Trans* Community Connection, Health, and Wellbeing: A Systematic Review

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Abstract

Purpose: Transgender and nonbinary (trans*) people are affected disproportionately by discrimination and violence, contributing to gender minority stress and negative health effects. Transgender community connection (TCC), defined as (i) emotional connectedness (internal sense of belonging) to the trans* community and/or (ii) behavioral participation in the trans* community (observable interaction with other trans* people, in person, online, or through media) may moderate these negative effects on health. This systematic review synthesizes research on links between TCC and health and wellbeing for trans* people.

Methods: Twenty research articles (3 quantitative, 3 mixed methods, and 14 qualitative) linking TCC to health and wellbeing were identified from systematic searches of PubMed, CINAHL, and PsycINFO. Data regarding TCC were extracted, synthesized, and grouped by (i) gender transitioning, (ii) mental health, (iii) sexual health, and (iv) access to care to illustrate the findings.

Results: TCC was linked to several positive outcomes, including improved mental health, increased connection to care, supported exploration of sexual and gender identities, and informed gender transition. For transgender women, especially, TCC was also linked to increased engagement in sex work (as a worker, not a client) and, in some cases, deterred them from getting sexual health testing and treatment due to fear of being observed at specialized clinics and subsequent loss of confidentiality among peers.

Conclusion: These findings highlight the overall protective nature of TCC and a need to consider best practices to ensure confidentiality for community members. The findings can be used to inform the development and adaptation of health care interventions aimed at decreasing the harmful effects of gender minority stress for trans* people.

Keywords: behavioral participation, connectedness, critical review, gender minority, LGBT, social support

Introduction

TRANSGENDER AND NONBINARY (trans*) people are those whose gender identity is different from their sex assigned at birth. This departure from societal gender norms has been met historically with cisgenderism—a multilevel and systemic prejudicial ideology that delegitimizes or denies a person's ability to self-determine their own gender^{1,2}—and transphobia—“negative emotional or affective responses” toward trans* people.³ Cisgenderism and transphobia have been observed as widespread discrimination and violence and have been associated with various socially produced health inequities when comparing outcomes among cisgender and trans* people.^{4,5} Specifically, current research suggests a higher

prevalence of sexual assaults against trans* people compared to their cisgender counterparts.^{6,7} This exposure to violence is associated with poor mental and physical health such as a high prevalence of lifetime symptoms of depression (55%),⁸ lifetime symptoms of post-traumatic stress (44%),⁹ lifetime suicide attempts (41%),¹⁰ and HIV acquisition (2.8% incidence).¹¹ Health disparities are often compounded by barriers to accessing and engaging in medical care, including discrimination by medical and service providers.^{12–18} Trans* patients report refusal of care by providers, encounter inadequately informed providers, and report postponement of care due to fear of discrimination.^{12–17}

The Minority Stress Model presents a framework to help describe the pathways whereby individuals of minority status

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face external socially produced stressors (e.g., discrimination and violence) and internal stressors (e.g., internalized homophobia—when a sexual minority person directs negative social attitudes and stigma toward themselves resulting in negative outcomes)¹⁹ that contribute to poor mental health.²⁰ Within this framework, social support has been identified as a moderating variable, with the potential to decrease the strength of the relationship between stressors and mental health.²⁰ The gender minority adaptation of the Minority Stress Model (the Gender Minority Stress Model) highlights trans*-specific stressors such as lack of gender-appropriate identity documents, discrimination when seeking medical care, and lack of access to safe public restrooms.²¹ The Gender Minority Stress Model proposes transgender community connection²² (TCC) as a moderator capable of reducing the negative effects of gender-related victimization, internalized transphobia, and anticipated future prejudice on mental health among trans* people.^{22,23} TCC has been described in different ways in the literature.^{21,22} For this review, it is defined as (i) emotional connectedness (internal sense of belonging to the trans* community) and/or (ii) behavioral participation in the trans* community (observable interaction with other trans* people, in person, online, or through media). This systematic research review searches qualitative, quantitative, and mixed-methods studies to identify, describe, and synthesize²⁴ the possible risks and protective value of TCC and its links to health and wellbeing among trans* people.

Methods

Search strategy and selection of articles

In contemporary digital media environments, visibility of and access to affirming trans*-focused media and trans* peers have improved; however, this also comes with additional risk of media-based discrimination and violence.²⁵ Contemporary digital media environments have altered the way in which trans* people may choose to interact with community; thus, to focus our findings on research most relevant to the lives and experiences of trans* people today, articles from the preceding decade, published from January 1, 2007 to November 1, 2017, were identified from three databases (PubMed, CINAHL, and PsycINFO) for systematic review.²⁵

Search terms were identified in two categories, community connection terms and trans* population terms. Search terms for community connection were as follows: “Community Networks,” “community participation,” “social participation,” “community connect*,” “social cohesion,” “community cohesion,” “social isolation,” “collectivism,” “isolation,” “social support,” and “social inclusion.” Search terms for trans* population were as follows: “transsexualism,” “transgender*,” “transsexual*,” “gender minority,” “FTM,” “genderqueer,” “crossdresser,” “drag king,” “drag queen,” “non-binary,” and “MTF.” Additional filters were used to narrow the results by English language only and human subjects only. Inclusion criteria consisted of the following: (i) having transgender participants, (ii) reporting results for trans* individuals separately from those of cisgender individuals, (iii) reporting QN or QL findings linking TCC with a health outcome, and (iv) being a peer-reviewed primary research article. The follow-

ing types of articles were excluded: review articles, psychometric measurement analysis, and dissertations.

Covidence systematic review software²⁶ was used to manage article selection. In total, 1166 articles were identified from the initial search, and 942 articles remained after duplicates were removed. Figure 1 shows the Preferred Reporting Items for Systematic Reviews and Meta-Analyses flow diagram.²⁷ Title and abstract screening led to the exclusion of 842 articles that did not meet the inclusion criteria. The remaining 100 articles received a full-text review, and 18 met all inclusion criteria. Two additional articles (not indexed in the three reviewed databases) were identified from a hand search of the reference lists of the 18 articles. The final 20 articles were retained for data extraction and qualitative synthesis.^{22,28–46} This systematic review was exempt from institutional review board review at Johns Hopkins University.

Data extraction, analysis, and synthesis

Data extraction was completed by the first author (A.D.F.S.), and a 25% audit was performed by an additional team member (T.N.). Extracted data included (i) demographic data on study participants; (ii) forms of TCC measurement; (iii) findings relating TCC to a health outcome; (iv) descriptive findings related to TCC; and (v) study design and methodology. The findings were then compared and grouped according to identified topic and subtopic areas.²⁴ The topics were (i) descriptive findings related to TCC and (ii) associations between TCC and health outcomes; the subtopics of area ii were (1) gender transitioning, (2) mental health, (3) sexual health, and (4) access to care.

The first author (A.D.F.S.) and an additional team member (K.R.) completed a critical appraisal of article quality using a modified version of the Checklist for Qualitative Research, and the Checklist for Analytical Cross-Sectional Studies from the Joanna Briggs Institute (JBI; see Table 1).^{47,48} These tools were chosen after a review of multiple quality assessment tools because they provided a multidimensional analysis of quality specific to quantitative and qualitative research.^{47,48} Due to a lack of critical appraisal tools focused on mixed-methods research, articles that employed both quantitative and qualitative methods were evaluated independently on each scale. All discrepancies were discussed and resolved among reviewers. Table 1 contains article quality scores.

Results

Description of reviewed articles

The median overall quality of the included articles was 7 out of 10 (interquartile range [IQR]=2) for those with mixed methods or qualitative analysis and 5 out of 8 (IQR=5) for those with mixed methods or quantitative analysis ($n=17$ mixed methods and qualitative^{28–33,36–46} and $n=6$ mixed methods and quantitative^{22,34–38}). See Table 1 for further details on quality assessment. Only 35% ($n=7/20$)^{29,30,34,35,38,42,44} of articles reported data collection dates, ranging from 1999 to 2011 (all included articles were published no earlier than 2007). Most studies took place in the United States ($n=16/20$).^{22,29–36,38–42,45,46} The six international studies reported samples from Canada,^{22,36,44} Croatia,³⁷

FIG. 1. The Preferred Reporting Items for Systematic Reviews and Meta-Analyses flow diagram.

Guatemala,²⁸ and the United Kingdom.⁴³ Data collection methods varied among studies and included self-administered in-person or online questionnaires ($n=7/20$),^{22,34–38,44} Photovoice focus groups ($n=1/20$),⁴⁶ general focus groups ($n=2/20$),^{29,31} case studies ($n=1/20$),³⁰ and individual interviews ($n=14/20$).^{28–33,36,38–43,45} Most studies used convenience sampling methods ($n=15/20$),^{22,31–36,38,39,41–46} recruiting from trans*-associated venues such as support groups, health clinics, community-based organizations, and social media pages (Table 1).

Most articles reported eligibility requirements ($n=16/20$).^{22,28–33,35–38,40–42,44,46} Two of the sixteen articles^{32,33} included transgender youth 15–25 years of age, while the remainder included only adults 18 years or older.^{22,28–31,35–38,40–42,44,46} Ethnic/racial diversity varied among the studies, with 40% ($n=8/20$)^{22,30,33–36,39,44} of articles including samples comprised of over 50% White-identified participants, 30% ($n=6/20$)^{29,32,41,42,45,46} included only people of color, 15% ($n=3/20$)^{31,38,40} had a more equitable distribution of ethnicities/races, and 15% ($n=3/20$)^{28,37,43} failed to report race/ethnicity. Of the articles that had gender-diverse samples ($n=11/20$),^{22,31–35,37,39,40,43,44} only three articles examined nuances based on gender identity.^{22,34,35} Thirty-five percent ($n=7/20$)^{28,29,38,41,42,45,46} of samples included transgender women only (not including comparison groups of gay/bisexual and heterosexual-identifying men who have sex with men),²⁸ compared to 5% ($n=1/20$)³⁶ of studies that focused on transgender men only (not including the comparison group of nontransgender gay and bisexual

men).³⁶ No studies focused exclusively on nonbinary people and one article failed to report gender identities of the full sample.³⁰ Of the six articles with a quantitative component, inconsistent methods were applied to measure TCC and they did not capture both domains of TCC.^{22,34–38} See Table 2 for details regarding measurement.

TCC and contextual associations

The majority of studies reviewed were not designed specifically to identify the influence of TCC on outcomes; however, they did report findings related to TCC in addition to the main analysis. Few articles ($n=3/20$) examined the association between demographic information (e.g., age, race/ethnicity, living environment, and gender identity variations) and TCC.^{22,32,33} Trans* youth (ages 15–25) from two small qualitative studies of high quality (JBI quality score for qualitative studies [QL]=9/10³² and 10/10³³) reported receiving more support for and affirmation of their gender identities and expressions from other trans* youth rather than from older trans* people.^{32,33} Some individuals, regardless of age, felt a need to distance themselves from the community out of fear of being “outed” by affiliation, whereas others became more active in their communities despite the risk.^{32,33}

Trans* youth (ages 15–24) from one of the studies ($N=13$) that focused on behavioral participation reported that ethnic/racial subgroups within the trans* community were supportive of participants’ multiple identities and “whole self” (e.g., supportive of both their gender and racial identities).³²

TABLE 1. DESCRIPTIONS OF IDENTIFIED STUDIES

<i>Authors, reference</i>	<i>JB1 quality score: QL (QN)</i>	<i>Location (data collection years)</i>	<i>Study design: sampling (data collection method)</i>	<i>Sample characteristics: N (gender spectrum; race/ethnicity)</i>	<i>Type of TCC (measures used)</i>	<i>Findings related to TCC</i>	<i>Themes</i>
Qualitative studies Boyce et al. ²⁸	7	Guatemala City, Guatemala	Individual semistructured in-person interviews (Purposive)	29 (28% TW ^a ; NR)	Behavioral	Trans peer support encouraged health-seeking, engagement in care, and STI testing; fears of nonconsensual disclosure of HIV status to peer group was identified as a barrier to health seeking	Sexual health/transitioning
Sausa et al. ²⁹	8	San Francisco, CA, United States of America (November 1999–February 2000)	(i) Individual semistructured in-person interviews, (ii) ethnicity-specific focus groups (Purposive)	48 (100% TW; 33% AA, 31% L, 10% MR, 25% API)	Behavioral	Sex work as a means of accessing community, resulting in high rates of STIs and drug use	Sexual health
Shapiro ³⁰	9	Santa Barbara, CA, United States of America (July 2002–September 2004)	Ethnographic case study, including (i) individual semistructured interviews in-person or by phone, (ii) review of documents from group and annual conference, (iii) video content analysis of performances, and (iv) participant observations (Purposive)	28 (Unclear ^b ; 82% W, 4% AA, 11% MR, 4% O)	Behavioral	Trans peer support and affirmation of gender identity improved mental health and access to care during transition	Mental health/ access to care/ transitioning
Singh et al. ³¹	9	Southeastern region, United States of America	(i) Individual semistructured series of three interviews per participant, (ii) focus groups (Convenience and snowball)	21 (43% TM, 52% TW, 5% OT; 29% W, 52% AA, 19% MR)	Behavioral	Providing and receiving peer emotional support improved individual and community resilience	Mental health
Singh ³²	9	Southeastern region, United States of America	Individual semistructured interviews in person or by phone (Convenience)	13 (38% TM, 38% TW, 23% NB; 46% AA, 23% L, 15% MR, 15% O)	Behavioral	Online exposure to peer community, racial/ethnic identity, and family support influenced resilience; social institutions (church, school) challenged that resilience	Mental health

(continued)

TABLE 1. (CONTINUED)

<i>Authors, reference</i>	<i>JBPI quality score: QL (QN)</i>	<i>Location (data collection years)</i>	<i>Study design: sampling (data collection method)</i>	<i>Sample characteristics: N (gender spectrum; race/ethnicity)</i>	<i>Type of TCC (measures used)</i>	<i>Findings related to TCC</i>	<i>Themes</i>
Singh et al. ³³	10	United States of America	Individual semistructured interviews in person or by phone (Convenience)	19 (84% TM, 5% TW, 11% NB; 68% W, 11% AA, 16% MR, 5% O)	Behavioral	Trans peer support was identified as a significant component of resilience in the face of prejudice	Mental health
Budge et al. ³⁹	10	Midwest, United States of America	Individual semistructured in-person interviews (Convenience)	18 (11% TM, 72% TW, 11% NB, 6% AMAB cross dresser ^c ; 78% W, 22% MR)	Behavioral	Providing and receiving peer emotional support, protective from suicidality	Mental health/ transitioning
Budge et al. ⁴⁰	9	Midwest/Southern region (Illinois, Indiana, Kentucky, and Ohio), United States of America	Individual semistructured in-person interviews (Unreported)	15 (27% NB, 27% TM, 47% TW; 40% W, 13% L, 40% MR, 7% O)	Behavioral	Actively seeking social interactions (by accepting and providing support from/to other trans and cis people in support groups/in person/online) was identified as a coping mechanism	Mental health/ transitioning
Cerezo et al. ⁴¹	10	Northern CA, United States of America	Individual semistructured in-person interviews (Convenience)	10 (100% TW; 100% L)	Behavioral	Trans peer support influenced quality of life and mental health by combating acculturative stress and increasing resilience, via providing basic needs and resources	Mental health/ transitioning
Graham et al. ⁴²	7	Detroit, MI, United States of America (2011)	Individual semistructured in-person interviews (Convenience)	10 (100% TW; 80% AA, 20% AA/MR)	Behavioral	Validation and affirmation from peers reduced feelings of isolation and increased resource pooling and safety among those engaged in sex work	Mental health/ sexual health/ transitioning
Hines ⁴³	2	United Kingdom	Individual semistructured in-person interviews (Convenience)	30 (43% TM, 57% TW; Unclear)	Behavioral	Providing and receiving trans peer support reduced feelings of isolation and improved access to resources and health care	Mental health/ transitioning

(continued)

TABLE 1. (CONTINUED)

<i>Authors, reference</i>	<i>JB1 quality score: QL (QN)</i>	<i>Location (data collection years)</i>	<i>Study design: sampling (data collection method)</i>	<i>Sample characteristics: N (gender spectrum; race/ethnicity)</i>	<i>Type of TCC (measures used)</i>	<i>Findings related to TCC</i>	<i>Themes</i>
Moody et al. ⁴⁴	9	Canada (September 2010–February 2011)	Internet-based survey with open-ended questions (Convenience)	133 (42% TM, 47% TW, 25% NB ^d ; 82% W, 9% O, 5% MR, 5% API)	Emotional and behavioral	Realizing that other trans people exist and direct trans peer support were both protective against suicide	Mental health/transitioning
Pinto et al. ⁴⁵	5	New York City, NY, United States of America	Individual semistructured in-person interviews (Convenience)	20 (100% TW; 20% AA, 80% L)	Behavioral	Trans peer support improved access to care, resources, and support during and following transition	Access to care/transitioning
Rhodes et al. ⁴⁶	8	Durham and Wake counties, NC, United States of America	Photovoice (Convenience)	9 (100% TW; 100% L)	Emotional and behavioral	Trans peer support served to fill gaps in health services during and following transition; stigma associated with being trans impacted sexual health outcomes; family support improved individuals' sense of self-worth	Mental health/transitioning/sexual health
Quantitative studies Pflum et al. ²²	(8)	United States and Canada	Internet-based, self-administered quantitative cross-sectional survey (Convenience)	865 (31% TW, 47% TM, 4% NB/AMAB, 18% NB/AFAB; 88% W, 2% AA, 6% L, 4% MR)	Emotional	Among trans feminine spectrum participants, transgender community connectedness was significantly negatively correlated with depression and anxiety separately	Mental health
Bockting et al. ³⁴	(7)	United States of America (2003)	Internet-based, self-administered quantitative cross-sectional survey (Convenience)	1093 (58% TW; 43% TM; 79% W, 2% AA, 5% L, 2% API, 7% MR, 1% NA, 4% O)	Behavioral	Low and moderate levels of trans peer support reduced effects of stigma on psychological distress, but high levels did not	Mental health

(continued)

TABLE 1. (CONTINUED)

<i>Authors, reference</i>	<i>JBQ quality score: QL (QN)</i>	<i>Location (data collection years)</i>	<i>Study design: sampling (data collection method)</i>	<i>Sample characteristics: N (gender spectrum; race/ethnicity)</i>	<i>Type of TCC (measures used)</i>	<i>Findings related to TCC</i>	<i>Themes</i>
Testa et al. ³⁵	(2)	United States of America (2005–2006)	Internet-based, self-administered quantitative cross-sectional survey (Convenience)	3087 (70.5% TW, 21.1% TM, 5% NB/AMAB, 3.4% NB/AFAB; 87% W, 12% O)	Behavioral	Prior awareness and interaction with trans people were separately found to be correlated with lower levels of suicidality	Mental health
Mixed-methods studies							
Bockting et al. ³⁶	7 (6)	United States of America and Canada	(i) Individual semistructured interviews in person or by phone; (ii) Self-administered quantitative cross-sectional survey (Convenience and snowball)	101 (25% TM ^a 84% W, 4% API, 8% NA, 4% O)	Behavioral	Trans peer support provided a safe environment to explore sexuality and gender expression	Mental health/sexual health
Jokić-Begić et al. ³⁷	5 (2)	Croatia	(i) Internet-based, self-administered quantitative cross-sectional survey, including (ii) open-ended questions (Purposive)	6 (50% TM, 50% TW; Unclear)	Behavioral	Peer support assisted participants with self-acceptance during the transition process	Mental health/transitioning
Reisner et al. ³⁸	7 (4)	Boston, MA, United States of America (August–November 2008)	(i) Individual semistructured in-person interviews; (ii) self-administered quantitative cross-sectional survey (Convenience)	11 (100% TW; 36% W, 64% O)	Behavioral	Trans/gay mothers were pivotal in assisting health care navigation around sexual health and transitioning	Sexual health/access to care/transitioning

JBQ quality ratings: QL (0–10 best), QN (0–8 best). Mixed-methods studies were rated on both the qualitative and quantitative JBI scales.

^aThese studies also included comparison groups of gay/bisexual and heterosexual-identifying men who have sex with men³⁸ or a comparison group of nontransgender gay and bisexual men.³⁶ Findings from these participants were not reported in the review unless explicitly compared to findings from trans* people; thus, their demographics were not included in Table 1.

^bGender demographics for the participants of this study were not reported overall; thus, it is unclear how many trans*-identified people were in the study. However, findings reported in this study were extrapolated from trans*-identified participant data and quotes.

^cOne participant in this study identified as a cross dresser. Although considered a gender diverse identity, a cross dresser may not identify as trans* as defined in this review; thus, the findings reported in this review were extrapolated from reports of trans*-identified participants only.

^dParticipants were able to use multiple words to describe their gender identities; thus, the gender category percentage is over 100%.

AA, African American; AFAB, assigned female sex at birth; AMAB, assigned male sex at birth; API, Asian/Pacific Islander; JBI, Joanna Briggs Institute; L, Latinx; MR, multiracial; NA, Native American; NB, a person whose gender identity is nonbinary or lies outside of the man/woman dichotomy; NR, not reported; O, Other race not specified; OT, other transgender or nonbinary identity; POC, person of color; QL, qualitative; QN, quantitative; STI, sexually transmitted infection; TCC, trans* community connection; TM, trans man, that is, assigned female sex at birth and identifies as a man/masculine gender; TW, trans woman, that is, assigned male sex at birth and identifies as a woman/feminine gender; W, White.

TABLE 2. DESCRIPTION OF QUANTITATIVE MEASURES OF TRANSGENDER COMMUNITY CONNECTION

<i>Authors, reference</i>	<i>Type of TCC</i>	<i>Measures used</i>	<i>Description of scale</i>	<i>Reliability/validity</i>
Quantitative studies				
Pflum et al. ²²	Emotional	Gender Minority Stress and Resilience Measure [GMSR]; [Emotional] Transgender Community Connectedness Subscale	Five item; five-point Likert scale from strongly disagree to strongly agree	Cronbach's alpha 0.61–0.93
Bockting et al. ³⁴	Behavioral	(1) “What portion of your social time is spent with transgender people?” (2) “How often have you felt like you were the only transgender person in the area that you live?”	Seven-point Likert scale from none of the time to all of the time for Q1 and never to always for Q2	Test–retest reliability for $n=20$ was 0.87
Testa et al. ³⁵	Behavioral	“At what age did you first meet another transgender person?”	Participants were coded as having met another trans person before identifying as trans if the age span in which they first met another trans person was before the age span in which they first felt trans themselves	NR
Mixed-methods studies				
Bockting et al. ³⁶	Behavioral	Qualitative interviews displayed theme, “The Importance of Community”; participants reported sexual exploration with others in the transgender community	No quantitative scale reported	N/A
Jokić-Begić et al. ³⁷	Behavioral	Asked the degree to which participants were satisfied with the support provided to them during the ‘sex reassignment surgery’ process by trans individuals	No quantitative scale reported	N/A
Reisner et al. ³⁸	Behavioral	“If we were to develop an intervention or program for male-to-female transgender persons who perform sex work, what do you see as the most important areas on which to focus our efforts?”	No quantitative scale reported	N/A

NR, not reported; N/A, not applicable.

In addition, participants in this study reported that the Internet and social media were good places to connect with other youth who shared their racial/ethnic and gender identities.³² Participants found that interactions with racial/ethnic concordant trans* peers were affirming of both their racial/ethnic and trans* identities unlike among nonconcordant racial/ethnic peers.³² Concordant peers often became role models and a source of validation for racial and/or trans-specific life experiences.³²

A quantitative study of high quality (JBI quality score for quantitative studies [QN]=8/8; $N=865$ trans* people), which focused on emotional connectedness, found no significant differences in mean scores for emotional connectedness when comparing people of color who were categorized as having gender identities on the trans feminine spectrum (TFS)

(defined, in this specific study, as women or transgender women assigned male at birth, or nonbinary people assigned female at birth^a) and White TFS people.²² No other quantitative studies analyzed TCC by race/ethnicity. In the same study, there were no significant differences in emotional

^aThe TFS and TMS definitions in Pflum et al.²² are uncommon. Commonly, TFS and TMS are defined using sex assigned at birth and gender identity in the following manner: TFS is anyone assigned male at birth whose gender identity is more feminine than masculine (e.g., transgender woman and trans female); TMS is anyone assigned female at birth whose gender identity is more masculine than feminine (e.g., transgender man and trans male); and people with nonbinary identities that do not align with masculinity or femininity are categorized separately (e.g., agender and genderqueer).⁴⁹

connectedness scores when compared by living environment using one-way analysis of variance for TFS participants ($n=427$; 45% urban, 33% suburban, 14% small town, and 8% rural) and trans masculine spectrum (TMS) participants (defined, in this specific study, as men or transgender men assigned female at birth, or nonbinary people assigned male at birth; $n=438$; 53% urban, 25% suburban, 15% small town, and 7% rural).²² No other studies examined the influence of geographic location on TCC.

TCC and health outcomes

Gender transitioning. Among 20 included articles, 12 (60%) addressed the subject of gender transition related to TCC.^{28,30,37–46} Gender transition refers to the process whereby a person changes their gender expression from that associated with their sex assigned at birth to one that matches their current gender identity.⁵⁰ Most articles in this category focused on behavioral participation with trans* peers only ($n=10/12$),^{28,30,37–43,45} while 2 of 12 covered behavioral participation and emotional connectedness.^{44,46} Most of these articles employed varying qualitative methods ($n=10/12$)^{28,30,39–46} and 2 of 12 applied mixed methods^{37,38}; see Table 1 for details regarding all included articles. Almost half of the samples in this group included people of different genders ($n=5/12$).^{37,39,40,43,44} Six of the 12 articles included only transgender women^{28,38,41,42,45,46} and the final study did not report gender identities for all participants ($n=1/12$).³⁰

Although quality varied (see Table 1 for quality scores), several articles reported that TCC helped to improve health-related behaviors, such as setting appointments to receive hormones.^{28,30,38,43,45} Participants from three qualitative studies of high quality (ranging QL=9/10–10/10) indicated that providing emotional support or guidance to others during their gender transition improved the mental health of the provider of said support.^{31,39,40} However, the most common theme noted among the majority of these studies was that receiving emotional support and validation from trans* peers helped trans* people feel less alone and aided in improving mental health related to gender transition for the receiver.^{28,30,37,39,40,42–46}

Mental health. TCC was found to be linked to mental health/wellbeing and was the topic of the majority of articles identified ($n=16/20$).^{22,30–37,39–44,46} Mental health/wellbeing topics included emotional resilience ($n=3/16$),^{31–33} suicidality ($n=3/16$),^{35,39,44} undefined general mental health ($n=3/16$),^{30,36,41} isolation ($n=2/16$),^{42,43} depression ($n=2/16$),^{22,34} anxiety ($n=2/16$),^{22,34} sense of self-worth ($n=1/16$),⁴⁶ positive coping behaviors ($n=1/16$),⁴⁶ and self-acceptance ($n=1/16$).³⁷ Most of these articles focused on behavioral participation only ($n=13/16$),^{30–37,39–43} whereas one explored emotional connectedness only ($n=1/16$)²² and two covered both behavioral participation and emotional connectedness ($n=2/15$).^{44,46}

The largest number of articles in this area employed qualitative methods ($n=11/16$),^{30–33,39–44,46} with far fewer using quantitative methods ($n=3/16$),^{22,34,35} and two using a mix of both quantitative and qualitative methods.^{36,37} Most samples included multiple subgroups of trans* people ($n=11/16$),^{22,31–35,37,39,40,43,44} while three studies had homogeneous samples that only included transgender women.^{41,42,46}

A large ($N=1093$), predominantly White (79%), sample of transgender men and transgender women participated in a high-quality (QN=7/8) cross-sectional survey study, which revealed that TCC, through behavioral participation, moderated the association between stigma and psychological distress at low and moderate, but not high levels of trans* peer support, which suggests a ceiling effect (referring to the point at which the amount of behavioral participation no longer affects the psychological distress noted) that was not explored elsewhere.³⁴ A similarly designed high-quality study (QN=8/8; $N=865$, including transgender men, transgender women, and nonbinary people; 88% White) found that emotional connectedness was significantly negatively correlated with symptoms of depression and anxiety for TFS participants, but not for TMS participants.²²

As seen among articles focused on gender transition,^{28,30,37,39,40,42–46} qualitative interviews from several studies of trans* people showed that trans* peer support had a positive relationship with participants' emotional experiences and helped reduce suicidality through the provision of emotional support.^{31,39,44} Specifically, one of these articles reported that it was typically trans* peers who provided support when participants were suicidal.³¹ Participants from another study reported being known and respected in the trans* community for not acting on suicidal intentions.⁴³

TCC has been linked with the development of coping strategies and emotional resilience.^{31,33,39,40} Budge et al. (QL=9/10) used grounded theory among a sample of 15 trans* people to identify facilitative and avoidant coping behaviors throughout gender transition and found that actively seeking social interactions with the trans* community, attending support groups, and relying on trans* people for help were found to be facilitative coping behaviors.⁴⁰ Another high-quality study (QL=10/10) with 19 trans* youth reported that some trans* support groups were either not tailored to their other social identities (e.g., race/ethnicity) or focused too highly on medical transitioning.³³ Trans* people also reported that being able to provide and receive guidance and support from trans* peers provided them with a sense of pride, meaning, success, and increased emotional resilience.^{31,33,39}

Sexual health. Among 20 included articles, 6 articles (30%) addressed the subject of sexual health in relation to TCC, specifically related to behavioral participation in the trans* community.^{28,29,36,38,42,46} Most of these articles employed qualitative methods ($n=4/6$),^{28,29,42,46} while the remainder employed both quantitative and qualitative methods ($n=2/6$).^{36,38} One of the six studies had only transgender men³⁶ (not including the comparison group of nontransgender gay and bisexual men) and the remaining studies only included transgender women ($n=5/6$, not including comparison groups of gay/bisexual and heterosexual-identifying men who have sex with men);²⁸ see Table 1.^{28,29,38,42,46}

Many trans* people who disclose their gender identity to their family experience rejection, which can result in social vulnerability to exploitation.^{38,42} This biological family void is often replaced by “chosen families” (e.g., self-identified family members who are not related by blood or marriage) comprised of lesbian, gay, bisexual, transgender, and queer (LGBTQ+) peers.^{29,38,42} One study (QN=6/8; QL=7/10) with a sample of transgender men who were predominantly White ($n=21/25$) found that interaction with trans*

peers provided a safe environment to explore one's sexuality and gender expression.³⁶ Meanwhile, in some instances, a gender questioning person's first access to the visible community of transgender women has been through street engaged transgender women who trade sex.²⁹ One participant from this qualitative study (QL=8/10) noted that sex work was almost like a rite of passage for young transgender women and was viewed as a way to connect with the trans* community.²⁹ In some instances, chosen families and trans* mothers (trans* people who take on a maternal role for nonbiological kin) have introduced transgender women to sex work (e.g., trading sex for money, housing, and/or safety); however, transgender women who trade sex often report doing so to offset a lack of income and shelter due to employment and housing discrimination.^{28,29,38} Trans* mothers and trans* peers in these situations have provided support to newly transitioning trans* people by teaching them how to find sex work clients and care for their sexual health, and by sharing shelter and resources.^{29,38,42}

However, sex work environments can be dangerous and competitive, stemming from the limited number of sex work clients.^{28,51} This competition affected the lives of a few participants from one qualitative study (QL=7/10) of transgender women ($N=8$) who, in turn, expressed concerns about confidentiality while attending trans*-specific clinic days.²⁸ These participants reported a fear of trans* peers starting rumors or disclosing the participant's HIV status against their will to potential sex work clients or peers.²⁸ In contrast, a common theme from this study found that some participants felt a sense of belonging (emotional connectedness) at the clinic in their area because they provided a designated clinic schedule for trans* sex workers with knowledgeable staff and free services.²⁸

Access to care. Among 20 included articles, 3 (15%) assessed relationships between access to care and TCC, specifically behavioral participation in the trans* community.^{30,38,45} Two articles used qualitative methods,^{30,45} while one article used mixed methods.³⁸ Samples were limited to transgender women and were comprised of more than 50% people of color.^{38,45} In one study, the gender identities were not reported clearly, and over 80% of the sample was White.³⁰ All articles provided context for how community engagement encouraged transgender individuals in urban environments to seek out health care for gender transition-related needs, sexually transmitted infection testing, and preventive care.^{30,38,45}

Discussion

Across all of the articles reviewed, TCC was linked with several positive health outcomes, including improved mental health, increased connection to care, increased comfort with the exploration of sexual and gender identities, and informed gender transition. Unfortunately, TCC was not the primary focus of the majority of articles; therefore, the breadth and depth of results (both quantitative and qualitative) were minimal. This lack of detail and the limited number of articles addressing a broad range of relationships to TCC made data synthesis challenging.

Some specific findings may guide and inform future research. Variations in the strength of the effect of TCC on symptoms of depression and anxiety were noted between TFS and TMS participants in one quantitative study²²; how-

ever, this study used unique categorizations for TFS and TMS that are not reflective of many studies in trans* health research.^{52,53} This study defined TFS generally as women or transgender women assigned male at birth, or nonbinary people assigned female at birth, and TMS as men or transgender men assigned female at birth, or nonbinary people assigned male at birth.²² This unique categorization makes the findings from Pflum et al.'s study unclear; however, this article was one of only three included articles that looked at gender differences at all.^{22,34,35} Findings from those studies suggest that there may be differences in how people of different gender identities interact with the trans* community and how influential TCC may be; thus, more research with gender diverse samples using consistent measurement is needed to better understand these potential differences.^{22,34,35}

Another finding from one high-quality quantitative study with transgender women stood out among the research and suggested a potential ceiling effect—referring to the point at which the amount of behavioral participation no longer affected the psychological distress noted.³⁴ This potential ceiling effect is understudied, and it is unclear what could be influencing this phenomenon. One may infer that those with the highest behavioral participation scores could be exposed to additional stigma or other factors affecting psychological distress, such as being publicly “outed” by association with others who are visibly trans*.^{17,32–34} More research is needed to better understand this effect.

TCC was also associated with exposure to sex work and may deter transgender women from getting sexual health testing and treatment due to fear of being observed at specialized clinics and subsequent loss of confidentiality among peers.²⁸ This finding regarding a potential loss of confidentiality is troubling, especially because there are strong calls for trans* community representation in health care settings.⁵⁰ Many clinics are recruiting trans* people as staff, and this may further deter health-seeking if proper confidentiality training and community trust are not assured.¹⁸ In addition, participants reported that the clinic provided a trans*-specific clinic day, which caused concern that their trans* peers (who were also patients attending the clinic) would disclose their presumed health information to others in the community.²⁸ This finding may be related to a heightened awareness of other trans* peers due to the modest size of many local trans* communities and the potential competition for resources as noted previously.

Intersectionality—the experiences of oppression and/or privilege experienced by a person based on their multiple, co-occurring identities (e.g., race, ethnicity, sexual orientation, and gender identity)—is an important consideration for the examination of TCC and related health outcomes.⁵⁴ The effects of intersectional identities are far-reaching, influencing interactions with health systems and health professionals, and whether one has access to care, ultimately affecting health outcomes.^{55–57} The research included in this review alluded to the intersectional nature of ethnicity/race, gender, geographic location (urban/rural), and age as important to consider when discussing TCC; however, the included articles (even those that alluded to the effect of additional social variables) failed to examine the nuanced relationship between health outcomes and TCC through an intersectional lens. For example, geographic location may affect the size of the community, and the accessibility of

community members or community, thereby affecting TCC. In addition, health disparities may be heightened in less populated areas with reduced access to trans* health providers. However, only one article examined the effects of geographic location and found no significant difference in TCC by location, most likely related to the small sample sizes within each group—highlighting the need for trans* research with more robust sample sizes.²²

Similar findings of no difference in TCC were found regarding race/ethnicity in the aforementioned study.²² Racial/ethnic communities may have social norms that could affect TCC and health outcomes differently. Connections to multiple different communities may provide additional protections or opportunities for harm^{32,33}; for example, race- or ethnicity-based community may provide protection from racism, but may perpetuate cisgenderism, or vice versa. Regardless, Pflum et al.'s study had a small sample of people of color and was unable to look at nuances between subgroups, and did not find any differences between White participants and participants of color.²² This study also did not take an intersectional lens to extrapolate any nuance in findings, while considering multiple identities.²²

Often, articles included in this review that used rigorous methods and study designs did not recruit large, diverse samples based on ethnicity/race and gender identity; therefore, the extent to which intersectionality, identity, and demographic factors influence TCC and health disparities remains unclear. This issue calls for researchers to strive to recruit more diverse and representative samples to investigate whether differences are significant and nuances impact health outcomes for different groups. The overrepresentation of transgender women in many studies also may affect how the larger trans* population is understood and how systems and programs are developed by assuming uniformity in experience. More research with transgender men and nonbinary people is needed, and future research should consider the implications of power and oppressive differentials and their effects on interacting subcommunities of trans* people.

As mentioned previously, many of the included articles were narrow in scope and depth concerning the investigation of TCC and health outcomes. Among the included articles, topic areas included (i) gender transitioning, (ii) mental health, (iii) sexual health, and (iv) access to care. The majority of the research focused on mental health (80%) and the gender transition (60%) period, which may work to perpetuate historical pathological models that viewed gender nonconformity as a symptom of psychopathology. Such pathologizing models have since been removed from the Diagnostic and Statistical Manual of Mental Disorders (DSM), and the International Statistical Classification of Diseases and Related Health Problems (ICD), as has the stigmatizing diagnosis of Gender Identity Disorder.^{58,59} The DSM, for example, now includes the diagnosis of gender dysphoria, which emphasizes that the focus of treatment is on the dysphoria, not the gender identity, while the ICD has named this entity “Gender Incongruence” and does not classify it as a mental disorder.^{58,59}

Much research refutes earlier notions that trans* people are inherently mentally ill by identifying socially produced disparities in exposure to oppression, stigma, and violence, as well as associated health outcomes. This early emphasis

on mental health combined with influential funding streams incentivizing HIV-related inquiry has skewed trans* health research resulting in minimal physical health coverage beyond HIV and mental health contexts. Overall, further research is needed to investigate additional physical health outcomes that could be influenced by TCC.

The articles in this review suggest that TCC increases health care access; however, the duration of this effect was not addressed. There are not enough data to determine whether transgender people continue to seek services regularly or if the effect dissipates over time. No evaluation of treatment-related behaviors or medication adherence was made. Further examination of how TCC may be related to treatment and medication adherence for those with chronic diseases is an important area for future research.

The validity and reliability of many current measures assessing TCC and behavioral participation have yet to be adequately psychometrically evaluated with trans* samples. The included articles also did not adequately measure both behavioral participation and community connectedness; thus, the findings often do not provide a holistic picture of TCC. In addition, the recruitment of participants from trans-focused outlets and by snowball sampling may have produced a bias toward people who are more connected to the transgender community, and therefore limits the generalizability of the findings.

Finally, the current TCC literature presents mostly cross-sectional data, which limit causal inferences being made about the relationship between community connectedness and potential health outcomes. More robust longitudinal data would establish whether there are stronger connections and assist in the identification of modifiable factors to improve the impact of TCC. In addition, more mixed methods and rigorous sampling for future studies are needed to provide a comprehensive understanding of nuances within subgroups of trans* people.

Strengths and limitations

The dual reviewer systematic identification and appraisal of the included articles is a considerable strength of the review. Data extraction was completed solely by the first author; however, this limitation was addressed by a 25% audit of extracted data performed by an additional team member. The standardized measures used in the appraisal process increase the reliability of the review; however, the quality appraisal method to assess mixed-methods articles was not ideal because of a lack of tools available to assess mixed-methods articles. Thus, appraisals for mixed-methods articles reviewed should be considered within this limitation. In addition, relevant articles may have been missed due to the exclusion of articles published before 2007, gray literature, dissertations, and quantitative articles on processes or measure development. Although articles had to be published from January 1, 2007, to November 1, 2017, several articles reported findings from data collected many years before 2007. Thus, findings from these more dated sources may be less representative of the current community influences within trans* communities. However, this review provides a meaningful synthesis of the current state of TCC peer-reviewed research in attempts to guide further investigation.

The way forward: recommendations

This systematic research review highlights the main findings despite the inconsistencies within the research addressing associations between TCC and trans* health and wellbeing. The quality of the articles varied widely. Results referencing subgroup analysis by gender and ethnicity/race were often unreliable due to sampling size and measurement inadequacies. Future development and testing of new and current instruments to accurately measure TCC among different subgroups will improve the quality and rigor of the data that emerge. With valid and reliable measures, the next step would be to design more longitudinal studies to allow for causal effects to be evaluated. Recruitment of participants from non-trans*-specific environments will allow researchers to capture a broader sample of people with high and low TCC and that is more representative of different races/ethnicities in all subgroups of trans* people. Moreover, rigorous purposive sampling methods may assist in recruiting more ethnically/racially and gender diverse samples to provide a better understanding of the nuances affecting different subgroup communities.^{60,61}

Finally, the current literature examining TCC has focused overwhelmingly on the gender transition period, which fails to acknowledge potential influences on health before and following transition. Health care professionals have an obligation to address health disparities throughout the lifespan, especially for trans* people who are disproportionately exposed to violence and stigma. It is paramount that health professionals and researchers work together to better understand health disparities affecting trans* people and develop interventions to reduce barriers to care, ultimately contributing to the improvement of health among trans* people. Future research should expand upon existing literature and investigate how to leverage TCC to improve physical health, mental health, and general health care access and utilization.

Conclusion

Although there is substantial literature describing a predominantly positive relationship between TCC and the health and wellbeing of trans* people, opportunities remain. This review establishes that the measurement of TCC and its application are broad and inconsistent. The development of more consistent measures of TCC could provide effective tools in future intervention-based studies leveraging TCC to improve health outcomes for trans* people.

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