a space that signified safety and privacy, I would wet my pants and cry. I cried because of the relief I experience in nearly being home and finally being able to relieve my aching bladder. I cried with embarrassment and frustration that I couldn't make it for one more minute or one more block after a day long fight to hold it. Once I got home, I would hide my wet clothes by doing the laundry and changing into pajamas, masking the daily bullying and discomfort I experience in a routine that I'd hope to my parents, made it look like I just wanted to be comfortable and was good at certain chores.

But this did not fool my parents. They too experienced the daily frustrations of my moving through the world with a conflict between my gender identity and my sex assigned at birth. As any physician and parent should know, holding your bladder for an unconscionable amount of time leads to reoccurring bladder infections, countless trips to the doctor, and a standard run of antibiotics to clear the infections. Being unable to use the restroom at school effected my mental, emotional, and physical well-being.

Senate File 224 is a bill that perpetuates harm to countless transgender youth across Iowa by banning them from using restrooms at school based on their gender identity. There is no doubt that transgender youth already experience bullying much like what I experienced growing up without this legislation in place. The main difference between my childhood and theirs is that I

did not have the resources to come out and understand my gender identity and I did not have my state legislature attempting to violate my rights and my privacy, which would have ultimately caused more harm to my mental and emotional health.

There are well-documented and sadly high rates of suicide and suicide attempts among transgender people and transgender youth in particular. Self-harm and suicide are not due to being born transgender or gender non-conforming. Self-harm and suicide among transgender people are caused by being born into a society with so much hate and lack of acceptance. I am terrified that even the proposal of this legislation will lead to our community losing another transgender Iowan to suicide because this legislation communicates that transgender youth should not be given respect, privacy, and most of all safety in their elementary and secondary schools according to Senator Jim Carlin who proposed this bill and sits on this subcommittee. If this bill moves forward, even if it fails to pass (which it should), the message remains clear: there are legislators in Iowa, who call themselves Iowans, who were voted in and supported by other Iowans, who do not want transgender youth to exist safely in our schools and in our state.

Legally, this bill violates the Iowa Civil Rights Act of !963 that includes gender identity as a protected class status in regard to education and public accommodations specifically. It also violates President Joe Bidens Executive Order on Preventing and Combating Discrimination on the Basis of Gender Identity or Sexual Orientation enacted on January 20th, 2021. If this bill passes it will have dire consequences for transgender youth in our community. It will also affect Iowa as a state and jeopardizes federal funding for violation of Biden's executive order. As we witnessed North Carolina's "bathroom bill" HB2 go into effect in 2016, businesses, organizations, and entertainers will pull out of commitments they've made in Iowa for large events, concerts, and job creation just as they did in North Carolina, leading to the bill's repeal in 2018.

As North Carolina Governor Roy Cooper stated when signing the law to repeal HB2, "For over a year now, House Bill 2 has been a dark cloud hanging over our great state. It has stained our reputation. It has discriminated against our people and it has caused great economic harm in many of our communities," that stain, that dark cloud already shrouds Iowa with all of the hateful anti-trans bills proposed so far this year. Moving Senate File 224 forward would make this looming cloud permanent, until we vote new legislators in office who truly support the freedoms, rights, and privacy of all Iowans, transgender people and youth included.

I am writing today as a transgender man who is a proud Iowan and thankful to be alive after the bullying and harassment I faced as a youth due to my gender identity. I am here to stand up for the transgender and gender non-conforming youth who do not have a voice in your eyes, precisely because they do not yet have a vote. I should not have to make a public testimony with this much detail about my personal life, but the legislation being proposed regarding transgender people is not based upon the lived experience of transgender people nor the medical and academic expertise that proves bills like Senate File 224 cause harm and violence, protecting no one and infringing upon individual rights and freedoms. I've attached scholarship and medical publications that support my argument with evidence and are written by professionals with more experience and knowledge than Senator Jim Carlin, an attorney and not a medical professional or scientist, will ever have when it comes to the health, safety, and well-being of transgender youth.

Mental Health of Transgender Children Who Are Supported in Their Identities

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abstract

OBJECTIVE: Transgender children who have socially transitioned, that is, who identify as the gender "opposite" their natal sex and are supported to live openly as that gender, are increasingly visible in society, yet we know nothing about their mental health. Previous work with children with gender identity disorder (GID; now termed gender dysphoria) has found remarkably high rates of anxiety and depression in these children. Here we examine, for the first time, mental health in a sample of socially transitioned transgender children.

METHODS: A community-based national sample of transgender, prepubescent children (n = 73, aged 3–12 years), along with control groups of nontransgender children in the same age range (n = 73 age- and gender-matched community controls; n = 49 sibling of transgender participants), were recruited as part of the TransYouth Project. Parents completed anxiety and depression measures.

RESULTS: Transgender children showed no elevations in depression and slightly elevated anxiety relative to population averages. They did not differ from the control groups on depression symptoms and had only marginally higher anxiety symptoms.

CONCLUSIONS: Socially transitioned transgender children who are supported in their gender identity have developmentally normative levels of depression and only minimal elevations in anxiety, suggesting that psychopathology is not inevitable within this group. Especially striking is the comparison with reports of children with GID; socially transitioned transgender children have notably lower rates of internalizing psychopathology than previously reported among children with GID living as their natal sex.

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Dr Olson conceptualized and designed the study, assisted in data collection, carried out the initial analyses, and drafted the initial manuscript; Ms Durwood and Ms DeMeules collected the data, supervised data entry, and reviewed the manuscript; Dr McLaughlin conceptualized the study and substantially reviewed and revised the manuscript; and all authors approved the final manuscript as submitted.

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WHAT'S KNOWN ON THIS SUBJECT: Transgender individuals have been found to have highly elevated rates of anxiety and depression, but little is known about the mental health of transgender children whose identities are affirmed and supported by their families.

WHAT THIS STUDY ADDS: More families are allowing their transgender children to live and present to others as their gender identity. This is the first study to examine mental health in these children, finding that they have low levels of anxiety and depression.

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National media are increasingly presenting stories of a subset of prepubescent transgender children (those who persistently, insistently, and consistently identify as the gender identity that is the "opposite" of their natal sex). More striking to many, a large number of these children have "socially transitioned": they are being raised and are presenting to others as their gender identity rather than their natal sex,[1–4] a reversible nonmedical intervention that involves changing the pronouns used to describe a child, as well as his or her name and (typically) hair length and clothing. These stories have sparked an international debate about whether parents of young transgender children should support their children's desire to live presenting as their gender identity.[5–9] Despite considerable and heated discussion on the topic, and despite these children's increasing appearance at gender clinics,[6] there have been no reports to date on the mental health of transgender children who have socially transitioned, forcing clinicians to make recommendations to parents without any systematic, empirical investigations of mental health among socially transitioned children.

Most studies of mental health among transgender people have examined adolescents and adults. These studies consistently report dramatically elevated rates of anxiety, depression, and suicidality among transgender people.[10–16] These elevated rates of psychopathology are likely the result of years of prejudice, discrimination, and stigma[11,17]; conflict between one's appearance and stated identity[18]; and general rejection by people in their social environments, including their families.[19,20] There is now growing evidence that social support is linked to better mental health outcomes among transgender adolescents and adults.[21–26] These findings suggest the possibility that social transitions in children, a form of affirmation and support by a prepubescent child's parents, could be associated with good mental health outcomes in transgender children.

Although there are no large studies of transgender prepubescent children, a number of studies have examined children who were at the time diagnosed with what was called gender identity disorder (GID), now termed gender dysphoria (GD; for more on both terms and others used throughout this article, see Table 1). The group of children diagnosed with GID likely included children who were transgender as well as others (eg, children who wished and acted but did not believe they were a member of the other gender and were distressed as a result). Importantly, most of the studies of children with GID/GD were conducted at a time when parental support and affirmation of children's gender nonconforming behaviors and identities were uncommon. In contrast, the current work focuses on what is likely a much narrower group of children, a small subset of the group that previously would have been diagnosed with GID: those who (1) identify as (not merely wish) they were the "opposite" gender as their sex at birth and (2) have socially transitioned so that they appear to others as the gender they feel, rather than that assumed by their sex at birth.

By and large, studies of children with GID reported high rates of psychopathology, especially internalizing disorders such as anxiety and depression[27–32]. For example, 36% of a group of 7- to 12-year-olds with GID reached the clinical range for internalizing problems.[33] Furthermore, 2 large studies of 6- to 11-year-olds with GID (including >100 children in Utrecht, the Netherlands, and 300 children in Toronto, Canada) found average internalizing scores in the clinical and preclinical range, respectively, suggesting that many children in both samples showed high levels of internalizing psychopathology. Some have argued that these high rates of internalizing psychopathology among children with GID/GD as a sign that GID/GD is itself a form or consequence of such psychopathology.[27]

In contrast, 2 smaller studies suggest that children whose gender identities are affirmed and supported have relatively good mental health. One study reported on 26 children aged 3 to 12 years with GID who were recruited through a clinic that advised parents to support their children's gender expression. These children showed reduced rates of psychopathology[34] compared with those reported in other studies conducted at clinics that do not support such gender expression.[35] However, this study has received some criticism for methodologic limitations[36] and had a small sample size. Furthermore, the degree to which these findings generalize to transgender children and especially to transgender children who have been allowed to fully socially transition, is unknown. In addition, a qualitative analysis of interviews of parents of 5 transgender children who had socially transitioned found that parents recalled a reduction in mental health problems after a social transition.[37] Although no formal quantitative measures were provided, these findings again suggest that socially supported transgender children might have better mental health than children with GD or transgender children who are not supported in their identities.

The current study addresses a critical gap in knowledge by examining parental reports of anxiety and depression among a relatively large cohort of transgender children, all of whom are supported by their families and have socially transitioned (ie, they present to others as the gender consistent with their identity, not

TABLE 1 Definitions of Terms

Term	Use in This Article	Other Uses, Terms, and Comments
Transgender	In this article, we use "transgender" to refer to children who have a binary identity (male or female) and for whom this identity is not aligned with their sex at birth. This means natal boys who identify as girls and natal girls who identify as boys. In our sample, these children have all socially transitioned as well.	"Transgender" is often used to mean a broader range of people—anyone whose gender identity does not align with his or her sex at birth. This categorization can include, for example, people who identify as male and female, neither male or female, or somewhere between male and female. The sample included in the current work does not include such children, hence our use of a narrower version of this term.
Social transition	This phrase is used to refer to a decision by a family to allow a child to begin to present, in all aspects of the child's life, with a gender presentation that aligns with the child's own sense of gender identity and that is the "opposite" of the gender assumed at the child's birth. Social transitions involve changes in the child's appearance (eg, hair, clothing), the pronoun used to refer to the child, and typically also a change in the child's name.	Social transitions are currently controversial in clinical psychology and psychiatry, but are increasingly being pursued by parents. More and more pediatricians, therapists, and teachers are supporting these transitions as well. Importantly, these transitions do not involve any medical, physiologic, or hormonal intervention.
Natal sex	We use this term to refer to the sex assigned by a physician at the child's birth. This phrase is meant as a synonym for "anatomical sex," "biological sex," or "sex assigned at birth."	The term "natal sex" is controversial, with many using the phrase "sex assigned at birth" instead. However, the latter term is still unfamiliar to many people with limited exposure to transgender individuals. Because this paper is aimed at reaching a broad audience of pediatric health professionals, we use the more commonly understood term "natal sex."
"Opposite" gender	We occasionally use the phrase "opposite" gender in this article when describing our sample of transgender children. Children whose gender is the "opposite" of their natal sex refers to natal boys who identify as girls and natal girls who identify as boys. Because the latter phrasing is longer and more awkward, we opted for the former.	This phrasing of "opposite" gender implies that gender is binary, when in fact it is not. There are many people who do not identify as male or female. We use this phrase because most readers will be more familiar with this terminology, and our goal is to reach a broad audience of pediatric health professionals.
Gender identity	We use this term to refer to a child's sense of his or her own gender. Although in most children, gender identity "aligns" with a child's natal sex, in transgender children, it does not.	Gender identity is often separated from gender presentation or gender expression (ie, the gender one appears to others as, or how a child expresses his or her gender identity). In this study, however, participants' gender identities align with their gender presentation/expressions because children have socially transitioned.
Gender Identity Disorder (GID)/Gender Dysphoria (GD)	Until 2014, GID was the official diagnosis given to children who had behavioral preferences and identities (or desires to be) the "other" gender. With the publication of the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, this diagnostic category was renamed gender dysphoria (GD) after substantial debate about whether this is or is not a "disorder."	The term GD describes a broader segment of the population than children qualifying as "transgender" for the current study. For example, a natal male who wishes to be a female, who behaves in accordance with female cultural stereotypes, and who has considerable concern about his identity but who does not believe he is female, would be diagnosed with GD but would not count as transgender in the current study.

their natal sex and use associated gender pronouns consistent with that identity). We focused on internalizing psychopathology because previous work indicates that transgender children are particularly likely to have internalizing, as opposed to externalizing, symptoms.[33,35] We compared these supported, transgender children's rates of anxiety and depression to their nontransgender siblings and to typically developing nontransgender children matched to transgender children on age and gender identity.

METHODS

This work, including recruitment and methods, was approved by the Institutional Review Board at the University of Washington.

Participants

To be included in this study, transgender children had to (1) identify as the gender "opposite" their natal sex in everyday life (ie, they identified as male or female, but not the gender that aligned with their sex at birth), (2) present in all contexts (eg, at school, in public) as that gender identity, (3) use the pronoun matching their gender rather than their natal sex, (4) be 3 to 12 years old, and (5) be prepubescent (ie, anyone eligible for hormone blockers was excluded from the present study). We recruited a national, community sample via support groups, conferences, a Web site advertised via media stories, and word of mouth. Our sample included 73 transgender children (M_{age} = 7.7 years; SD = 2.2 years; 22 natal females, 51 natal males;

TABLE 2 Sociodemographic Characteristics for Transgender and Nontransgender Children (n = 195)

	Transgender[a] (n = 73)	Controls[b] (n = 73)	Siblings[c] (n = 49)
Gender, %			
Male	30	30	61
Female	70	70	39
Natal boys[d]	70	30	61
Natal girls	30	70	39
Race/ethnicity			
White, non-Hispanic	70	71	76
Hispanic	8	5	10
Asian	6	4	2
Multiracial/other	16	19	12
Mean age, y	7.7 y	7.8 y	8.3 y
Age distribution, %			
3–5 y	30	30	22
6–8 y	40	37	37
9–12 y	30	33	41
Annual family income, %			
<$25 000	1	1	2
$25 001–$50 000	7	7	4
$50 001–$75 000	7	14	4
$75 001–$125 000	41	43	39
>$125 000	44	38	51

[a] Transgender children were all prepubescent and had socially transitioned.
[b] Controls were matched to transgender children for gender identity and age within 4 months.
[c] Siblings were the siblings who were closest in age to their transgender siblings.
[d] One natal male was diagnosed with a minor disorder of sex development, hypospadias, but consultation with endocrinologist indicated this condition is not associated with female identity.

70% white non-Hispanic) and included all consecutive cases run by our research group meeting these criteria, starting with the first for whom we had these measures.

In addition, we recruited 2 control groups. Our first control group was a set of 49 siblings (M_{age} = 8.3 years; SD = 2.5 years; 19 natal females, 30 natal males; 76% white non-Hispanic) of the transgender children reported earlier who were also aged 3 to 12 years. Whenever possible, the sibling closest in age was recruited. The second group of controls consisted of 73 typically developing children with no history of cross-gender behavior (M_{age} = 7.8 years; SD = 2.2 months; 51 natal females, 22 natal males; 71% white non-Hispanic) who were matched to each transgender child based on age and gender identity (eg, transgender girls had female controls). These unrelated controls were recruited from a university database of families in the Seattle area interested in participating in research about child development. Importantly, all parents were informed that this was part of a longitudinal study about gender nonconforming children's development, even though their children were not gender nonconforming. Recruitment and data collection is part of the TransYouth Project, a large, longitudinal study of American and Canadian transgender children's development, and matched controls from that larger study were used in the current work.

Measures

Internalizing Psychopathology

Symptoms of anxiety and depression were reported using the National Institutes of Health Patient Reported Outcomes Measurement Information System parental proxy short forms for anxiety and depression.[38] When possible, 2 parents completed these forms, and the averages are reported (n = 90); in all other cases, only 1 parent completed the forms (n = 115). (Importantly, results did not change if only mothers' responses [most often the only parent present when there was one reporter] were analyzed.) These scales are nationally normed and provide t-scores such that a score of 50 represents the national mean, with a SD of 10.

Demographics

Parents completed several demographic questions, including their child's race, sex, and age, and their household income (in quintiles: 1 = <$25 000/year, 2 = $25 001–50 000, 3 = $50 001–75 000, 4 = $75 001–$125 000, 5 = >$125 000/year). This information is reported by participant group in Table 2. With the exception of gender (siblings were more likely to have a male gender identity than transgender or age-matched control participants; the latter 2 groups were matched on this variable), the 3 groups did not differ on demographic variables.

RESULTS

Anxiety and depression t scores are reported in Table 3 by participant sample and natal sex. Transgender children's rates of anxiety and depression were first compared with the scale's midpoint (50), an indicator of average levels of depression and anxiety symptoms.[38] In terms of depression, transgender children's symptoms (M = 50.1) did not differ from the population average, P = .883. In contrast, transgender children had elevated rates of anxiety compared with the population average (M = 54.2), $t(72) = 4.05$, $P < .001$. Mean anxiety symptoms of transgender children were not in the clinical, or even preclinical, range, but were elevated.

To assess differences between transgender and control children in our sample, we ran a 3 (group: transgender, siblings, controls) × 2 (natal sex) between-subjects analysis of variance for depression and anxiety. Natal sex was used in

this analysis, rather than affirmed gender, because work with children with GID/GD used this convention,[35] allowing interested readers to make comparisons to past work with that sample and because previous work has suggested differences in internalizing psychopathology between natal boys compared with girls with GID.[35,39] For depression, there were no main effects of group, $P = .320$ or sex, $P = .498$, nor was there an interaction between condition and sex, $P = .979$. For anxiety, we found a marginally significant effect of group, $F(2189) = 2.91$, $P = .057$, and no effect of sex, $P = .990$, nor an interaction, $P = .664$.

TABLE 3 Anxiety and Depression *t* Scores by Sex and Sample

	Transgender ($n = 73$)	Controls ($n = 73$)	Siblings ($n = 49$)	*P*
Depression	50.1	48.4	49.3	.320
Anxiety	54.2[a]	50.9	52.3	.057
Depression by gender[b]				.979[c]
Natal boys	49.8 (trans-girls)	48.0	48.9	
Natal girls	50.8 (trans-boys)	48.5	49.9	
Anxiety by gender				.664[c]
Natal boys	53.7	51.1	52.8	
Natal girls	55.3	50.8	51.5	

[a] This is the only value that is significantly above the national average (50), although it is still substantially below the clinical (>63) or even preclinical (>60) range.
[b] Transgender children who are natal boys and live with a female gender presentation are often called transgender girls or trans-girls; transgender children who are natal girls living with a male gender presentation are often called transgender boys or trans-boys.
[c] Significance value of interaction between natal sex and group.

TABLE 4 Comparison of Present Sample With Previous Reports of Population-Normed Internalizing Scores for children with GID[24]

	Current Sample ($n = 73$)	Toronto ($n = 343$)	Utrecht ($n = 123$)
Mean age	7.7 y	7.2 y	8.1 y
Sample	Transgender[a]	GID[b]	GID[b]
Measure of internalizing	PROMIS[c]	CBCL	CBCL
Mean internalizing *t* score	52.2	60.8	64.1

Both the PROMIS and CBCL are normed such that the population mean is $t = 50$ and SD is 10. CBCL, Child Behavior Checklist; PROMIS, Patient Reported Outcomes Measurement Information System.
[a] The current participants were transgender, socially transitioned, and prepubescent.
[b] Participants in both the Toronto and Utrecht samples either met criteria for GID or showed subthreshold symptoms of GID.
[c] To compute an internalizing score for the PROMIS, depression and anxiety scores were averaged.

DISCUSSION

Socially transitioned, prepubescent transgender children showed typical rates of depression and only slightly elevated rates of anxiety symptoms compared with population averages. These children did not differ on either measure from 2 groups of controls: their own siblings and a group of age and gender-matched controls. Critically, transgender children supported in their identities had internalizing symptoms that were well below even the preclinical range. These findings suggest that familial support in general, or specifically via the decision to allow their children to socially transition, may be associated with better mental health outcomes among transgender children. In particular, allowing children to present in everyday life as their gender identity rather than their natal sex is associated with developmentally normative levels of depression and anxiety.

Critically, socially transitioned transgender children showed substantially lower rates of internalizing symptoms than children with GID reported in previous studies[35] (see Table 4). Our findings align with at least 1 other report of low mental health problems among children with GID supported in their gender identities,[34] a sample that may have included some socially transitioned transgender children. Comparisons between previous reports of children with GID and the current sample should be made cautiously, however, because the criteria for inclusion (transgender identities vs GID) and specific measures of internalizing psychopathology (PROMIS vs CBCL) differ across studies.

One might reasonably ask whether this study provides support for all children with gender dysphoria to socially transition. A few points are key to consider. First, all children in our study (unlike many children with the GD classification), had binary identities, meaning they identified as male or female. Thus, we cannot make predictions about the expected mental health of children who identify as male and female, as neither male nor female, or who identify as the gender associated with their natal sex but nonetheless exhibit behavior more often associated with the "other" gender after a social transition. Thus, just because a child behaves in a way consistent with a gender other than their natal sex does not mean that child is transgender nor that a social transition is advisable. Second, the children in this study were unique in many critical ways. They transitioned at a time when such transitions are quite controversial[5–9] and yet did so anyway. Surely not all families with transgender children make this decision, meaning there are likely characteristics that are unique to these families. In addition, the transgender children in this study all socially transitioned much earlier than nearly all transgender adults alive today in the United States and

Canada. Why might they have done so? Possibilities that we cannot rule out are that these children displayed earlier signs of their transgender identities, that they were more insistent about those identities, that they represent the most extreme end of the spectrum of transgender identities, or that parents today are just more educated about the existence of transgender children. It is too early to tell the ways in which these children and these families are unique. Finally, the children in this study were not randomly assigned to social transitions, precluding the ability to make causal claims about the impact of social transitions on mental health. These data are suggestive, nonetheless, that social transitions are associated with positive mental health outcomes for transgender children.

We cannot rule out several alternative explanations for our findings. First, rather than a direct impact of parental support, these generally positive mental health findings could be a more indirect result of parent support: namely, feeling supported in general (independent of a social transition) may lead to higher self-esteem,[40] which in turn may lead to better mental health.[41] Second, as alluded to earlier, there could be some unique third variable that explains the observed occurrence of typical mental health among socially transitioned transgender children. For example, perhaps some attribute unique to the subset of transgender children who are able to convince their parents to allow them to transition (eg, verbal skill, self-confidence) is responsible for these children having particularly good mental health, and it was this unique cognitive ability or aspect of personality that is either correlated with better mental health or leads to better mental health when a child feels he or she achieved his or her goal. Future studies examining children before and after social transitions may be able to address this concern. Finally, parents of transgender children could have biased reporting, reflecting a desire for their children to appear healthier than they are. We have no reasons to believe this was an issue but in the future aim to include other reporters (eg, teachers) to address this concern that others are likely to raise.

In addition to studying other explanations for these data, the current work begs for more research not only on children with other transgender identities (eg, children who identify as both or neither male and female), but also for work with children who have clear binary transgender identities, like the children in the current study, but who are not supported or affirmed by their families in these identities. Finding such children and particularly convincing their parents to allow them to participate in research, will be a challenge but one that is ultimately necessary for a clear understanding of the specific impact of transitions for these children.

Despite their overall relatively good mental health, socially transitioned transgender children did experience slightly more anxiety than the population average, although still well below the preclinical range. What might explain this result? Despite receiving considerable support from their families, these children likely still experience relatively high rates of peer victimization or smaller daily micro-aggressions, particularly if their peers know that they are transgender[42] which can in turn lead to marked elevations of anxiety symptoms and anxiety disorders.[43–45] Additionally, any transgender children who are living "stealth" or "undisclosed" (ie, whose peers are unaware of their transgender status), may experience anxiety about others discovering their transgender identity; previous work with adults has suggested that concealing a stigmatized identity can lead to psychological distress.[46] Furthermore, transgender children do not have the typical bodies of children with their gender identities, which could be a source of distress. Even when transgender children are allowed to use the bathroom, locker room, or be on the team with children who share their gender, the mere existence of these distinctions likely highlights the ways in which their bodies do not align with cultural expectations for children of their gender identity group. Relatedly, some children in our sample are approaching puberty, and most are aware that puberty will cause physical changes in an unwanted direction (unless puberty blockers are administered), which could generate considerable worry and anxiety.

Importantly, although these socially transitioned prepubescent children are doing quite well in terms of their mental health at this point, parents and clinicians of such children should still be on the lookout for potential changes in the status of their children's mental health. In general, the prevalence of depression is relatively low in prepubescent children and rises dramatically during adolescence.[47] It is possible that transgender children will exhibit greater anxiety and depression than their peers during the adolescent transition because of the sources of distress mentioned earlier, which will likely become worse with time (a possibility we aim to test with prospective follow-up of this sample). Thus, while adolescence is a time of increased perceptions of stress for many adolescents,[48] many of these issues are exacerbated for transgender teens. Transgender adolescents, whether they do or do not delay puberty through medical intervention, often experience body dysphoria (as their bodies do not match the bodies of their

same-gender peers), making sex and relationships even more worrisome than among their nontransgender peers.[49]

CONCLUSIONS

In sum, we provide novel evidence of low rates of internalizing psychopathology in young socially transitioned transgender children who are supported in their gender identity. These data suggest at least the possibility that being transgender is not synonymous with, nor the direct result of, psychopathology in childhood.[27] Instead, these results provide clear evidence that transgender children have levels of anxiety and depression no different from their nontransgender siblings and peers. As more and more parents are deciding to socially transition their children, continuing to assess mental health in an increasingly diverse group of socially transitioned children will be of utmost importance.

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ABBREVIATIONS

GD: gender dysphoria
GID: gender identity disorder

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Mental Health of Transgender Children Who Are Supported in Their Identities

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Transgender and Gender Nonconforming Youths' Public Facilities Use and Psychological Well-Being: A Mixed-Method Study

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Abstract

Purpose: In this study, we explored experiences and feelings of safety in public facilities in relation to psychological well-being among transgender and gender nonconforming (TGNC) youth in the Midwest in the summer of 2016, in the context of ongoing legislative proposals and regulations regarding school and public bathroom use in the United States.

Methods: We used a mixed-method approach, with (1) a self-administered, paper-and-pencil survey of 120 TGNC youth, focusing on differences of self-esteem, resilience, quality of life (QoL), perceived stigma, feelings of safety, and experiences of public facility use and (2) two focus group interviews ($n = 9$) in which TGNC youth discussed individual perceptions, attitudes, and experiences of bathroom use outside participants' homes. The samples consisted predominantly of individuals assigned female at birth and currently of trans-masculine identity.

Results: TGNC youth in our sample who reported that they had felt unsafe in bathrooms due to appearance or gender identity had significantly lower levels of resilience ($\text{mean}_{(\text{felt safe})} = 125.7$ vs. $\text{mean}_{(\text{felt unsafe})} = 116.1$; $p = 0.03$, Cohen's $d = 0.44$) and QoL ($\text{mean}_{(\text{felt safe})} = 59.1$ vs. $\text{mean}_{(\text{felt unsafe})} = 51.9$; $p = 0.04$, Cohen's $d = 0.39$), compared to those who felt safe. Meanwhile, feeling unsafe in bathrooms was associated with a greater level of perceived LGBT stigma ($\text{mean}_{(\text{felt safe})} = 2.3$ vs. $\text{mean}_{(\text{felt unsafe})} = 2.6$; $p = 0.03$, Cohen's $d = 0.41$) and problematic anxiety in the past year (χ^2 (1) = 4.06; $p = 0.04$). Individuals in the focus groups provided specific examples of their experiences of and concerns about locker room or bathroom use in public facilities, and on the impact of school bathroom-related policies and legislation on them.

Conclusion: Perceptions of safety related to bathroom use are related to psychological well-being among TGNC youth. Our predominantly trans-masculine youth sample indicated that choice of bathroom and locker room use is important and that antiharassment policies need to support students' use of their choice of bathrooms. This is particularly important information given debate of so-called bathroom bills, which attempt to restrict public bathroom use for TGNC youth, creating less choice and more stress and fear among these individuals.

Keywords: anti-transgender legislation; bathroom use; gender-expansive; gender minority youth; health disparities; transgender

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Introduction

The United States is experiencing widespread political debate on transgender[†] and gender nonconforming (TGNC) youths' use of public facilities, such as bathrooms and locker rooms, in accordance with their gender identity. In May 2016, after several court cases had developed and several states had attempted to create laws restricting transgender student's bathroom use, agencies of the Obama Administration issued a directive instructing public schools across the country to allow transgender students to use the bathroom that matches their gender identity.[1,2] Jointly, the U.S. Department of Education (DOE) and the U.S. Department of Justice (DOJ) clarified that the civil rights of transgender school students are protected under Title IX (of the Education Amendments of 1972), which prohibits sex discrimination. In the weeks that followed, 11 states sued the federal government over the directive.[3] Meanwhile, North Carolina had passed into law House Bill 2, which required all people to use public bathrooms in accordance with their sex assigned at birth, regardless of their gender identity or physical presentation[4] and the DOJ sued that state to overturn the law. Many other states have proposed legislation and continue to hold public debates on the issue. In January 2017, the Trump Administration's DOJ and DOE rescinded the previous guidance on and federal support for transgender students, indicating they would not pursue federal enforcement of title IX violations. As these political debates continue and laws are proposed, it is crucial to understand the impact on the health and well-being of transgender youth, who must navigate the impact of these policies in the context of well-documented and widespread victimization from peers and others in their daily lives due to their gender identity and expression.[5]

Proponents of laws and policies restricting public facility use to correspond with sex assigned at birth claim to protect individuals from violence or indiscretion by perpetrators if transgender people are allowed to use facilities according to their gender identity. Yet, major national antiviolence organizations have disputed these scenarios as a myth, and suggest that forcing transgender people into facilities that do not align with their gender places them at increased risk for experiencing harm.[6]

Data collected from adults indicate that the majority of transgender people are fearful of using public facilities, according to the 2015 National Transgender Survey of more than 28,000 transgender people age 18 years and older, collected in 2015 before the introduction of most bathroom bills.[7] In this survey, 59% of respondents reported avoiding using public restroom facilities in the past year because they were afraid of confrontations, with 12% experiencing verbal harassment and 1% reporting being the victim of physical or sexual assault in a public restroom.[7] In one of the few studies with youth, the 2015 National School Climate Survey found that 39% of students said they avoided gender segregated spaces because they felt uncomfortable or unsafe due to their gender presentation, and 60% of transgender students reported they were forced to use a facility that matched their sex assigned at birth instead of one that aligned with their gender identity.[5] There are scarce data from the perspective of school-age transgender youth for whom public facilities use policies and debate may have a daily effect.

In general, the relationship between marginalization and mental health sequelae in gender minority populations is well documented. In one community-based sample of transgender people age 18–72 years ($n=412$), 44% reported clinically significant symptoms of posttraumatic stress disorder (PTSD), which were both independently and significantly associated with higher everyday discrimination scores as well as greater number of reasons for discrimination.[8] Another study of 216 transgender young women aged 16–24 years found that youth who reported higher exposure to transgender-based discrimination had almost three times the odds of PTSD compared to those with lower exposure and eight times higher odds of stress related to thoughts of suicide.[9] Earlier studies have documented mental health outcomes of experiences in public facilities among transgender adults, with individuals who have been denied access to a public facility being 1.45 times as likely to have attempted suicide than those who had not been denied. Seelman found that denial of access to bathrooms or gender appropriate housing was significantly related to suicidality.[10]

The gender minority stress model provides an important perspective for the relationship between experiences of discrimination and mental health disparities among transgender individuals.[11,12] The model suggests that proximal and distal stressors resulting from experiences of discrimination and victimization have a direct and negative impact on psychological health outcomes, whereas resilience factors can act as mediators to improve psychological well-being in the face of minority stress. For example, previous mixed-methods research

[†]The term transgender will be used interchangeably throughout this article with the term gender minority to describe individuals who have a gender identity that is different from the sex assigned at birth. We intend for these terms to encompass a wide spectrum of diverse identities that may or may not fall within traditional binary categories of male or female genders.

with adults navigating gendered public facilities did not measure mental health outcomes, but found that proximal and distal minority stressors impacted functioning at work or school and participants described the negative psychological impact of stigmatization and consistent challenges to their identity.[13] Given that transgender youth are now at the center of a highly public debate regarding their identity and how it relates to their access to public facilities, a space where transgender youth are already reporting high rates of discrimination and bullying,[5] research with transgender youth to explore stress and resilience in relationship to public facilities is timely and important.

In this mixed methods study, we surveyed TGNC youth to examine how school bathroom experiences might be associated with psychological well-being. We also recruited TGNC youth to participate in focus groups to learn about their reactions to the bathroom debates described above and understand in more detail their experiences related to bathroom and locker room use in school. We collected both sets of data in an urban area of a Midwestern state during June 2016. The timing of the study allowed us to assess individuals targeted by legal and policy conflicts about gender identity and sex assigned at birth as these events were unfolding. The survey component of the study is presented first, followed by the focus group component. Discussion of both aspects of the study concludes the article.

Study 1: Quantitative Survey

Based on the gender minority stress model, we hypothesized that TGNC youth who felt unsafe or experienced problems in bathrooms due to appearance and gender identity would have significantly adverse psychosocial and health outcomes compared to those who did not.

Participants

The Gender Identity and Health Youth Survey was conducted over several days of a LGBTQ Pride Event held in a Midwest urban center. A convenience sample of 127 youth, aged between 13 and 20 years (mean = 17.2, standard deviation [SD] = 1.8) participated.

Procedures

Graduate students conducted surveys at the booth of a national transgender support and education organization. Every attendee who passed by the booth who appeared to be under 21 was invited to complete a 6-item screening form for eligibility. This approach was used to maximize representation and minimize researcher bias, as well as to protect participants from revealing their gender identities in public. As opposed to the focus groups, parental consent was waived for the surveys due to the following reasons: the survey was anonymous and posed minimal risk to participants, disclosure of transgender identity to parents who were not aware could put some participants at risk for confrontational responses, and parental consent was not feasible due to the venue of data collection—most youth attended the festival without parents. All participants were aware that all responses were voluntary, and that the data were to be used for research purposes.

Of the individuals approached for the study, 406 agreed to be screened and 127 (31%) met the inclusion criteria and completed the survey. The survey was an anonymous, paper-and-pencil, and self-administrated questionnaire. The survey took an average of 20 min to complete (range: 15–30 min). Participants received a gift worth $5 for their participation. The research protocol was approved by the University of Wisconsin-Milwaukee's Institutional Review Board.

Measures

Demographic characteristics. Participants were asked about their race/ethnicity, age, living environment/situation, sex assigned at birth, gender identity, sexual orientation, and gender and sexual alliance (GSA) involvement. Two questions about gender identity were asked, both with multiple options and open-ended context where respondents could provide the best fitting response. The first question was "what is your current gender identity"; the responses included: (1) man/boy, (2) women/girl, (3) genderqueer, neither exclusively male nor female, and (4) additional gender. To further articulate individual gender identity and whether it corresponds to their assigned sex at birth, another self-identification question was prompted to exclusively capture their transition status or non-cisgender identity (e.g., agender, transgender male, transgender female, gender nonconforming, genderqueer, non-binary, and other) at their unique identity development stage. There were two questions of GSA involvement that asked participants to check "yes" if involved in a school GSA and defined their role. Three single dichotomous items were asked for self-reported depression, anxiety, and medical problems in the past 12 months. An example of the items was "Have you experienced anxiety that caused problems for you in the past year?"

Self-esteem. Self-esteem was assessed by the 10-item Rosenberg Self-Esteem Scale (RSES),[14] a widely used

measure. Participants responded to questions on a 4-point Likert scale ranging from 1 (strongly agree) to 4 (strongly disagree). An example item was "On the whole, I am satisfied with myself." Responses were summed, yielding an overall score ranging from 10 to 40. The greater the score, the more self-esteem reported by the participants. The reliability and validity of the instrument has been found to be acceptable in adolescents (Cronbach's α range: 0.89–0.95).[15,16]

LGBT stigma (stigma). We adapted Logie and Earnshaw's sexual stigma scale to measure frequencies of experienced discrimination, including stereotype, enacted stigma, and harassment.[17] We added two items related to stigma or discrimination experiences in school and public bathrooms, and removed two items that were not relevant for youth. This 12-item scale uses a 4-point scale ranging from 1 (Many times) to 4 (Never). After conducting an exploratory factor analysis using principal components analysis with varimax rotation, 12 items loaded on two factors, consistent with the analysis of the original scale: perceived stigma and enacted stigma.[17] *Perceived Stigma* (six items) reflected experiences of perceived or felt-normative stigma (i.e., hearing or feeling social devaluation of queer, lesbian, and bisexual women), which included such statements as "How often have you heard that LGBT+ people are 'not normal.'" Another factor, named *Enacted Stigma* (six items), referred to the tangible behaviors and interactions of discrimination, hate, prejudice, or stigma from others; one such item is "How often have you been harassed by teachers, school staff, or police for being LGBT+." All items were reverse scored so that higher scores indicated greater perceived stigma. The internal reliability for this overall scale was 0.88 (Perceived Stigma Subscale: Cronbach's $\alpha = 0.84$; Enacted Stigma Subscale: Cronbach's $\alpha = 0.84$).

Resilience. The Resilience Scale (RS) is a 25-item self-report questionnaire using a 7-point Likert scale from 1 (strongly disagree) to 7 (strongly agree).[18] An example question is "When I make plans I follow through with them." The RS is well-adapted to evaluate resilience in adolescents due to good psychometric properties (Cronbach's α range: 0.91–0.93) and applications in a variety of age groups.[19–21]

Quality of life. We used the youth quality of life (YQoL) scale.[22,23] The scale includes four domains of quality of life (QoL): sense of self, social relationships, culture and community environment, and general QoL.[23–25] Responses are rated on an 11-point Likert-type scale, ranging from 0 (Not at all) to 10 (Very much). A sample item is "I am able to do most things as well as I want." The YQoL-SF 2.0 scale has acceptable internal consistency (Cronbach's α range: 0.77–0.96).[23]

Policy and environment. Two dichotomous questions assessed participants' awareness of the U.S. policies regarding public facility usage, including local state bills and the joint announcement from the DOJ and DOE (yes/no). Also, three items were used to measure safety and bathroom use in public; a sample question asked "Have you felt unsafe in bathrooms due to your appearance or gender identity." In addition, we assessed current public facility use with a single item: "Which bathrooms do you typically use when outside the home" with possible responses: "I use bathrooms according to my gender identity," "I use bathrooms consistent with my gender assigned at birth," "I only use unisex/family bathrooms," and "It depends on the situation and setting."

Data analyses

Before conducting data analyses, we excluded seven participants who reported being cisgender or did not provide current gender identities in the survey, leaving a final sample of $n = 120$. We examined missing data patterns and mean-imputed variables with 7.5% of values missing at random. *t*-Tests were used to determine differences in self-esteem, resilience, perceived stigma, and YQoL by feelings of using bathrooms in school (safe vs. unsafe). Another set of one-way analysis of variance tests was conducted to determine differences in self-esteem, resilience, perceived stigma, YQoL by individual discriminatory experiences of using bathrooms in school. Chi-square analyses were used to assess differences in anxiety, depression, and medical problems by descriptive characteristics (feeling safety and experience problems in bathrooms). In addition, we explored the relationship between social support and feelings and experiences of using bathrooms in school. Analyses were conducted using SAS 9.4 for Windows.

Quantitative results

Demographic and descriptive characteristics. See complete demographics in Table 1. The majority of participants were assigned female sex at birth ($n = 107$, 89%). Regarding current gender identity, 40 currently identified as man/boy (32%), and 51 were genderqueer (40%). When given an open choice on gender identity, 32% identified as gender queer/non-binary, 29%

Table 1. Demographics and Descriptive Statistics in the Gender Identity and Health Youth Survey ($n = 120$)

Variable	Mean (SD)	*n* (%)
Age (years)	17.2 (1.8)	
Race/ethnicity		
White		84 (70.6)
Hispanic/Latino		11 (9.2)
Black		2 (1.7)
Native American/American Indian		4 (3.4)
Other		18 (15.1)
Type of living environment		
Urban		37 (31.1)
Suburban		63 (52.9)
Rural area		10 (8.4)
Other		9 (7.6)
Assigned sex at birth		
Male		13 (10.8)
Female		107 (89.2)
Gender identity 1[a]		
Man/boy		37 (31.1)
Women/girl		15 (12.6)
Genderqueer/non-binary		51 (42.9)
Other		16 (13.4)
Gender identity 2[b]		
Agender		7 (5.9)
Transgender		34 (28.6)
Gender nonconforming		6 (5.0)
Genderqueer		22 (18.5)
Non-binary		16 (13.4)
Other		15 (12.6)
Multiple		19 (16.0)
Sexual orientation		
Lesbian, gay, or homosexual		23 (19.2)
Straight or heterosexual		9 (7.5)
Bisexual or pansexual		57 (47.5)
Questioning		6 (5.0)
Other or multiple		22 (18.3)
School access to bathrooms consistent with gender identity[c]		
Yes		37 (30.8)
No		25 (20.8)
Don't know		35 (29.2)
Don't go to school currently		23 (19.2)
Wisconsin legislature[d]		
Yes		74 (63.8)
No		42 (36.2)
Joint announcement[e]		
Yes		72 (61.5)
No		45 (38.5)
Negative bathroom experience[f]		
Yes		54 (45.8)
No		64 (54.2)
Felt unsafe[g]		
Yes		66 (56.4)
No		51 (43.6)
Bathroom use[h]		
Gender identity		19 (16.2)
Assigned sex at birth		40 (34.2)
Unisex/family bathrooms		12 (10.3)
Situational choices		46 (39.3)
Problematic depression in past year		
Yes		104 (87.4)
No		15 (12.6)
Problematic anxiety in past year		
Yes		113 (95.0)
No		6 (5.0)
Medical problems in past year		
Yes		47 (39.8)
No		71 (60.2)

[a]Gender identity 1 denotes self-identified gender identity.
[b]Gender identity 2 denotes self-identified non-cisgender identity.
[c]School access denotes whether school allows them to use the bathroom consistent with their gender identity.
[d]Wisconsin legislature denotes a bill proposal last year trying to limit transgender people's bathroom use to their sexual assigned at birth in Wisconsin.
[e]Joint announcement denotes the U.S. Department of Justice and Department of Education released policies that instruct schools and colleges to treat transgender students according to their gender identity on bathroom and locker room use.
[f]Bathroom experience denotes discriminatory experiences of using bathrooms related to their appearance or gender identity in public.
[g]Felt unsafe denotes whether they have felt unsafe in bathrooms due to their appearance or gender identity in public.
[h]Bathroom use denotes bathrooms they usually use in public.
SD, standard deviation.

transgender, 6% as agender, 5% gender expansive, and 29% another gender identity. About 69% of participants were non-Hispanic white, 10% identified as Hispanic or Latino, 14% were multiracial identities.

About 64% of participants were aware of local state legislation proposals regarding transgender people's bathroom access. Also, 62% were aware of the joint announcement from the DOJ and DOE.

Regarding public facility experiences, 46% reported having experienced problems using public bathrooms ($n = 54$). In addition, 56% ($n = 66$) felt unsafe using public bathrooms. Thirty-four percent of participants ($n = 40$) said they used the bathrooms consistent with their sex assigned at birth while 16% ($n = 19$) went to public bathrooms corresponding to their current gender identity. Another 39% ($n = 46$) reported it depended on the situation, and 10.3% ($n = 12$) only used unisex/family bathrooms.

In this sample of 120 predominantly transmasculine TGNC youth, the mean score for the RSES was 24.9 (range: 10–39, SD = 6.4). Scores below 25 indicate low-esteem and scores of 25–35 are considered typical self-esteem.[14] In our sample 44% of participants had low-self-esteem (overall RSES score <25).

The mean score for the RS was 120.3 (range: 53–169, SD = 23.1). After repeated applications of the RS with a variety of samples, Wagnild concluded that scores greater than 145 indicated moderately high-to-high resilience,

Table 2. Psychological Scales in Gender Identity and Health Youth Survey ($n = 120$)

Scale	Range	Mean	SD
RSES[a]	10–39	24.9	6.4
LGBT stigma[b]	1–4	2.5	0.7
Perceived stigma	1–4	2.9	0.7
Enacted stigma	1–4	2.1	0.8
Resilience[c]	53–169	120.3	23.1
YQoL[d]	14–100	55.0	18.3

[a]Scores below 25 indicate low-esteem. A score of 25–35 is considered typical self-esteem.[14] In our sample 44.4% of participants had low-self-esteem (overall RSES score <25).

[b]We adapted the sexual stigma scale, which was designed for LGB adult women. The authors provide their original sample means for the total scale as 2.0 (SD = 0.45).[17] They also provide means for the *Perceived Stigma* subscale as 2.67 (SD = 0.70) and for the *Enacted Stigma* subscale as 1.51 (SD = 0.40).[17]

[c]Wagnild reviewed three adolescent health studies that used the RS.[21] Among these three studies, the overall mean scores were 146.6 (SD = 14.1) in adolescent mothers, 111.9 (SD = 17.6) in homeless adolescents, and 132.5 in high-risk adolescents.[21] Possible scores range from 25 to 175. After repeated applications of the RS with a variety of samples, scores greater than 145 indicated moderately high-to-high resilience, 125–145 indicated moderately low to moderate levels of resilience, and scores of 120 and below indicated low resilience.[21]

[d]Patrick et al. used a 6-item version of this scale in a large sample of high-school age LGB youth.[25] They reported scores across different categories of participants (by grade, by gender, and by whether or not they were bullied due to perceived sexual orientation or other factors). QoL scores ranged from 54 to 83 across these different combinations of categories. The observed score here is at the lower end of the range of scores reported in Patrick, consistent with LGB students who had been bullied because of perceived sexual orientation.[25] Scores are comparable between studies because the total scale score on the YQoL is the total of transformed item scores divided by the number of items.

QoL, quality of life; RSES, Rosenberg Self Esteem Scale; YQoL, youth QoL.

125–145 indicated moderately low to moderate levels of resilience, and scores of 120 and below indicated low resilience.[21] In our sample, 13% ($n = 16$) reported moderately high-to-high resilience, 41% ($n = 49$) reported moderate to moderately low resilience, and 46% ($n = 55$) reported low resilience.

The mean score for the LGBT Stigma scale was 2.5 (range: 1–4, SD = 0.71). The mean score for the YQoL was 55.0 (range: 14–100, SD = 18.3). See psychological scales and additional normative/comparison data in Table 2.

Feelings of safety in bathrooms in relation to psychological and physical well-being. TGNC youth who reported that they had felt unsafe in bathrooms due to appearance or gender identity had significantly lower levels of resilience ($\text{mean}_{(\text{felt safe})} = 125.7$ vs. $\text{mean}_{(\text{felt unsafe})} = 116.1$; $p = 0.03$, Cohen's $d = 0.44$) and QoL ($\text{mean}_{(\text{felt safe})} = 59.1$ vs. $\text{mean}_{(\text{felt unsafe})} = 51.9$; $p = 0.04$, Cohen's $d = 0.39$), compared to those who felt safe. Meanwhile, feeling unsafe in bathrooms was associated with a greater level of perceived LGBT stigma ($\text{mean}_{(\text{felt safe})} = 2.3$ vs. $\text{mean}_{(\text{felt unsafe})} = 2.6$; $p = 0.03$, Cohen's $d = 0.41$). Individuals who felt unsafe were also more likely to report problematic anxiety in the past year (χ^2 (1) = 4.06; $p = 0.04$; Table 3).

Table 3. Comparison on Psychological Variables and Well-Being Among Transgender and Gender Nonconforming Youth Based on Feeling Unsafe in Bathrooms ($n = 117$)

Variable	Felt safe in bathrooms, mean (SD), or *n* (%)	Felt unsafe in bathrooms, mean (SD), or *n* (%)	*t*-test/χ^2 (1)
Self-esteem[a]	26.22 (6.71)	23.98 (6.08)	−1.88
Resilience[a]	125.67 (24.31)	116.06 (21.86)	−2.25*
QoL[a]	59.09 (20.29)	51.89 (16.17)	−2.14*
LGBT stigma[a]	2.34 (0.77)	2.64 (0.63)	2.23*
Anxiety in past year[b]	46 (90.2)	65 (98.5)	4.06*
Depression in past year[b]	43 (84.3)	59 (89.4)	0.66
Medical problems[b]	16 (31.4)	30 (46.2)	2.61

*$p < 0.05$.
[a]A composite score.
[b]A dichotomous variable.

Problems experienced in bathrooms in relation to psychological and physical well-being. As shown in Table 4, participants who reported experiencing problems using bathrooms due to appearance or gender identity reported higher levels of perceived LGBT stigma compared to those who reported no problems ($\text{mean}_{(\text{experienced no problems})} = 2.3$ vs. $\text{mean}_{(\text{experienced problems})} = 2.8$; $p < 0.001$, Cohen's $d = 0.80$). There were no significant differences on self-esteem, resilience, and QoL between those who had experienced problems and those who had not.

To complement the quantitative data and to examine in more depth the relationships between perceptions and experiences of bathroom use, legislation,

Table 4. Comparison on Psychological Variables and Well-Being Among Transgender and Gender Nonconforming Youth Based on Experiencing Problems in Bathrooms Due to Gender Identity or Expression ($n = 118$)

Variable	Did not experience problems in bathroom, mean (SD), or *n* (%)	Did experience problems in bathroom, mean (SD), or *n* (%)	*t*-test/χ^2 (1)
Self-esteem[a]	25.19 (6.39)	24.65 (6.46)	−0.45
Resilience[a]	121.00 (25.02)	119.44 (21.17)	−0.36
QoL[a]	55.40 (18.74)	55.02 (18.16)	−0.11
LGBT stigma[a]	2.26 (0.70)	2.79 (0.62)	4.26***
Anxiety in past year[b]	59 (92.2)	53 (98.1)	2.16
Depression in past year[b]	57 (89.1)	46 (85.2)	0.40
Medical problems[b]	21 (32.8)	25 (47.2)	2.51

***$p < 0.001$.
[a]A composite score.
[b]A dichotomous variable.

and mental health, and to better understand the lived experiences of TGNC youth in these areas, we conducted qualitative focus groups.

Study 2: Qualitative focus groups

Participants

Qualitative focus groups were organized with the assistance of the LGBT student resource center on the campus of a local university during outreach activities with LGBT high school students in the region. Before data collection, written informed assent was obtained from the teens and informed consent from their legal guardians. Potential participants of high school age who self-identified as transgender or had a gender identity other than the sex they were assigned at birth were invited to participate in a focus group. A total of nine people between the ages of 15 and 18 years and currently in high school participated in groups of four to five members. Six participants were non-Hispanic white; three were ethnic/racial minorities (Black or Hispanic). All participants were assigned female sex at birth, with current gender identities self-described as transgender, genderqueer, or man/boy.

Procedure

The focus groups were facilitated by an experienced qualitative researcher and attended by a student member of the research team, and lasted about 2 h. We began each focus group by bringing up the general topic of regulating bathroom use in schools, asking the teens for their reactions. Then, we invited them to share their own experiences around bathroom and locker room use in school. We continued with discussions about coming out as transgender, family support, and resilience. In this article, we present findings about bathroom and locker room use; findings about the other topics are presented elsewhere.

The focus groups were digitally recorded and transcribed. Using thematic analysis[26,27] we examined how participants interpreted the public controversy about bathroom use, and how they described their experiences using bathroom and locker room facilities in school. Similarities in meaning and experience, as well as their variation, were iteratively identified and categorized, highlighting the social contexts youth described.[28] We concluded our analysis by finding exemplar quotes to substantiate the findings.

Qualitative results

Personal relevance of bathroom use policy. The TGNC teens who participated in the focus groups were keenly aware and critical of state legislatures trying to limit transgender people's bathroom use to their sex assigned at birth. They referred specifically to North Carolina, calling the state "dumb and mean" for passing the contentious House Bill 2 restricting transgender bathroom access. Participants found it hard to fathom why such a restriction would be mandated by law, and how it could be enforced:

> When people won't let me use male bathrooms, it's like what are they going to do - look through the cracks in the bathroom stalls to see if I have the right genitalia?

They talked about how some people have religious objections to rights for the LGBTQ+ community, and they voiced compassion for those who, like some of their relatives, might need time to become informed about the issue. But, they were clear about the ethics of the situation:

> Since gay marriage (being legalized) and all these new rights, everybody is just trying to take it down with bathroom bills. They believe they are right. But, in reality, if you use your faith or morals to hurt or exclude someone else, you have no morals or faith at all.

They brought up the topic of corporate backlash against North Carolina, which they considered a positive outcome of the controversy. They felt supported by news of prominent individuals and groups decrying restrictive bathroom bills:

> You hear about Target that came out saying you can use the bathroom of your choice at our stores. Companies can help in a big way. We need people and corporations, big name companies, who will stand up for our rights.

A source of support identified by participants was the DOE's policy directive instructing schools to treat transgender students in a supportive and nondiscriminatory way.[1] Participants were aware of the protections offered by the document, emphasizing the guideline that transgender students not be limited to bathrooms and locker rooms corresponding to their assigned sex at birth:

> To hear that the government is saying- yes, what you are thinking is correct- it is fine that you use the bathroom of your choice. That is uplifting.

They were also aware of widespread objections to the Directive, however:

> The President's letter is getting a lot of hate.
>
> It is really scary that people are saying President Obama can't do this.

Of immediate importance to them was how their own high schools were responding to the Directive. For the

most part, these teens were disappointed. What they perceived in the reactions of school officials was denial of the need for structural change to make schools inclusive of transgender teens, marginalization of transgender people, or complete disregard for the issue:

> When President Obama sent the letter to let trans people use the bathroom of their choice, my school district sent out an email that said we're going to do it case-by-case. Case-by-case means we are not going to do it. It just sounds nice.

> At my school they were very vague. They talked about us like these special people, making us sound like a very small group, like there's only one or two of us in the state. That makes me mad. And, they aren't presenting full information. Not a lot of people know about transgender stuff and understand, so they need education.

> At my school there hasn't been any talk about it at all. No assemblies, no nothing by the principal or anything. They don't validate the issue.

Individual experiences related to bathroom policy. Bringing policy discussion down to the particular, participants were eager to explain what happens at their schools in regard to bathroom and locker room use.

Single-User Bathrooms: Accommodating or Discriminatory? Access to single-user bathrooms in school was important to participants; but according to the experiences they shared, it could be a double-edged sword; offering privacy on the one hand, but singling them out on the other. One difficulty they encountered was being restricted from multiple-user bathrooms altogether. Another difficulty was that single-user bathrooms were locked or located in faculty/staff-only areas, potentially exposing students to unwanted attention from peers and adults and being seen as different from their peers:

> I definitely have a problem at my school. I'm not allowed in any bathroom that is gendered. I have to ask for the key from a teacher in order to use the gender neutral bathroom. It is supposed to be for faculty only, so the door is locked.

> At my school there is no gender neutral bathroom. But in the school office there is the only restroom that doesn't have a gender marker on it. It is not gender neutral- it just doesn't have a marker because it is for the teachers. They let me use it.

Participants talked about how access to single-user gender neutral bathrooms was helpful in negotiating clothes changes before and after gym class, but that this accommodation still had the potential to make them stand out from others. For instance, they might be the only person traversing a school hallway or entering a classroom in gym clothes:

> I didn't feel comfortable in the female locker room. And, I wasn't allowed in the male locker room. I changed in the one gender neutral bathroom we have, but it was way on the other end of the school from the gym.

> I didn't get a locker. I have legit valuables in my backpack just like everybody else, but I was supposed to put my stuff on a shelf in the health room. Sometimes there was a class in there and I had to walk in in front of everybody to put my stuff in there.

A private dressing room was not the only solution needed to make gym class comfortable for transgender students. For instance, one participant did not feel comfortable having to transit through gendered locker rooms just to attend:

> The whole gym thing- our gym is like Fort Knox. No one's getting in and no one's getting out. I could change in an alternate place, but, the only entrance into the gym is through the gendered locker rooms. All the other doors are locked. I need to be able to get into the gym in a safe way.

Multiple-user bathrooms: What if they are hostile environments? Only a few participants reported they were allowed to use school bathrooms and locker rooms that corresponded to their gender identity. Although this was the preferred policy among participants, the practice did not resolve all problems for them. They recounted incidents of harassment and fear in multiple-user bathrooms consistent with their gender identity:

> In the boys' bathroom at school, I guess you could say I have been harassed- called names.

> My school said I could use the boys' locker room, like I could technically change with the boys. But, for safety reasons, until I'm on Testosterone, they put me in this official [referee's] room. It is still in the boys' locker room area, though.

Using multiple-user bathrooms corresponding to sex assigned at birth did not shield transgender teens from harassment, either:

> I always hated long hair and dresses. I got my Mom to let me get all my hair cut off. After that I remember going into female restrooms and getting called a boy a lot, especially by the younger girls.

> I've been kicked out of the female bathroom because I looked like a guy. This girl yelled at me for being a pervert because I was a guy in the girls' bathroom.

Further, transgender teens' inclinations about multiple-user bathrooms may be neither static nor easy. In determining whether they preferred to use a bathroom corresponding to their gender identity or to their sex assigned at birth, they might make calculations on any number of factors: how comfortable and self-assured they were feeling that day, whether the environment seemed safe, what their ideas about gender norms were,

and how their appearance compared to peers. This quote conveys some of the complexity in their decision making:

> I don't usually use the men's bathroom, even though I identify as gender queer. Personally, I wouldn't feel comfortable around guys, especially with how they would see me. I don't appear that masculine all the time, even though I don't identify as female. I feel like I don't need to appear as the gender norm. So, I might use the women's bathroom because it feels easier. But, I notice myself acting more feminine when I go in there just so I don't get looked at weird, especially if I am looking more masculine that day.

Stark contrast: Best and worst bathroom experiences in school. Developing a deeper understanding of the best and worst of any phenomenon can build knowledge and help guide practice. Such a contrast can be found in these focus group data. The most positively evaluated bathroom use experience shared in the focus groups happened in a school that publicly recognized gender identity as being more than the forced binary of male or female. With advice from its LGBTQ+ students, the school labeled its restrooms in a way that welcomed all students:

> My school is really good about this. We have two gender neutral bathrooms that we officially got plaques for that say ALL GENDERS.

The most negatively evaluated bathroom use experience shared in the focus groups was offered by a male-identified transgender participant who was habitually made to feel unsafe in his school's multiple-user bathrooms. He used the bathrooms corresponding to his gender identity:

> My school lets me use the bathroom I want to use, which is the male bathroom. Students in my grade know me, and they say like, "You aren't supposed to be in here." They call me tranny or dyke or whatever. And, I just think, "Guess what- I could care less about your opinion. I'm going to piss now." I really don't care about verbal stuff. I just walk it off until it's nothing to me.

He deals with harassment in the bathroom, what he calls "verbal stuff," by privately undervaluing its significance and "walking it off." When threatened with violence in the male bathroom, he seems to again use self-talk to reassure himself:

> I've been threatened a couple times in the male bathroom like, "Next time you come in here I'm going to kick you out." But I'm thinking, "How are you going to kick me out? You can't really hurt me. If you hurt me, my school will back me up."

He went on to sum up his school experience in disquieting terms:

> Freshman year (of high school) wasn't extremely bad. I wasn't like bullied to death or anything- just a little bit here and there.

He explained further:

> Nobody really wants to be my friend, but I could care less because I have always been an outcast to people. And with being alone, I kind of dealt with a lot of dysphoria. I had no one to talk to, so I was really quiet. And, I think that really impacted me.

In this transgender teen's narration, he indicated his bathroom experiences contributed to his feelings of being bullied and feeling isolated from others; and he uses the medical term "dysphoria" to describe his deep unhappiness.

Discussion

The current mixed method research contributes to the literature about TGNC youth in several important ways. First, both studies provided data from nonclinical samples of transgender youth. Quantitative survey results show that overall, the majority of this sample of predominantly transmasculine TGNC youth had felt unsafe using public bathrooms and almost half reported negative experiences using public bathrooms. Second, these data are from gender minority youth themselves, who are experiencing the effects of policies and practices in their daily lives, which has not been often represented in the literature. The quantitative data also provide evidence that gender minority youth who felt unsafe in bathrooms have adverse mental health impacts and lower QoL. The focus group interviews revealed narratives of negative experiences in locker rooms and bathrooms and discrimination, which has been impacted by ongoing transgender bathroom policies at federal and local levels.

Our qualitative findings suggest that transgender teens are aware of both the national debate on so-called bathroom bills, and the actions their own communities take to structure schools as inclusive or exclusive of transgender students. According to the experiences participants shared, bathroom and locker room use policy and practice affected their feelings of comfort, belonging, and safety in school. Our quantitative findings begin to document such associations. From the surveys we learned that more than half of gender minority youth feel unsafe using public bathroom facilities, and that these feelings of lack of safety are related to their own resilience, sense of perceived stigma, anxiety, and recent medical problems. Our findings are consistent with previous surveys regarding high rates of discrimination in public facilities.[7,13] Our findings on resilience are consistent with previous findings among TGNC youth; experiencing invalidation of gender identity was related to lower levels of resilience.[29]

From the focus groups we learned that access to multiple-user bathrooms corresponding to gender identity is not a panacea for transgender students if not accompanied by policies and actions that support those who use them. Second, access to single-user bathrooms is

important in conjunction with efforts to normalize their use for all students, so that transgender students are not singled out for discrimination. Third, transgender students want agency in their choices about bathroom use; what feels safe and appropriate on any given day in a particular social context at school may not feel safe and appropriate on another day given different circumstances. These findings suggest that navigating bathrooms and changing rooms at school, particularly when policies are not supportive or limit choice, are daily stressors for TGNC youth. According to the gender minority stress model,[12] this can negatively impact mental health outcomes.

Based on the gender minority stress model, we hypothesized that TGNC youth who felt unsafe or experienced problems in bathrooms due to appearance and gender identity would have significantly adverse psychosocial and health outcomes compared to those who did not. In the quantitative survey, we found that TGNC youth who felt unsafe in bathrooms reported less psychological well-being across several measures, including self-esteem, resilience, QoL, and perception of stigma, and problematic levels of anxiety. Negative experiences in bathrooms were directly associated only with greater perception of stigma, while associations with other outcomes were not significant. This pattern of findings could be explained by the following: TGNC youth who feel unsafe in bathrooms due to their appearance or gender identity might avoid public bathroom situations to avoid dealing with discrimination.

Transgender people who avoid using public facilities out of fear may experience not only adverse psychosocial effects, such as lower QoL as we found in our study, but the resultant health consequences such as bladder or kidney infections resulting from avoiding public restroom use due to fear or inability to succeed academically due to avoiding days of school due to feeling unsafe or uncomfortable in bathrooms or locker rooms.[5,7,30] Ongoing research building on our findings can further elaborate experiences and inform policy that will improve the QoL and health for TGNC youth.

Study limitations and strengths

The quantitative surveys were cross sectional and therefore cannot be used to determine the direction of causal relationships. The focus groups were a complementary approach to add depth and context to the quantitative findings. Both studies used convenience sampling, and the majority of the sample was non-minority, female-to-male transgender or transmasculine individuals; thus our findings might not be generalizable to other settings or segments of the TGNC population. The present research focused on TGNC youth perspectives in the Midwest. Although this is not a nationally representative sample, we have no theory-based reason to expect relationships between feelings of safety and psychological and physical well-being to differ geographically. Our qualitative findings are limited by the fact that the focus groups were comprised exclusively of male- or non-binary-identified transgender teens whose sex assigned at birth was female, which does not allow us to draw conclusions about the experiences of female- or non-binary-identified transgender teens whose sex assigned at birth was male. Further research is clearly warranted to understand the experiences and impacts on the full range of TGNC youth, and to document the direction of causality between the observed associations. Despite these limitations, this study contributes unique and timely data and findings to the literature on this important public health issue.

Conclusion

This study provides initial evidence from a nonclinical setting addressing the potential impacts of current policies and so-called "bathroom bills" on distress and experiences of using public bathrooms among gender minority youth. The inclusion of voices of transgender youth themselves based on their direct experiences gives additional weight to these findings. Taken together, our qualitative and quantitative findings converge on a primary message and recommendations: transgender-related bathroom policies limiting use to sex assigned at birth or requiring use of only single-stall bathrooms will likely have a negative impact on health outcomes among TGNC youth. Policies that create more restrictive bathroom options for transgender students will likely create environments in which TGNC youth feel less safe in bathrooms and in school. Based on our data, this could lead to an increase in perceived stigma and discrimination, and less resilience, self-esteem, and lower QoL for these youth.

Feeling unsafe in public facilities may be an important contributing factor to perceived stigma and gender-minority-related stress for TGNC youth, which may contribute to mental and physical health disparities in this population. Supportive school policies should allow bathroom choices for TGNC students. However, bathroom choice is not enough; policies and personnel must also clearly protect TGNC students from harassment. Promoting safety is paramount to improving the well-being of these students.

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Abbreviations Used

DOE = U.S. Department of Education
DOJ = U.S. Department of Justice
GSA = gender and sexual alliance
PTSD = post-traumatic stress disorder
QoL = quality of life
RS = Resilience Scale
RSES = Rosenberg Self-Esteem Scale
SD = standard deviation
TGNC = transgender and gender nonconforming
YQoL = youth quality of life

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Youth Perspectives regarding the Regulating of Bathroom Use by Transgender Individuals

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Youth Perspectives regarding the Regulating of Bathroom Use by Transgender Individuals

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ABSTRACT

Regulations regarding bathroom use by transgender people affect youth across the United States. This study examines youth opinions on bathroom use regulations. Data were obtained from MyVoice, a weekly text messaging survey of youth aged 14–24 years. Youth were recruited nationally at community events and online; Southeast Michigan was over-represented. Mixed methods analysis was performed using grounded theory methodology. The majority of respondents (n = 683) were white (71.4%) and had education beyond high school (56.5%). Most (79%) stated that bathroom use by transgender people should not be restricted, rationalizing: 1) bathroom use is private and should be a personal decision; 2) choosing bathrooms is a matter of equality, freedom, and human rights; 3) transgender people are not sexual perpetrators; and 4) forcing transgender people to use particular bathrooms puts them at risk. Contrary to the current policy in many schools, respondents do not support restrictions on bathroom use by transgender people.

KEYWORDS

Transgender; LGBT; bathroom; public policy; youth

Introduction

In recent years, many state legislatures and school boards in the United States have considered regulations regarding bathroom use by transgender people (Kosciw, Greytak, Bartkiewicz, Boesen, & Palmer, 2016; Kralik, 2018; Sanders & Stryker, 2016). In 2016, two contrary efforts brought public bathroom use regulation to the national forefront; North Carolina passed House Bill 2, which required individuals to use the restroom that corresponds with the sex on their birth certificate, and the Obama administration released a letter to schools stating that "a school may not require transgender students to use facilities inconsistent with their gender identity" (Bishop, 2016; Kralik, 2018; Lhamon & Gupta, 2016). Under new administrations, these discrepant regulations were both rescinded in 2017, leaving the issue of which bathrooms

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transgender people should be allowed to use up for debate in state houses, municipalities, and schools across the country (Battle & Wheeler, 2017; Kralik, 2018).

The debate regarding public bathroom regulation in the U.S. is occurring in the context of a federal legal system with sparse protections for transgender individuals (Hart, 2014). The U.S. federal government has yet to codify any laws specifically detailing protection for transgender individuals from discrimination on the basis of gender identity. However, an increasing numbers of federal court rulings have concluded that federal discrimination laws, such as Title VII of the Civil Rights Act of 1964 which barred racially segregated public accommodations, forbade the use of federal funds for any discriminatory programs, and banned discrimination based on race, color, religion, sex and national origin, as well as Title IX of the Educational Amendments Act of 1972, should be interpreted as protecting transgender people against discrimination (Title VII of the Civil Rights Act of 1964 (1964)). Yet the issue remains debated as the Supreme Court and Congress have yet to take on discrimination on the basis of gender identity and the current administration's Department of Justice recently indicated that "sex" in the Civil Rights Act of 1964 referred to "biologic sex" and thus does not apply to discrimination against individuals based on gender identity. Without federal precedence, more than a dozen states and numerous municipalities have adopted laws officially protecting people from discrimination in public accommodations based on gender identity ("Transgender people and access to public accommodations," 2014). And rare legislation, such as California Assembly Bill 1266, has specifically addressed public accommodations in schools, legislating that California schools must allow transgender students to use sex-segregated facilities based on their gender identity (Pupil rights: sex-segregated school programs and activities, 2013).

It is estimated that at least 150,000 13–24 years olds in the U.S. (0.7%) identify as transgender (Herman, Flores, Brown, Wilson, & Conron, 2017), with new data from one multi-state survey suggesting an even higher prevalence, with 1.8% of 9th to 12th graders identifying as transgender (Johns et al., 2019). These findings suggest that youth are more likely to identify as transgender than current U.S. adults (Herman et al., 2017). Transgender youth experience high rates of violence and harassment in schools and are less likely to attend college than their cisgender peers (Crissman, Berger, Graham, & Dalton, 2017; James et al., 2016).

Many schools have instituted bathroom use regulations. While at the individual case level student plaintiffs have succeeded in gaining access to school bathrooms aligned with their gender identity through the courts, 60% of transgender youth in a national school climate survey reported being required by their school to use the restroom corresponding with their sex assigned at birth, and 70% of transgender students reported avoiding public

bathrooms because of feeling unsafe or uncomfortable (Kosciw et al., 2016). Transgender people who are uncomfortable with public bathroom options report self-dehydration and "holding it" to avoid public restrooms (Herman, 2013), with some evidence for higher rates of urinary tract infections in individuals who avoid using public restrooms (James et al., 2016).

The minority stress model describes the ways in which marginalized communities, including transgender people, are subject to stress as a result of alienation from social structures, norms and institutions (Bockting, Miner, Swinburne Romine, Hamilton, & Coleman, 2013; Meyer, 2003). Aligned with minority stress theory perspective, gender minority youth who feel unsafe in public restrooms reported less psychological well-being (Weinhardt et al., 2017). Denial of public accommodations has been associated with emotional distress, adverse physical symptoms, and has even been associated with suicidality among transgender people (Reisner et al., 2015; Seelman, 2016). Legal rulings have also levied the minority stress theory, such as the case of Coy Mathis where the Colorado Civil Rights Division ultimately found that forbidding Coy, a transgender girl, from using the girls' bathroom at school created "an environment rife with harassment and inapposite to a nurturing school atmosphere" (Johnson, 2014).

However, the focus of the debate and media campaigns surrounding regulation of the use of public accommodations by transgender people has galvanized less attention for the implications for the wellbeing of transgender individuals, and has instead focused on fears regarding shielding and ensuring the safety of presumed cisgender women and girls in women's bathrooms (Madigan, 2016; Sanders & Stryker, 2016; Schilt & Westbrook, 2015; Stones, 2017). Specifically, the focus has been on what some have termed "penis panic" – the fear that individuals with natal penises will be allowed to "dress in sheep's clothing" and will have open reign to violate "vulnerable women" in women-only spaces (Schilt & Westbrook, 2015). Recent polling and studies suggest that many adults in the U.S. believe transgender people should not use the restroom aligned with their gender identity (Callahan & Zukowski, 2019; Parent & Silva, 2018; "Transgendered students and school bathrooms," 2014). While adult opinions of transgender youth appear more favorable, older and reported more socially conservative political views were associated with hesitance to allow transgender youth to use the restroom corresponding to their gender (Elischberger, Glazier, Hill, & Verduzco-Baker, 2016).

While transgender youth continue to face harassment at levels far beyond their cisgender peers, school environment surveys suggest schools are gradually becoming less hostile spaces for transgender youth (Kosciw et al., 2016). A small qualitative analysis of interviews with lesbian, gay, bisexual and transgender youth (n = 25) recently concluded that gender-neutral bathrooms are important in fostering a sense of safety and inclusivity, but the perspective of larger populations of youth remains unclear (Porta et al., 2017). We hypothesize that

in an era where a growing number of youth identify as transgender, many youth may not support restrictions on bathroom use by transgender people. If there is indeed peer support among youth for allowing transgender individuals to use bathrooms concordant with their gender identity, there may be profound positive implications for minority stress among upcoming generations of transgender youth (Bockting et al., 2013). Moreover, it may suggest that youth perspectives on bathroom use policies may differ from the narratives otherwise represented in debates regarding bathroom regulations.

Methods

We conducted a cross-sectional mixed methods study to collect demographic and qualitative data from youth across the U.S. Data were obtained from MyVoice, a weekly text messaging survey that solicits the opinions of youth on health and policy issues. MyVoice sampling and topic selection methods were previously described by Dejonckheere et al. (DeJonckheere et al., 2017). In brief, participants were recruited nationally at community events and online via Facebook and Instagram advertisements. Social media advertisements were created to target specific nationally representative demographic characteristics using weighted samples from the American Community Survey, with adjustments in recruitment advertisement targeting to meet benchmarks (DeJonckheere et al., 2017). Youth in Southeast Michigan were overrepresented. Eligible participants (14–24 years of age, fluent in English, with access to a phone with SMS capabilities) were assented or consented, and completed an online demographic questionnaire (n = 1010). The active MyVoice sample includes 906 youth who have responded to at least one text message survey from MyVoice.

MyVoice participants were asked via text message survey whether they had heard of the debate regarding bathroom use by transgender people: "There is a debate in some states about which bathroom transgender people are allowed to use. Have you heard about this?" (Yes/No). Participants who responded "No" received the following information, "What this means is that a person who was born a female but identifies as a male can only use female bathrooms and vice versa." Participants were then asked the following open-ended questions: "What do you think about this issue?" and "Is this important? Why?" Of the 906 active MyVoice participants, individuals were excluded from the analysis if they did not respond to any portion of the survey (n = 198) or did not respond to at least one of the two open-ended questions (n = 25), resulting in a sample size of n = 683 participants who responded to at least one of the two open-ended questions.

Open-ended responses were analyzed using qualitative content analysis, with a focused analysis of youth perspectives on which bathroom or

bathrooms they believe transgender people should be able to use and why (Hsieh & Shannon, 2005). This focus was established prior to data analysis to address the gap in knowledge surrounding youth opinions on policy options being debated nationally. Emergent themes, including groupings of beliefs about the bathroom types transgender people should use, and the rationale for opinions about bathroom use beliefs were identified. A codebook was codebook-created and iteratively refined by two researchers (HC, NK). The data were independently coded (HC, NK) with discrepancies discussed to reach consensus.

Descriptive statistics were used to calculate the percent of respondents expressing a particular view, using the number of respondents who expressed an opinion about the type of bathrooms transgender individuals should use as the denominator (n = 508), as not all of the 683 participants expressed an opinion regarding the type of bathroom transgender individuals should use. Some respondents (n = 36) identified two acceptable bathroom use options without a clear preference for one of the bathroom types; in this case, their response was coded under both of the bathroom use opinions they endorsed.

This study was approved by the University of Michigan IRB; a waiver of parental consent for participants under the age of 18 years was granted by the IRB.

Results

Among 906 eligible youth, the 683 participants (response rate 75.4%) had a mean age of 18.9 years (SD = 3.1 years), and half identified as non-transgender females (57.4%), labeled as ciswomen, henceforth (Table 1). Approximately 2.2% of participants identified as transgender, and another 1.5% identified as non-binary. The majority of respondents identified as White (71.4%), more than half had education or training beyond high school (56.5%), and the majority lived in the Midwest (69.8%). When the demographic characteristics of our survey respondents were compared to those of active MyVoice participants who did not respond, respondents were more likely to identify as non-transgender females or be from the Midwest compared to non-responders (data not shown).

Nearly all respondents (93%) were aware of the debate regarding bathroom use by transgender people. In open-ended responses, 74% (n = 508) expressed an opinion about policy regulating bathroom use by transgender people. Youth perspectives on bathrooms use policies were categorized as: 1) transgender people should be able to choose which bathroom they use; 2) bathroom use by transgender people should be restricted based on anatomy or sex assigned at birth; or 3) transgender people should use gender neutral or unisex bathrooms (Table 2).

Table 1. Respondent demographic characteristics (N = 683).

Demographic characteristic	n (%)
Age, mean (SD)	18.9 (3.1)
Gender, n (%)	**N = 681**
Male, non-transgender	247 (36.3)
Female, non-transgender	391 (57.4)
Transgender, female-to-male	14 (2.1)
Transgender, male-to-female	1 (<0.1)
Non-binary	10 (1.5)
Other	18 (2.6)
Race	**N = 681**
White	486 (71.4)
Black	54 (7.9)
Asian	65 (9.5)
Other (including multi-racial)	76 (11.2)
Hispanic	82 (12.0)
Education	**N = 681**
Less than high school	296 (43.5)
High school graduate	56 (8.2)
Some college or tech school	201 (29.5)
Associates or tech school graduate	19 (2.8)
Bachelors +	109 (16.0)
Region	**N = 679**
East	44 (6.5)
Midwest	474 (69.8)
South	98 (14.4)
West	63 (9.3)

Transgender people should be able to choose which bathroom they use (79%; n = 399)

The majority of respondents who expressed an opinion on bathroom use policies stated that transgender people should be able to use whichever bathroom they choose: *"I think transgender people should be allowed to use the bathroom of their choice, not what they are assigned at birth" (16 yo, White ciswoman, West)*. Respondents stated that people should be able to make bathroom use decisions based on their gender identity, or comfort using a particular restroom. Respondents made four main arguments for this position:

1) Public Facilities Choice as a Private Decision

Respondents described choosing a restroom as a private, personal decision: *"Going to the bathroom is a private activity and should be no one else's business" (18 yo, White transwoman, South)*. Individuals espousing privacy arguments also asserted that because an individual's bathroom use should not adversely impact others, an individual's right to privacy should be maintained in making bathroom use decisions: *"We should allow people who are trans go to their bathroom of choice it's not like it's going to affect anyone else" (17 yo, Black and White ciswoman, Midwest).*

Table 2. Youth perspectives on bathrooms use regulation and core rationales.

Transgender individuals should be able to choose which bathroom they use (79%)	
Bathroom use is private and should be a personal decision	*"People should be allowed to go into whatever bathroom they feel comfortable using.. It's no one's business what someone really has in their pants" (23 yo, White cisfemale, East).*
Choosing bathrooms is a matter of equality, freedom, and human rights Transgender individuals are not sexual perpetrators Forcing transgender individuals to use particular bathrooms may put transgender individuals at risk	*"I believe that banning them [transgender people] from restrooms of their identity is just another way for people to keep their rights unequal to that of a cisgendered person" (16 yo, American Indian or Alaska Native and White cisfemale, Midwest).* *"There's a huge misconception that transgender people are using a bathroom as 'predators'. This is inaccurate…" (22 yo, White cisfemale, Midwest).* *"If they [transgender people] are forced to use a restroom of the gender which they do not present themselves as, that could put them in danger… I don't think trans people should have to fear violence when using the restroom" (19 yo White cisfemale, Midwest).*
Transgender individuals should use bathrooms as restricted based on anatomy or natal sex (17%)	
Transgender identity is not a legitimate or acceptable identity Genital anatomy should be important in determining bathroom use There is a risk of perpetrators masquerading as transgender	*"If you are male, I mean if you were born male you use the male restroom. It's as simple as that. Because it's a ridiculous thing to have a conversation over. Males go to male bathroom. That's how that works. Real males. X,y chromosomes" (14 yo, White cismale, South).* *"I think that people with penises should use the men's and people with vaginas should use the women's" (14 yo White cismale, Midwest).* *"It really doesn't bother me that a person who got a sex change wants to use the bathroom they got the parts for. But it also bothers me that a child molester or rapist could pretend to be a transgender and use that as an excuse to be around kids" (17 yo White cisfemale, South).*
Transgender individuals should use gender neutral or unisex bathrooms (10%)	
	"We should have all gender neutral bathrooms" (18 yo White cismale, Midwest).

2) Public Facilities Choice as a Human Right

Other respondents used a framework of equality, freedom, and human rights as the rationale for their beliefs about bathroom use regulation: *"I think trans folks should be able to use whatever bathroom they would like. Because trans rights are human rights, and I think it is important and necessary to advocate for human rights and equity for marginalized groups." (21 yo, White cis-woman, Midwest)*. Respondents recognized transgender people as a marginalized minority group, and perceived the regulation of their basic bodily functions (through bathroom use) as a violation of human rights.

Participants called for laws regulating bathroom use as discriminatory: *"Lawmakers are blowing up a non-issue to discriminate against minorities… I don't think our legislators should be encouraging hate and discrimination against a disadvantaged group" (20 yo, White cisman, Midwest)*. Respondents drew parallels between the bathroom use debate and the civil rights

movement, suggesting that the debate is truly about valuing transgender people as people, and is not about bathrooms:

> *"I saw a post online that said 'it's not about bathrooms, just like it was never about drinking fountains.' That really resonated with me. Bathroom bills draw lines between first and second class people, and it's important to respect people's identities instead of spreading hate" (19 yo, White ciswoman, Midwest).*

3) Public Facilities Choice and the Myth of the Transgender Perpetrator

A group of respondents described legislation limiting bathroom use by transgender people as, *"based on the fallacy that transgender people are a danger to others" (23 yo, White cisman, West)*. These respondents understand restrictions on bathroom use by transgender individuals as propagated by inaccurate portrayals of transgender people: *"So called 'bathroom bills' are couched in the belief that trans people are sexual deviants or deceptive in some way, which is a harmful mischaracterization of trans people…" (20 yo, White ciswoman, Midwest).*

Specifically, youth pointed out that restricting bathroom use by transgender people is, in part, driven by a conflation of gender non-conformity with criminal sexual deviance, particularly pedophilia:

> *"I believe these bills are ineffective and offensive, they serve only to pander to transphobic ideologies and accomplish nothing regarding a non-existent threat (trans people aren't pedophiles) while simultaneously reaffirming bigoted beliefs…"(20 yo, White cisman, Midwest).*

Respondents emphasized that transgender people are not inherently, or disproportionately, sexual predators or pedophiles.

Others noted that assault or violence in a bathroom is illegal, and will remain illegal, regardless of the genders allowed in a particular bathroom:

> *"Many may argue that it [allowing transgender people in bathrooms aligned with their gender identity] lets people get away with sexual crimes, but sexual crimes are illegal no matter what gender or bathroom…" (15 yo, White ciswoman, Midwest).*

These respondents viewed restrictive bathroom policies as legitimizing fears steeped in transphobic mischaracterizations of transgender individuals and their behaviors, under the guise of improving public safety.

4) Public Facilities Choice and the Safety of Transgender People

In addition to transgender people not posing a threat to other bathroom users, respondents noted that forcing transgender people to use a particular bathroom may put transgender people in danger: *"Transgender people are most safe in the bathroom they identify with the most" (24 yo, White ciswoman, Midwest)*. One respondent explained: *"As a stealth transguy my safety depends on being able to use the men's bathroom" (23 yo, White transman, Midwest)*. These respondents argue

that, for example, a transgender individual who "passes" as their affirmed gender may be at increased risk of harassment or violence if they are forced by bathroom use restrictions to use the bathroom aligned with their sex assigned at birth. Respondents expressed concerns that transgender individuals may not be well accepted in bathrooms corresponding with their sex assigned at birth: *"…it is absurd to expect a trans man with a beard to use the women restroom" (23 yo, White cismale, West).*

This group concluded that restricting bathroom use may have negative implications for the well-being of transgender people, in terms of immediate physical safety, emotional and mental health, and marginalization and devaluing of the transgender community:

> *"Trans people are in greater danger in bathrooms than cispeople. They pose 0 threat. Forcing someone to use the bathroom opposite to their gender identity and expression would cause more shame, confusion and alarm. This is just another way to delegitimize an entire community for the narrow-mindedness of a few" (23 yo, Asian ciswoman, Midwest).*

Transgender people should use bathrooms as restricted based on anatomy or sex assigned at birth (18%; n = 92)

Some respondents stated that restroom use by transgender people should be restricted based on an individual's genital anatomy or sex assigned at birth. This group of respondents rationalized bathroom use restrictions with the following arguments:

1) Public Facilities Restrictions: Transgender identity as illegitimate

A cohort of respondents questioned the legitimacy of transgender identity – instead endorsing sex and gender as fixed and binary: *"People should use the bathroom that is on their birth certificate" (15 yo, White cisman, South).* Individuals explained these beliefs by describing transgender identity as diverging from what they saw as an obvious, strict, biologic binary of both sex and gender:

> *"If one has XY chromosomes, they are male. If one has XX chromosomes, they are female. Males need to use the male restroom, and females need to use the female restroom.. Also, it furthers the ignorance of facts by allowing men to believe they are women, and vice versa" (16 yo, White cisman, Midwest).*

This group of respondents expressed a belief that sex and gender should always remain concordant, and that this relationship is inflexible. Thus, transgender people using bathrooms corresponding with their gender identity was seen as unnatural, unacceptable, and pathologic: *"Transgender is a mental disorder and shouldn't be praised or accepted" (15 yo, White ciswoman, South).*

2) Public Facilities Restrictions Based on Genital Anatomy

Other respondents who felt bathroom use by transgender people should be restricted emphasized the importance of genital anatomy in determining which bathroom transgender people should be allowed to use.

Some respondents of this belief regarded gender affirming surgery on the genitals as a legitimate reason to allow transgender people to use the bathroom aligned with the gender they affirm:

> *"I don't think transgender people should use whichever bathroom they want to. I think they should be based on the reproductive organs the person has. Therefore, if a trans person had surgery to change their genitals they should use the bathroom that matches their genitals" (23 yo, White ciswoman, East).*

In part, respondents noted that this rationale stemmed from a fear of individuals, specifically cisgender girls, being exposed to phalluses: *"We need a male and female bathroom. That is it, plain and simple. Because a little girl should not have to be forced to see a penis in the bathroom in the name of 'tolerance'" (17 yo, White and Hispanic cisman, South)*. Respondents described concerns about the potential for individuals to see genitals different from their own, using language that suggested genital viewing may be forced or inherent in bathroom use.

3) Public Facilities Restrictions and the Risk of Falsified Perpetrators

Some respondents raised concerns about the safety implications of codifying the right of transgender people to use restrooms aligned with their gender identity. These respondents did not express a concern that transgender people would act as perpetrators. Instead, they feared that non-transgender people could masquerade as transgender in order to legitimize their entering other genders' restrooms for a nefarious purpose: *"Sexual predators under a transgender facade can be very dangerous if they have free reign to use whatever restroom" (21 yo, White cisman, West).*

These individuals at times explicitly recognizing that their fears were not actually of transgender people. Instead, they expressed fears that the right for transgender people to use bathrooms aligned with their gender identity would create an avenue for increased bathroom violence by non-transgender perpetrators, particularly against young people and females:

> *"Honestly I have nothing against transgender people. But I think they should have a separate bathroom or go in family bathrooms. Not because of who they are but because of bad people in the world. With that law passed, any man can dress in women's clothes and go in a woman's bathroom and take advantage of anyone including young girls" (17 yo, White ciswoman, South).*

> *"I think transgender people should use the bathroom based off of their body part… I kind of don't care as long as no harm is caused to anyone, but I also don't really like the idea of using the bathroom with a man who wants to be a woman. So many rapists could play that off" (19 yo, Black ciswoman, Midwest).*

Transgender people should use gender neutral or unisex bathrooms (10%; n = 53)

A minority of respondents described gender neutral or unisex bathrooms as the preferred bathroom for proposed use by transgender persons, and more fundamentally challenged the need for the existence of gendered bathrooms. These respondents rationalized that gender neutral bathrooms were not only an ideal option for transgender people, but for all people: *"I think the issue would be solved if we got rid of separate gender bathrooms and just created universal bathrooms labeled "Bathroom" instead of "Men" and "Women" (21 yo, White ciswoman, Midwest)*. These respondents questioned the need for gendered restrooms, with some suggesting universal gender neutral restrooms.

Discussion

In this sample, nearly 8 in 10 youth stated that transgender people should be able to use the bathroom they feel most comfortable in. Youth justified protecting the ability of transgender people to choose the restroom they use with a narrative of privacy and minority rights. This relative peer acceptance aligns with trends suggesting school environments are gradually becoming less hostile spaces for transgender youth (Kosciw et al., 2016). These findings suggest that the majority youth perspective in this survey sample is in disagreement with the current bathroom use policies in many schools, and with legislation considered by many states in recent years to restrict bathroom use by transgender people (Kosciw et al., 2016; Kralik, 2018).

With an eye to civil rights implications, we recognize that the majority opinion should not be the lynchpin in determining the rights of a minority group. While the volume of peer youth support we describe here does not implicate the validity of human rights arguments for public restroom access, it may have significant implications for reducing minority stress associated with public bathroom exclusion. Whereas enacted and felt stigma, such as gendered bathroom exclusion, have been associated with psychological distress in the transgender population, peer support has been found to be protective (Bockting et al., 2013). Our findings suggest that there is significant peer youth support for transgender people using the bathroom concordant with their gender identity.

Moreover, given the lack of codified federal protections against transgender discrimination, and thus the current role for local and state legislation in determining public bathroom regulations, the opinion of the next wave of potential youth voters has significance, particularly as it appears to differ from the current opinion of U.S. adults (Callahan & Zukowski, 2019; "Transgendered students and school bathrooms," 2014).

A minority cohort of respondents in support of restrictions for bathroom use by transgender people expressed a strong essentialist belief in a fixed alignment of binary sex and gender (Callahan & Zukowski, 2019). These respondents referenced sex chromosomes and genitalia as the determinants of both sex and gender, asserting that deviance from this was pathologic. All major American medical societies disagree with this assertion, endorsing gender affirming treatment of transgender people and rejecting the notion that transgender identity is a mental illness (Coleman et al., 2012). It is unclear whether youth with essentialist beliefs lack education regarding gender and sex differences, but regardless of the etiology of these beliefs, respondent quotes indicate clear associated transphobia. Binary conceptions of gender have previously been associated with negative attitudes toward transgender people (Norton & Herek, 2013). While the transphobia associated with essentialist views of gender may be rooted in ingrained value systems, there is some evidence to suggest anti-prejudice interventions can reduce transphobia and increase support for transgender nondiscrimination laws (Broockman & Kalla, 2016). This raises the potential for anti-prejudice interventions as a mechanism to address the transphobic views of some youth.

While parental concerns for the safety of presumed cisgender women and children in bathrooms was a focal point during "bathroom bill" media coverage, safety in this context was mentioned by a minority of youth (Johnson, 2014; Madigan, 2016; Schilt & Westbrook, 2015). Interestingly, youth respondents expressed concerns not of transgender people specifically acting as sexual predators in bathrooms, but rather, a fear of enabling natal male sexual predators to enter women's bathrooms for nefarious purposes. Described by Schilt & Westbrook as "penis panic," this narrative suggests a fear of the perceived propensity of individuals assigned male sex at birth to commit assault, regardless of gender (Schilt & Westbrook, 2015). The National Task Force to End Sexual and Domestic Violence Against Women issued a consensus statement directly addressing this concern, stating: "Nondiscrimination laws do not allow men to go into women's restrooms–period… discriminating against transgender people does nothing to decrease the risk of sexual assault" ("National Consensus Statement of Anti-Sexual Assault and Domestic Violence Organizations in Support of Full and Equal Access for the Transgender Community," 2016). Youth proponents of allowing transgender individuals to use the bathroom corresponding with their gender identity echoed this argument. Regardless of the prevalence of these fears, and clear transphobia from some individuals with these concerns, ingrained fears of natal males (regardless of gender) as sexual predators signal a serious need to address societal factors that enable sexual assault, including toxic masculinity.

Some respondents in support of allowing transgender individuals to use the restroom most aligned with their gender noted that safety considerations for transgender people likely require more attention. These respondents recognized that transgender people may be at higher risk of physical violence, stigmatization, and harassment if their bathroom use is restricted. These concerns align with research that shows transgender students report significantly lower self-reported safety in bathroom facilities compared to cisgender students and high rates of assault while trying to use the restroom (Herman, 2013; Wernick, Kulick, & Chin, 2017).

Our findings are limited by response bias, and may represent incomplete participant perspectives despite the open-ended nature of responses. Though the sample of respondents represents a large population of youth, our findings are not nationally representative and may have excluded other minority viewpoints. Within the MyVoice cohort, individuals with little knowledge or opinions regarding issues affecting transgender people may have been less likely to respond. The opinions of youth in Southeast Michigan were overrepresented; this is likely due to community recruiting events were held in Southeast Michigan. Participants from Southeast Michigan may also have been more likely to recognize and engage with the host university. Southeast Michigan is politically Democratic-leaning; while the political leanings of the participants were not solicited, and youth tend to be more liberal than adults (Pew Research Center, 2018), if respondents were disproportionately of liberal ideology this may impact the generalizability of the results and suggest an over-estimation of broader youth support for transgender people using restrooms aligned with their gender identity (Norton & Herek, 2013).

Conclusion

In this sample of youth, the majority of respondents support transgender people having the right to choose which bathroom they use without restriction. Young people are more likely than U.S. adults to identify as transgender (Herman et al., 2017) and restrictive policies have been shown to have significant implications for the wellbeing of transgender youth (Johnson, 2014). As schools, states, and federal officials consider policies regarding bathroom use by transgender people, the voices of youth deserve to be heard; the next generation of voters may be more likely to support gender identity nondiscrimination laws for public accommodations than "bathroom bill" legislation enshrining strict bathroom segregation by natal sex.

Moreover, our findings indicating support among a large sample of youth for transgender rights, suggest a large number of youth may be willing and able to provide peer support to transgender youth. This has positive implications for potential reductions in minority stress, and psychologic distress, in the transgender population.

More work is needed to understand whether our finding are nationally representative, how youth opinions evolve as transgender people continue to become more visible in our society, and whether the rejection of "bathroom bills" by youth in this sample will predict a broader shift in public opinion regarding the regulation of gender.

Disclosure statement

The authors declare that they have no conflict of interest.

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Author Contributions

HC performed the data analysis, data interpretation, and initial manuscript preparation. CC performed data analysis, aided in interpretation of the data, and provided manuscript revisions. MM and TC aided in drafting survey items, interpretation of the data, revision of the manuscript, and conceptualization of the study design. MP aided in interpretation of data, aiding in study design, and contributed to manuscript revisions. All authors read and approved the final version of this manuscript before submission.

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